AMERICAN COLLEGE OF SURGEONS

Optimal Resources for Breast Care

2027 STANDARDS

Effective January 2027

ACS AMERICAN COLLEGE OF SURGEONS SURGICAL QUALITY PARTNER

ACS NAPBC Breast Center Accreditation

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Important Note
The intent of the ACS NAPBC *Optimal Resources for Breast Care (2027 Standards)* is to provide healthcare professionals with evidence-based information regarding care of the patient. The *Optimal Resources for Breast Care (2027 Standards)* does not include all potential options for prevention, diagnosis, and treatment, and are not intended as a substitute for the provider's clinical judgment and experience. Responsible clinicians must make all treatment decisions based upon their independent judgment and the patient's individual clinical presentation.

The *Optimal Resources for Breast Care (2027 Standards)* is not intended to be a comprehensive guide to all services, personnel, and processes needed to conduct surgery. The guidance herein does not constitute a standard of care and is not intended to replace the medical judgment of the physician or healthcare professional in individual circumstances. Although these have been reviewed with significant care, these 2027 Standards are provided "as is" with all faults and without liability. To the maximum extent permitted by law, ACS disclaims any and all express or implied representations and warranties with respect to these materials, including any express or implied warranty of merchantability, fitness for a particular purpose, accuracy, or non-infringement. The entire risk as to the satisfaction, quality, performance, and use of this licensed material shall be with the user. The ACS and any entities endorsing these 2027 Standards shall not be liable for any direct, indirect, special, incidental, or consequential damages related to the use or misuse of the information contained herein. The ACS may modify the 2027 Standards at any time without notice.

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Important Information

These standards are intended solely as qualification criteria for National Accreditation Program for Breast Centers (NAPBC) accreditation. They do not constitute a standard of care and are not intended to replace the medical judgment of any physician or healthcare professional in individual or general circumstances.

"Standard" as used in *Optimal Resources for Breast Care (2027 Standards)* is defined as a "qualification for accreditation," not standard of care.

In order for a program to be found compliant with the NAPBC standards, the program must be able to demonstrate compliance with the entire standard as outlined in the **Definition and Requirements, (including, if applicable, the Requirements for Integrated Network Breast Programs [INBP]), Documentation,** and **Measure of Compliance** sections under each standard. The **Documentation** and **Measure of Compliance** sections under each standard are intended to provide summary guidance on how compliance must be demonstrated but are not intended to stand alone or supersede the **Definition and Requirements.**

In addition to verifying compliance with the standards as written and outlined in *Optimal Resources for Breast Care (2027 Standards),* the NAPBC may also consider additional administrative factors when reviewing a program for accreditation. The NAPBC reserves the right to withhold accreditation based on such factors. Examples include, but are not limited to, non-payment of accreditation invoices and outstanding fees, failure to schedule or complete an accreditation site visit in a timely manner, and failure to properly remit any or all contracts and contractual obligations related to NAPBC accreditation.

Confidentiality Requirements

The American College of Surgeons (ACS) National Accreditation Program for Breast Centers (NAPBC) expect NAPBC-accredited programs to follow local, state, and federal requirements related to patient privacy, risk management, and peer review in complying with or providing information to demonstrate compliance with standards of accreditation. These requirements vary from state to state.

Acknowledgments

The National Accreditation Program for Breast Centers (NAPBC) is thankful to its Member Council, the representatives of the national professional organizations dedicated to breast health, and the members of the NAPBC Standards Revision Project who were vital to the completion of *Optimal Resources for Breast Care (2027 Standards)*. The NAPBC is grateful to all those who provided thoughtful and essential comments during the public feedback period. The NAPBC acknowledges the extensive contributions of the following people who participated in the creation of *Optimal Resources for Breast Care (2027 Standards).*

Contributors

Volunteer Contributors
Zahraa Al-Hilli, MD, FACS
Amanda Amin, MD, FACS
Wendy Austin, RN, MS, AOCN, COA, NEA-BC, FACHE
Lora Barke, DO
Paul Baron, MD, FACS
Arnold Baskies, MD, FACS
Clara Beaver, DNP, MSN, RN, AOCNS, ACNS, BC
Richard Bleicher, MD, FACS
Cynthia Boudreaux, LPN, ODS
Vanessa Bramble, MS, MBA, FACHE, CRA, RT (R)(M) (ARRT)
Susan Brown, MS, RN
Helen Cappuccino, MD, FACS
Teralyn Carter, MD, FACS
Lauren Chatalian, LMSW
Lynn Damitz, MD, FACS
Jill Dietz, MD, MHCM, FACS
Firas Eladoumikdachi, MD, FACS
Ricki Fairley
Amy Fowler, MD, PhD
Jana Fox, MD
Sarah Friedewald, MD
Sue Friedman, DVM
Megan Frone, MS, CGC
Nancy Gantt, MD, FACS
Hannah Gilmore, MD
Mehra Golshan, MBA, MD, FACS
Teresa Heckel, MBA
Suzanne A. Hoekstra, MD, FACS
Regina Hooley, MD
Andrew J. Huang, MD
Christie Jett, MS, LCGC
Kathie-Ann Joseph, MD, MPH, FACS
Laurie Kirstein, MD, FACS
Scott Kurtzman, MD, FACS
Melissa Lazar, MD, FACS
Christoph Lee, MD, MS, MBA
Stacy Lewis
Xiaoxian (Bill) Li, MD, PhD
Sharp Malak, MD, MPH
Denise Mammolito, MD, FACS
Colleen McCarthy, MD
Jane Meisel, MD
Shirley Mertz, MA, JD
Meena Moran, MD
Linda Moy, MD
Timothy Mullett, MD, FACS, MBA
Toan Nguyen, MD, FACS
Penne J. Perry, ODS-C
Megan Pfarr, DPT, CLT
Susan Pories, MD, FACS
Liza Quintana, MD
Richard Reitherman, MD, PhD
Jean Rosiak, DNP, RN, ANP-BC, AOCNP, CBCN
Colette Salm-Schmid, MD, FACS
Terry Sarantou, MD, FACS
Tara Schapmire, PhD, MSSW, OSW-C, FNAP, FAOSW
Kathryn Schmitz, PhD, FACSM, FTOS, FAK
Georgia Spear, MD
Randy Stevens, MD
Roberta Strigel, MD, MS
Margaret Szabunio, MD, FACR
Lauren Teras, PhD
Deborah Toppmeyer, MD
Kimberly VanYsseldyk, FNP-BC, AOCNP
B. Marie Ward, MD, FACS
Sally Werner, RN, BSN, MHA
Barbara A. Wexelman, MD, MBA, FACS
Lee Wilke, MD, FACS
Katharine Yao, MD, MS, FACS
Robin Zon, MD, FACP, FACS

American College of Surgeons Staff Contributors
Karen Taubert-Boone
Vicki Chiappetta, RHIA, ODS
Lauren Dyer
Paul Jeffers
Marci Ramahi
Allison Reese
Erin Reuter, JD, MS
Ciara Rounsaville
Amy Sachs, MSHS
Jacob Schamber
Karen Stachon, CPHQ
Alana Swanson
Amy Szkorla, MPH
Ronald Weigel, MD, FACS
Kalea Whitmore, MBA

About the NAPBC

The National Accreditation Program for Breast Centers (NAPBC) is a quality program of the American College of Surgeons, assisted by representatives from other national professional organizations focused on breast health. The NAPBC is dedicated to the improvement of quality outcomes for patients with breast disease and breast cancer through the implementation of multidisciplinary care guided by evidence-based accreditation standards and comprehensive professional and patient education.

The NAPBC: Background and the Value of Accreditation
The evaluation and management of patients with diseases of the breast historically occurred in a fragmented and disorganized clinical setting. In a complex clinical environment involving a multitude of healthcare professionals and clinicians, patients are best served by utilizing multidisciplinary coordination. This team-based approach to patient care resulted in the birth of the "breast center" concept in the United States in the 1970s. In recent decades, there has been a proliferation of breast centers providing care to the thousands of patients diagnosed with breast cancer, as well as addressing the equally compelling needs of the many patients presenting with non-malignant breast diseases.

Evidence-based and consensus-developed standards have garnered widespread recognition and ever-increasing importance. The United States healthcare system is undergoing a dramatic transformation centered on data-driven quality improvement and documentation of adherence to widely accepted standards of care for all diseases, including those of the breast.

In order to improve the quality of patient evaluation and management of patient care, NAPBC accreditation is granted to breast programs that demonstrate compliance with the standards established herein.

CoC Accreditation
Commission on Cancer (CoC) accreditation is required for NAPBC accreditation starting with programs that apply for an initial site visit in 2026 and beyond. The NAPBC standards build upon the CoC standards with focus on caring for patients with breast disease or breast cancer.

If the affiliated CoC accreditation is withdrawn or discontinued, the NAPBC accreditation will also be discontinued.

Integrated Network Breast Programs
Facilities belonging to an organization that owns a group of facilities that offer integrated and comprehensive breast care services may participate in NAPBC accreditation as an Integrated Network Breast Program (INBP). These facilities must be overseen by a centralized governance structure/board and CEO. Participating in an INBP is voluntary and includes a separate application process. The NAPBC standards have modifications for INBPs that must be followed, which are outlined within each applicable standard under "Requirements for Network Breast Programs." More information on INBPs may be found in the Quality Portal.

Standards Interpretation

NAPBC-accredited programs must understand, implement, and demonstrate compliance with the accreditation standards outlined in *Optimal Resources for Breast Care (2027 Standards)* as written and defined by the NAPBC. While a full glossary of terms is provided at the end of this manual, it is important to establish definitions for several of these key terms prior to reading the accreditation standards.

Accredited Program(s): A single or multiple-location medical institution providing diagnostic services, treatment services, and comprehensive multidisciplinary care for patients with breast disease or breast cancer, which has achieved accreditation by the National Accreditation Program for Breast Centers (NAPBC). This also refers to initial applicant programs that are actively pursuing accreditation with the NAPBC.

Calendar year review: Compliance criteria requiring annual review must be completed at least once for each full calendar year (January 1 – December 31).

"Each accreditation cycle" review: Compliance criteria requiring review each accreditation cycle must be completed at least once every three years during the NAPBC-accredited program's accreditation cycle.

Protocol: 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 affiliated, but individually accredited, NAPBC-accredited programs are acceptable. Such protocols must be specifically stylized for each affiliated program and formally approved by each BPLC, as applicable. Protocols do not need to be officially recognized hospital or institutional policies. **Please refer to the NAPBC 2027 Standards FAQ for guidelines and recommendations related to the development of protocols.**

It is the responsibility of all NAPBC-accredited programs to read *Optimal Resources for Breast Care (2027 Standards)* in its entirety and demonstrate compliance with all applicable requirements for all applicable standards.

Breast Program Leadership Committee Evaluations

Specific NAPBC standards require the BPLC to review and assess various aspects of the NAPBC-accredited program, such as elements of care, adherence to required protocols, resource allocation, and patient services.

The following NAPBC standards require annual review, at least once **each calendar year.** These BPLC evaluations must be documented in the BPLC meeting minutes and must take place within the same calendar year on which they are based or no later than the first quarter of the following calendar year.

- Standard 5.5: Evaluation and Treatment Planning
- Standard 7.1: Quality Measures

The following standards must be reported at the first-quarter meeting of the following year. The report must include a full calendar year of reporting data. For example, reports on 2025 activity must include data from all of 2025 and be reported at a meeting in the first quarter of 2026. Reports provided to the BPLC without a full calendar year of reporting data do not meet the measure of compliance for these standards. The reports must be documented in the BPLC meeting minutes and include all required elements.

- Standard 2.4: Multidisciplinary Breast Care Conference
- Standard 9.1: Clinical Research Accrual

The annual review requirements are summarized in the table below:

The following NAPBC standards require review at least once **each accreditation cycle.** These BPLC evaluations must be documented in the BPLC meeting minutes and must take place within the same accreditation cycle on which they are based.

- Standard 5.1: Screening and Diagnostic Imaging
- Standard 5.2: Evaluation and Management of Benign Breast Disease
- Standard 5.3: Population-Based Risk Assessment and Management of Patients at Increased Risk for Breast Cancer
- Standard 5.4: Genetic Evaluation and Management
- Standard 5.6: Patient Navigation
- Standard 5.7: Function and Movement for Patients with Breast Cancer
- Standard 5.8: Lymphedema Assessment
- Standard 5.9: Breast Cancer Staging
- Standard 5.10: Surgical Care
- Standard 5.15: Return to Wellness
- Standard 5.16: Surveillance

The following NAPBC standard requires reporting to the BPLC on project status and completion. These reports must be documented in the BPLC meeting minutes and must take place twice per calendar year while the project is active.

- Standard 7.2: Quality Improvement Initiatives

Standard	Data Required	Review Timeframe
Standard 2.4: Multidisciplinary Breast Care Conference	Full calendar year	Q1 of the following year
Standard 5.5: Evaluation and Treatment Planning	12 months of observations	During the year of activity or Q1 of the following year
Standard 7.1: Quality Measures	Activity completed	During the year of activity
Standard 9.1: Clinical Research Accrual	Full calendar year	Q1 of the following year

Accreditation Process

Processes for accreditation are detailed and updated on the NAPBC website and within the Quality Portal. The NAPBC reserves the right to revise accreditation processes as needed.

Accreditation Awards

Compliance ratings for each standard are decided based on consensus by the assigned NAPBC site reviewer and the NAPBC staff. When required, the NAPBC executive reviewers will also contribute to the compliance rating decision as the final adjudicators.

Each standard is rated as "Compliant," "Non-Compliant," or "Not Applicable."

Accreditation Status	Definition
Accredited	Awarded when a program has completed the site visit process and demonstrated full compliance with all applicable standards. **Accredited** outcomes: • Program appears on the "Find an Accredited Program" website • Program has full access to the Quality Portal and its related resources • Certificate of accreditation is awarded
Accredited – Corrective Action Required ***Renewal Programs Only***	Awarded when a renewal program receives a non-compliant rating for at least one applicable standard but fewer than: • Six applicable standards rated during the site visit process if CoC-accredited OR • Seven applicable standards rated during the site visit process if not CoC-accredited **Corrective Action** outcomes: • Program has 12 months from the date of the accreditation report to resolve all non-compliant standards ratings • Program appears on the "Find an Accredited Program" website • Program has full access to the Quality Portal and its related resources • Certificate of accreditation is awarded after all non-compliant standards ratings have been resolved and **Accredited** status has been achieved
Not Accredited – Corrective Action Required ***Initial Applicants Only***	Awarded when an initial applicant, including new Integrated Network Breast Programs consisting of currently accredited programs, receives a non-compliant rating for three or fewer applicable standards rated during the site visit process. **Not Accredited Corrective Action** outcomes: • Program has 12 months from the date of the accreditation report to resolve all non-compliant standards ratings • Program does **not** appear on the "Find an Accredited Program" website • Program has full access to the Quality Portal and its related resources • Certificate of accreditation is awarded after all non-compliant standards ratings have been resolved and **Accredited** status has been achieved
Not Accredited	Awarded when a renewal program receives a non-compliant rating for: • Six or more of the applicable standards rated during the site visit process if CoC-accredited OR • Seven or more applicable standards rated during the site visit process if not CoC-accredited Awarded when an initial applicant receives a non-compliant rating for four or more applicable standards rated during the site visit process. Awarded when any program does not resolve all non-compliant standards within the established timeframe for corrective action. **Not Accredited** outcomes: • Program does **not** appear on the "Find an Accredited Program" website • Program does **not** have access to the Quality Portal • Program may re-apply for accreditation as an initial applicant after documenting one calendar year of compliance with all applicable standards

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Institutional Administrative Commitment

Rationale

This chapter is designed to help NAPBC-accredited programs utilize their available resources, services, and administrative support to provide the best possible care to all patients with breast disease or breast cancer. Institutional administration must support the NAPBC-accredited program with aligned goals for patient experience, service, and high-quality care.

1.1 Administrative Commitment

Definition and Requirements

NAPBC-accredited programs must provide a letter of authority from facility leadership (CEO or equivalent) demonstrating commitment to the NAPBC-accredited program. The letter of authority must include, but is not limited to:

- A high-level description of the NAPBC-accredited program
- Any initiatives involving the NAPBC-accredited program during the accreditation cycle that were initiated for the purposes of ensuring quality of care and patient safety
- Facility leadership's involvement in the NAPBC-accredited program
- Examples of current and future initiatives promoting equitable and inclusive healthcare practices and a culture of safety for providers and patients
- Examples of current and future financial investment in the NAPBC-accredited program (**for example**, plans for equipment purchases or expanded services)

Requirements for Integrated Network Breast Programs

In addition to or included within the letter of authority, the INBP must provide a descriptive document that addresses the following elements:

- The organizational structure of the network, including all facilities within the network
- The distribution of breast disease and breast cancer services across the network and its facilities, including surgery, reconstructive surgery, pathology, radiology, medical oncology, and radiation oncology
- Processes that facilitate integration, coordination, and collaboration across the facilities in the network

Documentation

Submitted with Pre-Review Questionnaire

- Letter of authority from facility leadership that includes all required elements
- **Networks:** A descriptive document outlining the organizational structure of the INBP that includes all required elements

Measure of Compliance

Each accreditation cycle, the NAPBC-accredited program fulfills all compliance criteria:

- NAPBC-accredited program authority is established and documented through a letter from facility leadership that includes all required elements.
- **Networks:** The organizational structure of the INBP is outlined in a document that includes all required elements.

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Program Scope and Governance

Rationale

The NAPBC Standards are designed to provide multidisciplinary care to all patients with breast disease or breast cancer. The leadership structure outlined in Chapter 2 promotes multidisciplinary oversight for the entire NAPBC-accredited program and accountability for fulfilling the measures of compliance for each standard.

2.1 Breast Program Leadership Committee

Definition and Requirements

The Breast Program Leadership Committee (BPLC) is the governing body of a NAPBC-accredited program and is chaired by the Breast Program Director (BPD). Each NAPBC-accredited program must have its own BPLC.

At minimum, the BPLC must consist of at least the following members:

- Three physicians representing three different medical disciplines
  - One of the physician members must be the BPD

AND

- Two healthcare professionals representing different disciplines related to the management and/or care of patients with breast disease or breast cancer
  - The healthcare professional members cannot be physicians
  - The healthcare professional members may represent any different disciplines, including, but not limited to, the non-physician BPLC member disciplines outlined below

The BPLC is responsible for establishing the core group of healthcare providers who contribute to the various patient care protocols developed by the NAPBC-accredited program. The BPLC must plan, implement, evaluate, and improve all breast-related activities provided by the NAPBC-accredited program. The BPLC must maintain accurate meeting minutes, including documentation of meeting attendance for all appointed members, designated alternates, and any additional individuals in attendance.

Examples of BPLC member disciplines include, but are not limited to:

- Pathology
- Radiology
- Surgery
- Medical oncology
- Radiation oncology
- Reconstructive surgery
- Physical medicine
- Genetic professionals
- Nursing
- Oncology Data Specialists (ODS)
- Research
- Radiology technologists
- Registered dietitian nutritionists
- Navigation professionals
- Social work
- Hospital administration

It is recommended, but not required, that a community representative and/or patient representative be a full member of the BPLC.

Membership appointments to the BPLC must occur at the first meeting of a calendar year at least once during the accreditation cycle. All appointments must be documented in the BPLC meeting minutes. If an appointed member cannot continue to serve on the BPLC, a new member must be appointed at the next BPLC meeting, with documentation of the new appointment included in the BPLC meeting minutes.

One designated alternate member may be identified for each appointed member of the BPLC. Designating an alternate is optional. Only one alternate may be designated for each appointed member of the BPLC.

Designated alternates must meet all the applicable requirements for BPLC membership outlined in this standard. Designated alternates for the three physician members must also be physicians who are qualified to serve on the BPLC. Designated alternates for the two healthcare professional members must also be healthcare professionals who are qualified to serve on the BPLC. Appointed BPLC members and their designated alternates are not required to represent the same medical discipline. An individual may only serve as an alternate for a single appointed member of the BPLC.

The identification of designated alternates must occur at the first meeting of a calendar year at least once during the accreditation cycle. All designated alternates must be documented in the BPLC meeting minutes. If a designated alternate cannot continue to serve on the BPLC, a new alternate may be designated at the next BPLC meeting, with documentation of the new designated alternate included in the BPLC meeting minutes.

Requirements for BPLC membership:
- Physician BPLC members must possess current medical licensure and active medical staff appointment
- Healthcare professional BPLC members must have appropriate qualifications/certifications in their field

Each calendar year, the BPLC must do the following:
- Meet a minimum of four times per year
- Ensure each BPLC member or their designated alternate attends at least 75% of the BPLC meetings held each calendar year
- Ensure program compliance with all NAPBC standards

Requirements for Integrated Network Breast Programs

The INBP must establish a unified BPLC chaired by a BPD or co-BPDs. The network BPLC must include one representative from each facility within the network. A protocol must be developed and implemented that outlines the structure of the network BPLC and defines how information will flow from the network BPLC to each facility within the network.

Documentation

Submitted with Pre-Review Questionnaire
- BPLC meeting minutes, including documentation of BPLC member attendance, and any additional individuals in attendance
- Breast Program Leadership Committee Template
- **Networks:** A protocol outlining the dissemination of information through the network BPLC

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:
- The BPLC must maintain multidisciplinary membership, including a minimum of three physicians representing three different medical disciplines, one of which must be the BPD, and two healthcare professionals representing different disciplines related to the management and/or care of patients with breast disease or breast cancer.
- BPLC membership, including any designated alternates, must be documented in the BPLC meeting minutes at the first meeting of a calendar year at least once each accreditation cycle.
- The BPLC must meet a minimum of four times each calendar year.
- All BPLC members or their designated alternate must attend at least 75% of BPLC meetings held each calendar year.
- **Networks:** The INBP develops a protocol that outlines the structure of the network BPLC and defines how information will flow from the network BPLC to each facility within the network.

2.2 Breast Program Director

Definition and Requirements

A physician must be appointed as the BPD to maintain the authority and accountability for the operations of the NAPBC-accredited program. Appointment of co-BPDs is permissible. If co-BPDs are appointed, at least one must be a physician.

The appointment of the BPD must be documented in the BPLC meeting minutes during the first BPLC meeting of the calendar year at least once during each accreditation cycle.

The responsibilities of the BPD include the following:
- Familiarity with the NAPBC standards and NAPBC site visit processes
- Ensuring the NAPBC-accredited program maintains compliance with the NAPBC standards
- Designating an individual(s) to prepare and submit all information required and requested by the NAPBC and confirming that the information submitted is accurate and complete
- Overseeing the selection of Breast Care Team (BCT) members
- Overseeing the development and maintenance of protocols for the BCT and other NAPBC-accredited program personnel
- Overseeing the distribution of protocols to the BPLC and the BCT

Requirements for Integrated Network Breast Programs

The INBP must appoint a physician as the BPD. The NAPBC network BPD maintains authority and accountability for the operations of the INBP. The appointment of co-BPDs is permissible for INBPs. If co-BPDs are appointed, at least one must be a physician.

Documentation

Submitted with Pre-Review Questionnaire
- BPLC meeting minutes documenting the appointment of the BPD

Measure of Compliance

Each accreditation cycle, the NAPBC-accredited program fulfills all compliance criteria:
- A physician with authority and accountability for the operations of the NAPBC-accredited program or INBP is appointed as the BPD.
- The appointment of the BPD is documented in the BPLC meeting minutes during the first BPLC meeting of the calendar year at least once during each accreditation cycle.
- The BPD maintains compliance with all the responsibilities of the position.

2.3 Breast Care Team

Definition and Requirements

The NAPBC-accredited program must have a defined, multidisciplinary BCT with a minimum of one physician member appointed by the BPLC and the BPD to represent each of the following specialties:

- Surgery
- Pathology
- Radiology
- Medical oncology
- Radiation oncology

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.

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 BPLC and the BPD at the facility of participation.

The BPD and the BPLC have discretion to appoint additional healthcare professionals as members of the BCT. These healthcare professionals include, but are not limited to, advanced practice providers, licensed/registered nurses, Oncology Data Specialists (ODSs), physical medicine providers, genetic professionals, researchers, supportive care team professionals, radiology technologists, navigation professionals, social workers, registered dietitian nutritionists (RDNs), exercise professionals, ordained clergy or religious leaders, financial advisors, certified lymphedema therapists, plastic or reconstructive surgeons, and clinical psychologists.

Requirements for BCT membership:

- Members must have appropriate qualifications/certifications/registrations in their field.
- Members must collaborate and develop treatment plans, including transition of care, that will lead to the best possible outcomes for patients.
- Members must provide patient care in compliance with the NAPBC standards and in accordance with institutional policies.
- Surgery, pathology, radiology, medical oncology, and radiation oncology BCT members must participate in Multidisciplinary Breast Care Conferences (MBCCs) as necessary to demonstrate compliance with Standard 2.4.
  - At least one surgeon, pathologist, radiologist, medical oncologist, and radiation oncologist must attend each MBCC.
  - Other specialties are encouraged, but not required, to attend the MBCC.

Requirements for Integrated Network Breast Programs

Each facility within the INBP must have a defined, multidisciplinary BCT as outlined in Standard 2.3. Individuals working at multiple facilities within the network should be listed on each appropriate BCT.

Documentation

Submitted with Pre-Review Questionnaire

- Breast Care Team Template
- **Networks:** A Breast Care Team Template for each facility within the INBP

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- The BCT is a defined, multidisciplinary team, with a minimum of one appointed physician member from each of the following specialties: surgery, pathology, radiology, medical oncology, radiation oncology, and additional appointed members at the discretion of the BPD and the BPLC.
- All new 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, are members of the BCT and maintain compliance with the NAPBC standards.
- Appointed members of the BCT meet all the membership requirements.
- **Networks:** Each facility within the INBP has a defined, multidisciplinary BCT.

2.4 Multidisciplinary Breast Care Conference

Definition and Requirements

MBCCs are integral to improving the care of patients with breast disease or breast cancer by reviewing and contributing to patient management and patient outcomes, while providing education to physicians and other staff in attendance. Attendance and active participation are encouraged by all members of the BCT. All participants attending the MBCC must maintain complete confidentiality for all information disclosed during each conference.

The BPLC is responsible for monitoring individual and specialty attendance on an annual basis. **At least one surgeon, radiologist, pathologist, radiation oncologist, and medical oncologist must attend each MBCC.** The BPLC must also set attendance requirements for surgeons, radiation oncologists, and medical oncologists attending the MBCC, which are applied at the individual level. **For example**, if the BPLC sets a 75% attendance requirement for surgeons, then each surgeon member of the BCT must attend 75% of MBCC meetings. The MBCC attendance requirements for each specialty must be documented in the MBCC protocol.

Onsite supportive care team professionals and reconstructive or plastic surgeons are strongly encouraged to attend each MBCC. Treating physicians are strongly encouraged to attend the MBCC when their patients are being presented.

Attending the MBCC via videoconference is acceptable, but the virtual attendee(s) must have access to all meeting materials required for full participation and input, such as imaging studies, specimen photographs, and pathology reports and/or slides.

The MBCC discussion must address the following elements for each case presented:

- Clinical and/or pathological stage
- Treatment planning using evidence-based guidelines
- Options and eligibility for genetic testing (where applicable)
- Options and eligibility for clinical research studies (where applicable)
- Options and eligibility for supportive care services (where applicable)
- Visual display of clinically relevant pathology slides
- Visual display of clinically relevant imaging studies

If an MBCC is shared between NAPBC-accredited programs, each participating NAPBC-accredited program must maintain their own separate MBCC records that document full compliance with this standard.

Multidisciplinary Breast Care Conference Protocol
NAPBC-accredited programs must develop and implement a protocol for MBCC. NAPBC-accredited programs with fewer than 100 analytic breast cancer cases each calendar year have the option of including these cases as part of a general cancer conference. The established protocol must address the following requirements:

- Attendance by at least one surgeon, radiologist, pathologist, radiation oncologist, and medical oncologist at each MBCC meeting
- Individual attendance requirements at MBCC meetings for each specialty: surgery, radiation oncology, and medical oncology
  - Each physician member of the BCT must meet the MBCC attendance requirement for their specialty.
  - The BPLC has discretion to determine the individual attendance requirements for each specialty.
- MBCC meeting frequency
  - NAPBC-accredited programs with an annual analytic case load of **1–250 breast cancer cases** must hold MBCC meetings **at least twice a month** and must hold at least **22** MBCC meetings each calendar year.
  - NAPBC-accredited programs with an annual analytic case load of **251+ breast cancer cases** must hold MBCC meetings **weekly**, defined as an average of four meetings per month, and must hold at least **45** MBCC meetings each calendar year.
- Criteria for selecting analytic breast cancer cases for presentation and discussion at the MBCC
  - NAPBC-accredited programs with an annual analytic case load of **1–250 breast cancer cases** must present and prospectively discuss a minimum of 50% of all analytic breast cancer cases (excluding classes of case 00 and 10).

  - NAPBC-accredited programs with an annual analytic case load of **251+ breast cancer cases** must present and prospectively discuss a minimum of 30% of all analytic breast cancer cases (excluding classes of case 00 and 10). The MBCC protocol must address any relevant factors affecting the number of breast cancer cases that are presented and prospectively discussed by the MBCC (**for example**, the delivery of breast cancer care in a multidisciplinary clinic).

Cases presented and prospectively discussed must include, but are not limited to:
- Newly diagnosed cases with treatment not yet initiated or treatment initiated and discussion of additional treatment is required
- Cases previously diagnosed, initial treatment completed, and discussion of adjuvant treatment or treatment for recurrence or progression is needed
- Cases previously diagnosed and discussion of supportive or palliative care is needed
- Cases in consideration for clinical trials/research

Evaluation by the BPLC
Each calendar year, the BPLC must develop an annual report. The annual report is presented during the first-quarter BPLC meeting of each calendar year and must include reporting data from the previous full calendar year. The annual report is documented in the cancer committee meeting minutes.

The report must include the following elements:
- MBCC protocol and compliance with the protocol
- MBCC meeting frequency
- MBCC attendance by physician specialists
- MBCC attendance by individual BCT members from surgery, radiation oncology, and medical oncology
- Number of cases presented and the percentage of cases presented and prospectively discussed
- For programs with 251+ breast cancer cases: If the number of cases presented and prospectively discussed by the MBCC is below 30% of the total number of analytic breast cancer cases for the calendar year, the BPLC must provide written justification in the BPLC meeting minutes for presenting fewer than 30% of the total number of analytic breast cancer cases during that calendar year
- Elements of discussion for each case, including, but not limited to, whether the following were discussed:
  - Clinical and/or pathological stage
  - Treatment planning using evidence-based guidelines
  - Appropriateness and availability for genetic testing, clinical research studies, and supportive care services (where applicable)
  - Visual display of clinically relevant pathology slides
  - Visual display of clinically relevant imaging studies

The method to document MBCC activity is left to the discretion of the cancer committee.

Requirements for Integrated Network Breast Programs

The MBCC protocol for the INBP must address all requirements outlined in Standard 2.4 and must also document how MBCCs are conducted throughout and across the network facilities. Each facility within the INBP must meet one of the following requirements:
- Participation in a network-level MBCC
- Participation with the MBCC at another facility within their INBP
- Establishment of their own MBCC

Analytic breast cancer cases from all facilities across the network must be presented and prospectively discussed at MBCC meetings, either at the network-level MBCC or at the MBCC at one of the facilities within the network. The number of analytic breast cancer cases from each facility that must be presented and prospectively discussed by the MBCC is determined locally by the network BPLC but should represent the proportion of analytic cases per facility.

Documentation

Reviewed Onsite
- The site reviewer must attend an MBCC.

Submitted with Pre-Review Questionnaire
- Multidisciplinary Breast Care Conference Template
- Required protocol
- BPLC meeting minutes documenting the required evaluation

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:
- The BPLC must develop and implement a protocol for MBCCs that includes all required elements.
- The MBCC evaluation is completed by the BPLC and documented in the BPLC meeting minutes each calendar year.
- **Networks:** The MBCC protocol must also document how MBCCs are conducted throughout and across the INBP, including MBCC participation and case presentation from all facilities within the INBP.

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3

Facilities and Equipment Resources

Rationale

Chapter 3 of the NAPBC Standards is designed to help NAPBC-accredited programs emphasize safety and continuity of care for patients with breast disease or breast cancer. While delivering the high-quality breast care associated with all NAPBC-accredited programs, maintaining the appropriate certifications and/or accreditations for the medical facility ensures high reliability and consistency across all service lines.

3.1 Facility Accreditation

NAPBC-accredited programs that are also accredited by the Commission on Cancer (CoC) are not evaluated for compliance with Standard 3.1 by the NAPBC.

NAPBC-accredited programs that are not accredited by the CoC must demonstrate compliance with CoC Standard 3.1: Facility Accreditation as outlined in *Optimal Resources for Cancer Care (2020 Standards).*

3.2 Radiation Oncology Quality Assurance

NAPBC-accredited programs that are also accredited by the CoC are not evaluated for compliance with Standard 3.2 by the NAPBC.

NAPBC-accredited programs that are not accredited by the CoC must demonstrate compliance with CoC Standard 3.2: Evaluation and Treatment Services as outlined in *Optimal Resources for Cancer Care (2020 Standards).*

3.3 Image-Guided Biopsy Quality Assurance

Definition and Requirements

The NAPBC-accredited program must follow recognized quality assurance practices for the safe performance of image-guided biopsy procedures, including accreditation from the American College of Radiology (ACR) as outlined below and/or surgeon certification from the American Society of Breast Surgeons (ASBrS) for Stereotactic Breast Procedures and Breast Ultrasound.

Stereotactic Core Needle Biopsy
Stereotactic core needle biopsy must be performed at an ACR Stereotactic Breast Biopsy–accredited facility or by an ASBrS Stereotactic Breast Procedures Certified Surgeon.

Surgeons performing stereotactic core needle biopsy at the NAPBC-accredited program must be certified to perform these procedures by the ASBrS Stereotactic Breast Procedures Certification Program. Surgeons performing stereotactic core needle biopsy must provide documentation of ASBrS Stereotactic Breast Procedures Certification at the time of the NAPBC site visit. Surgeons in the process of obtaining ASBrS Stereotactic Breast Procedures Certification must provide documentation of progress toward certification. Documentation of completion of the ASBrS Stereotactic Breast Procedures Certification Program for Surgical Fellows may also be utilized to meet the measure of compliance for this standard.

An ACR designation of Comprehensive Breast Imaging Center (CBIC) does meet the measure of compliance for radiology accreditation for ultrasound and magnetic resonance imaging (MRI). However, ACR CBIC designation does not meet the measure of compliance for surgeons performing image-guided biopsy.

Ultrasound-Guided Needle Biopsy
Diagnostic ultrasound and/or ultrasound-guided needle biopsy must be performed at an ACR Breast Ultrasound–accredited facility or by an ASBrS Breast Ultrasound Certified Surgeon.

Surgeons who perform breast diagnostic ultrasound and/or ultrasound-guided breast biopsy at the NAPBC-accredited program must be certified to perform these procedures by the ASBrS Breast Ultrasound Certification Program. Surgeons performing breast diagnostic ultrasound and/or ultrasound-guided breast biopsy must provide documentation of ASBrS Breast Ultrasound Certification at the time of the NAPBC site visit. Surgeons in the process of obtaining ASBrS Breast Ultrasound Certification must provide documentation of progress toward certification. Documentation of completion of the ASBrS Breast Ultrasound Certification Program for Surgical Fellows may also be utilized to meet the measure of compliance for this standard. The requirement for ASBrS Breast Ultrasound Certification does not apply to surgeons using ultrasound only as an extension of the clinical diagnosis or for localization.

The ACR CBIC designation does meet the measure of compliance for radiologists, but ACR CBIC designation does not meet the measure of compliance for surgeons performing diagnostic ultrasound and/or ultrasound-guided needle biopsy.

MRI Biopsies
The NAPBC-accredited program must have an ACR Breast MRI–accredited magnet if MRI biopsies are performed by the NAPBC-accredited program.

Requirements for Integrated Network Breast Programs

Each facility within the INBP providing image-guided biopsy services must have appropriate accreditation for image-guided biopsy services as outlined in Standard 3.3.

All surgeons performing stereotactic core needle biopsy, diagnostic ultrasound, and/or ultrasound-guided breast biopsy within the INBP must have appropriate certification as outlined in Standard 3.3.

Documentation

Submitted with Pre-Review Questionnaire

- Documentation of all required accreditations and certifications, based on the procedures performed by the NAPBC-accredited program

Measure of Compliance

The NAPBC-accredited program fulfills all applicable compliance criteria:

- Stereotactic core needle biopsy is performed by radiologists at a facility with ACR Stereotactic Breast Biopsy Accreditation.
- Surgeons performing stereotactic core needle biopsy are certified by the ASBrS Stereotactic Breast Procedures Certification Program or Surgical Fellows Program.
- Diagnostic ultrasound and/or ultrasound-guided needle biopsy are performed by radiologists at a facility with ACR Breast Ultrasound Accreditation.
- Surgeons performing diagnostic ultrasound and/or ultrasound-guided needle biopsy are certified by the ASBrS Breast Ultrasound Certification Program or Surgical Fellows Program.
- MRI biopsies are performed on ACR Breast MRI–accredited magnets.

3.4 Breast Imaging Quality Assurance

Definition and Requirements

The NAPBC-accredited program must follow recognized quality assurance practices for performing breast MRI. All mammography services must be provided in accordance with federal guidelines established by the Mammography Quality Standards Act (MQSA). NAPBC-accredited programs performing breast MRI onsite must have the capacity to provide all of the following services:

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

If the service is not provided onsite a referral relationship must be established that meets the following guidelines.

To demonstrate compliance with this standard, the NAPBC-accredited program must meet at least one of the following criteria:

- ACR Breast MRI Accreditation
- ACR Designated CBIC (preferred)
- Establish a referral relationship with a local facility to provide the breast MRI services outlined above. The referral facility must meet either of the following criterion:
  - ACR Breast MRI Accreditation
  - ACR Designated CBIC

Requirements for Integrated Network Breast Programs

Each facility within the INBP providing breast MRI services must meet compliance with this standard as written.

Documentation

Reviewed Onsite

- If breast MRI services are referred to a local facility, the site reviewer will evaluate the referral relationship to confirm the referral facility holds ACR Breast MRI Accreditation or ACR CBIC designation.

Submitted with Pre-Review Questionnaire

- Documentation of ACR Breast MRI Accreditation or ACR CBIC designation

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- NAPBC-accredited programs performing breast MRI onsite must hold ACR Breast MRI Accreditation or ACR CBIC designation.
- NAPBC-accredited programs not performing breast MRI onsite must have an established referral relationship with a local facility to provide these breast MRI services.
  - The referred facility must hold ACR Breast MRI accreditation or ACR CBIC designation.
- NAPBC-accredited programs must provide all mammography services in accordance with federal guidelines established by the MQSA.

3.5 Pathology Quality Assurance

NAPBC-accredited programs that are also accredited by the CoC are not evaluated for compliance with Standard 3.5 by the NAPBC.

NAPBC-accredited programs that are not accredited by the CoC must demonstrate compliance with CoC Standard 3.2: Evaluation and Treatment Services as outlined in *Optimal Resources for Cancer Care (2020 Standards).*

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4

Personnel and Services Resources

Rationale

Healthcare providers and staff take patients' lives in their hands every day. Each specialist must maintain appropriate credentials and complete continuing education in the treatment and/or management of breast disease and breast cancer to help ensure the delivery of high-quality care consistent with currently established best practices.

4.1 Physician Credentials

NAPBC-accredited programs that are also accredited by the CoC are not evaluated for compliance with Standard 4.1 by the NAPBC.

NAPBC-accredited programs that are not accredited by the CoC must demonstrate compliance with CoC Standard 4.1: Physician Credentials as outlined in *Optimal Resources for Cancer Care (2020 Standards).*

4.2 Oncology Nursing Credentials

NAPBC-accredited programs that are also accredited by the CoC are not evaluated for compliance with Standard 4.2 by the NAPBC.

NAPBC-accredited programs that are not accredited by the CoC must demonstrate compliance with CoC Standard 4.2: Oncology Nursing Credentials as outlined in *Optimal Resources for Cancer Care (2020 Standards).*

4.3 Physician Assistant Credentials

Definition and Requirements

Oncology care must be provided by physician assistants (PAs) with specialized knowledge and skill in breast disease or breast cancer as demonstrated by continuing education in oncology.

All PAs who provide direct breast oncology care must demonstrate ongoing education by earning 18 cancer-related continuing education hours each accreditation cycle.

- It is recommended, but not required, that continuing education hours applicable to patients with breast disease or breast cancer be prioritized over other cancer-related continuing education hours, whenever possible.
- A specific number of continuing education hours applicable to patients with breast disease or breast cancer is not required.

Scope of Standard

This standard applies to PAs who provide direct breast care in the NAPBC-accredited program for at least one calendar year. Specifically, the standard applies to PAs in medical oncology clinics, PAs in radiation oncology, PAs in infusion sites, and PAs in the breast center, cancer center, or breast clinics within the NAPBC-accredited program. This standard does not apply to PAs in the hospital who have occasional contact with cancer patients, and it does not apply to operating room or recovery room PAs. If the NAPBC-accredited program does not have PAs, this standard will be rated "not applicable."

Documentation

Submitted with Pre-Review Questionnaire

- Physician Assistant Education Template

Measure of Compliance

Each accreditation cycle, the NAPBC-accredited program fulfills all compliance criteria:

- All PAs providing direct breast oncology care earn 18 cancer-related continuing education hours, with a recommended emphasis on hours that are applicable to patients with breast disease or breast cancer.

4.4 Genetic Professional Credentials

NAPBC-accredited programs that are also accredited by the CoC are not evaluated for compliance with Standard 4.4 by the NAPBC.

NAPBC-accredited programs that are not accredited by the CoC must demonstrate compliance with the "Protocol for Genetic Counseling and Risk Assessment" section of CoC Standard 4.4: Genetic Counseling and Risk Assessment as outlined in *Optimal Resources for Cancer Care (2020 Standards).*

4.5 Navigation Professional Credentials

Definition and Requirements

Navigation services must be provided by qualified navigation professionals, including **Clinical Navigators** and **Patient Navigators**, who have documented training and education in providing individualized assistance to patients with breast disease or breast cancer, their families, and their caregivers.

Clinical Navigators hold healthcare licensure and/or certification required for their scope of practice by local and/or state laws. This includes Clinical Nurse Navigators and Clinical Social Work Navigators. Clinical Navigators must meet compliance with this standard either by holding a qualifying healthcare certification that includes patient navigation training or by documented completion of competency-based training and education in patient navigation for patients with breast disease or breast cancer from a qualifying training program.

Patient Navigators are navigation professionals who do not hold current healthcare licensure. Patient Navigators must meet compliance with this standard either by holding a qualifying certification that includes patient navigation training or by documented completion of competency-based training and education in patient navigation for patients with breast disease or breast cancer from a qualifying training program.

Qualifying certifications must include patient navigation within their exam to meet the measure of compliance for this standard. **Examples** of such qualifying certifications with documented patient navigation training and education include, but are not limited to:

- Oncology Certified Nurse (OCN®)
- Certified Breast Care Nurse (CBCN®)
- Oncology Nurse Navigator-Certified Generalist (ONN-CG™)
- Oncology Patient Navigator-Certified Generalist (OPN-CG™)
- Advanced Oncology Certified Nurse Practitioner (AOCNP®)
- Advanced Oncology Certified Clinical Nurse Specialist (AOCNS®)
- Advanced Oncology Certified Nurse (AOCN®)
- Breast Health Clinical Navigator (BHCN™)

Navigation professionals in the process of obtaining a qualifying certification must provide documentation of progress toward certification.

Qualifying training programs must include competency-based training and education in patient navigation for patients with breast disease or breast cancer to meet the measure of compliance for this standard. **Examples** of such qualifying training programs include, but are not limited to:

- National Consortium of Breast Centers (NCBC): Certified Navigator Breast Advocate Program (CN-BA)
- George Washington University School of Medicine and Health Sciences Education Program: Oncology Patient Navigator Training
- Oncology Nursing Society: Equipping the Novice Oncology Nurse Navigator: An ONS Collaboration with AONN+
- American Cancer Society Leadership in Oncology Navigation (ACS LION™)
- Board of Oncology Social Work Certification (BOSWC): Certified Oncology Social Worker (OSW-C)

Patient navigation training provided locally by the NAPBC-accredited program does not meet the measure of compliance for this standard.

Navigation professionals in the process of obtaining qualifying training and education in patient navigation must provide documentation of progress toward completion.

The requirements for patient navigation services provided by the NAPBC-accredited program are outlined in Standard 5.6.

Documentation

Submitted with Pre-Review Questionnaire

- Certification and/or training and education documentation for all navigation professionals providing patient navigation services

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- Patient navigation services are provided by qualified navigation professionals.

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5

Patient Care: Expectations and Protocols

Rationale

The standards in Chapter 5 support care that focuses on the patient journey from the patient's perspective.

5.1 Screening and Diagnostic Imaging

Definition and Requirements

The NAPBC-accredited program must utilize nationally recognized guidelines for breast cancer screening. Sources for nationally recognized guidelines include, but are not limited to:
- American College of Radiology
- American Cancer Society

The NAPBC-accredited program must develop and implement a protocol addressing the following:
- Notification and education for patients with increased breast density
- Guidelines for the provision of supplemental screening to patients with increased breast density
- Utilization of available supplemental screening techniques for patients with increased density, such as digital breast tomosynthesis, breast ultrasound, MRI, and/or contrast-enhanced mammography
- Access to biopsy services for patients that have an abnormal imaging study
- Process to notify patients of a recommended biopsy

Communication of Results
Biopsy pathology results and any follow-up recommendations must be communicated directly to the patient or the referring physician. A written or electronic copy of the biopsy pathology results must be provided to the patient.

Evaluation by the BPLC
Each accreditation cycle, the BPLC must review and assess the following:
- The protocol for screening and diagnostic imaging
- Utilization of available supplemental screening techniques for patients with increased density, such as digital breast tomosynthesis, breast ultrasound, MRI, and/or contrast-enhanced mammography
- The processes for patient follow-up, biopsy recommendations, and review of biopsy results

The BPLC evaluation and discussion must be documented in the BPLC meeting minutes.

Requirements for Integrated Network Breast Programs

The INBP must meet compliance with this standard as written. The required protocol must also document how screening and diagnostic imaging services are organized either centrally at the network level or at the individual facilities within the network. In either case, screening and diagnostic imaging services must meet compliance with this standard as written.

Documentation

Reviewed Onsite
- Preselected medical records for patients to confirm compliance with this standard

Submitted with Pre-Review Questionnaire
- Required protocol
- Example of education on additional screening provided to patients with increased density
- BPLC meeting minutes documenting the required evaluation

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- Nationally recognized guidelines for screening are utilized.
- A protocol is developed and implemented for:
  - Notification and education for patients with increased breast density
  - Guidelines for the provision of supplemental screening to patients with increased breast density
  - Utilization of available screening techniques for patients with increased density
  - Access to biopsy services for patients with an abnormal imaging study
  - Process to notify patients of a recommended biopsy
- Biopsy pathology results and any follow-up recommendations are communicated directly to the patient or the referring physician, and a written or electronic copy of the biopsy pathology results is provided to the patient.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each accreditation cycle.
- **Networks:** The required protocol also documents how screening and diagnostic imaging services are organized within the INBP, either centrally at the network level or at the individual facilities within the network.

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5.2 Evaluation and Management of Benign Breast Disease

Definition and Requirements

NAPBC-accredited programs must have a process in place to manage patients with benign breast disease or breast symptoms according to guidelines and offer interventions and follow-up for their conditions as needed.

Benign breast disease encompasses a broad grouping of breast conditions, including proliferative lesions with atypia, infectious and inflammatory conditions, breast cysts, fibroepithelial lesions, radial scars, papillomas, pseudoangiomatous stromal hyperplasia (PASH), and other benign-type pathology. Breast symptoms include breast pain, breast mass, or nipple discharge.

Programs must have a process in place to review pathology results for patients with benign breast disease who undergo either a biopsy or surgery. Radiology-pathology concordance is documented for those patients who undergo a breast biopsy.

Evaluation by the BPLC
Each accreditation cycle, the BPLC must review and assess the following:
- Guidelines utilized by the program for management of patients with breast symptoms or benign breast disease

The BPLC evaluations and discussions must be documented in the BPLC meeting minutes.

Documentation

Reviewed Onsite
- Preselected medical records to confirm compliance with this standard

Submitted with Pre-Review Questionnaire
- BPLC meeting minutes documenting the required evaluation

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:
- Guidelines are utilized for the management of patients with breast symptoms or benign breast disease.
- A process is in place to review pathology results for patients with benign breast disease who undergo a biopsy or surgery.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each accreditation cycle.

5.3 Population-Based Risk Assessment and Management of Patients at Increased Risk for Breast Cancer

Definition and Requirements

Risk Assessment
The NAPBC-accredited program must utilize risk assessment screening strategies based on the needs of their patient population. The NAPBC-accredited program has full discretion regarding when this risk assessment occurs within their programmatic workflow. The risk reduction strategies must either be discussed with the patient or provided to them in a written or electronic format. It is not required that an individualized discussion occurs with each patient if the written or electronic resources for risk reduction are provided to the patient.

Management of Patients at Increased Risk for Breast Cancer
The NAPBC-accredited program must develop and implement a protocol for the management of patients who are at an increased risk for breast cancer. **Examples** of patients at increased risk for breast cancer include patients with dense breast tissue, lifestyle risk factors, family history of cancer, and a history of atypical ductal hyperplasia (ADH), atypical lobular hyperplasia (ALH), or lobular carcinoma in situ (LCIS).

The established protocol must address the following requirements:
- How the program assesses risk for its population
- Consideration of risk reduction strategies
- Pharmacologic or surgical interventions for high-risk patients, when appropriate
- Imaging surveillance following evidence-based guidelines
- Referral to appropriate healthcare providers for patients with ADH, ALH, or LCIS discovered on a breast biopsy, with appropriate management according to nationally recognized guidelines

Evaluation by the BPLC
Each accreditation cycle, the BPLC must review and assess the following:
- The protocol for the identification and management of patients at increased risk for breast cancer

The BPLC evaluations and discussions must be documented in the BPLC meeting minutes.

Requirements for Integrated Network Breast Programs

The INBP must meet compliance with this standard as written. The required protocol must also document how services for risk assessment and the management of patients at increased risk for breast cancer are organized either centrally at the network level or at the individual facilities within the network. In either case, services for risk assessment and the management of patients at increased risk for breast cancer must meet compliance with this standard as written.

Documentation

Reviewed Onsite
- Preselected medical records to confirm compliance with this standard

Submitted with Pre-Review Questionnaire
- Required protocol
- Examples of risk reduction materials provided to patients
- BPLC meeting minutes documenting the required evaluation

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- Risk assessment strategies are utilized based on the needs of the patient population.
- A protocol is developed and implemented for the management of patients at increased risk for breast cancer.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each accreditation cycle.
- **Networks:** The required protocol also documents how services for risk assessment and the management of patients at increased risk for breast cancer are organized within the INBP, either centrally at the network level or at the individual facilities within the network.

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5.4 Genetic Evaluation and Management

Definition and Requirements

The NAPBC-accredited program must, at a minimum, **consider** genetic counseling and testing for the following patients:

- All newly diagnosed patients with breast disease or breast cancer
- Patients determined to be at high risk for genetic cancer predisposition

This consideration for genetic counseling and testing must be in accordance with nationally recognized guidelines and documented in the patient medical record.

The NAPBC-accredited program must develop and implement a protocol addressing the following requirements for managing patients for genetic evaluation:

- How the program assesses who is high risk for genetic cancer predisposition
- Evidence-based process for genetic evaluation, counseling, and testing that includes consideration of patient's medical and family history by a genetics professional that meets CoC Standard 4.4: Genetic Testing and Risk Assessment
- Provision of a written or electronic copy of the genetic evaluation and testing discussed with the patient, reported to the treatment team, and documented in the medical record
- Documentation of effort to help patients inform at-risk family members and/or provide cascade testing
- Consideration for referral to genetic professionals for patients with abnormal test results (such as pathogenic, likely pathogenic, or variant of uncertain significance) performed by non-genetic professionals or with test results performed at outside institutions

Any genetics services not provided onsite by the NAPBC-accredited program must be provided through a referral relationship with other facilities and/or local agencies or via telegenetics services. If programs utilize outside agencies, the program must still demonstrate that these services:

- Utilize genetics professionals that meet the requirements within CoC Standard 4.4
- Meet all of the required elements formerly listed

Evaluation by the BPLC

Each accreditation cycle, the BPLC must review and assess the following:

- Review the protocol for genetic evaluation and management

The BPLC evaluation and discussion must be documented in the BPLC meeting minutes.

Requirements for Integrated Network Breast Programs

The required protocol must also document how genetic evaluation and management services are organized either centrally at the network level or at the individual facilities within the network. In either case genetic evaluation and management services must meet compliance with this standard as written.

Documentation

Reviewed Onsite

- Preselected medical records to confirm compliance with this standard

Submitted with Pre-Review Questionnaire

- Required protocol
- BPLC meeting minutes documenting the required evaluation

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- Newly diagnosed and high-risk patients with breast disease or breast cancer are considered for genetic counseling and testing according to nationally recognized guidelines, with documentation in the patient medical record.
- A protocol is developed and implemented for managing patients for genetic evaluation.
- Genetic testing and counseling are offered to appropriate patients, and testing results are provided to and discussed with the patient.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each accreditation cycle.
- **Networks:** The required protocol must also document how genetic evaluation and management services are organized either centrally at the network level or at the individual facilities within the network.

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5.5 Evaluation and Treatment Planning

Definition and Requirements

The NAPBC-accredited program must complete the following workups for all newly diagnosed patients with breast cancer:

- Staging
- Biopsy
- Imaging
- Metastatic workup
- Laboratory workup

Staging
In this context, staging requires assignment of the proper cancer stage using the American Joint Committee on Cancer (AJCC) system. The core biopsy, biomarkers, imaging, and physical exam determine the clinical time point or clinical classification, which must be reported according to the most recent AJCC system. The clinical classification using the clinical prognostic stage table or the de novo metastatic prognostic stage table must be determined based on the information available during the diagnostic workup. The clinical stage classification must be discussed with the patient prior to treatment, and the stage must be documented in the patient medical record.

Over the course of ongoing patient evaluation and treatment, additional stage assignment at time points in a patient's care (classifications) must be appropriately determined and documented in the patient medical record. The additional stage classification assignments must be discussed with the patient and used during any MBCC. Pathological, post-neoadjuvant therapy, or recurrence stage classifications are examples of additional stage assignment.

Biopsy
The NAPBC-accredited program must review clinically relevant outside biopsy/surgical pathology slides before providing treatment. This includes patients who are newly diagnosed and patients with recurrence or previous treatment. Outside pathology must be reviewed by a pathologist member of the BCT. This review may be conducted as an official consultation or at the MBCC.

If the outside slides cannot be obtained for review, this must be discussed with the patient and documented in the patient medical record. In the absence of the outside slides, the outside pathology report must be reviewed by the treating physician.

Imaging
The NAPBC-accredited program must review all clinically relevant outside breast imaging studies that may affect loco-regional management decisions before providing treatment. Outside imaging studies must be reviewed by a physician member of the BCT. The review of outside imaging studies by a radiologist member of the BCT is recommended but not required. If the review is conducted at MBCC, the images must be shown.

If the outside breast imaging cannot be obtained for review, the NAPBC-accredited program must complete any necessary imaging studies before providing treatment.

Metastatic Workup
The NAPBC-accredited program must complete a metastatic workup as indicated by evidence-based national guidelines. The workup must be documented in the patient medical record.

Laboratory Workup
The NAPBC-accredited program must complete a laboratory workup as indicated by evidence-based national guidelines. The workup must be documented in the patient medical record.

Evaluation by the BPLC
Each calendar year, the BPLC must review and assess the following:

- Whether or not clinically relevant outside biopsy/surgical pathology slides and clinically relevant outside breast imaging studies are being obtained and reviewed before treatment at the NAPBC-accredited program

The BPLC evaluation and discussion must be documented in the BPLC meeting minutes.

Documentation

Reviewed Onsite

- Preselected medical records to confirm compliance with this standard

Submitted with Pre-Review Questionnaire

- BPLC meeting minutes documenting the required evaluation

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- Clinical staging is documented in the patient medical record and discussed with the patient before treatment at the NAPBC-accredited program.
- Clinically relevant biopsy/surgery pathology slides from outside facilities are reviewed by a pathologist member of the BCT at the NAPBC-accredited program before providing treatment.
- Clinically relevant breast imaging studies from outside facilities are reviewed by a physician member of the BCT at the NAPBC-accredited program before providing treatment.
- Appropriate workups (metastatic workup, laboratory including biomarkers needed to assign clinical stage classification) are documented in the patient medical record.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each calendar year.

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5.6 Patient Navigation

Definition and Requirements

Patient navigation begins at the time of patient presentation to the NAPBC-accredited program and continues beyond treatment. Patient navigation plays an integral role in the patient journey as it assists with transitions of care, continuity, and communication between the treatment team members.

A protocol must be developed and implemented to address patient navigation throughout the patient journey. **For example**:

- A point of contact (the navigation professional[s]) for the patient from the moment of diagnosis onward
- Facilitation of timely transitions between surgery and medical oncology treatment
- Assistance with addressing survivorship and surveillance throughout treatment
- Alerting the radiation oncology team if a patient cannot complete chemotherapy and finishes treatment early

Evaluation by the BPLC
Each accreditation cycle, the BPLC must review and assess the following:

- The protocol for patient navigation

The BPLC evaluation and discussion must be documented in the BPLC meeting minutes.

Requirements for Integrated Network Breast Programs

The INBP must meet compliance with this standard as written. The required protocol must also document how patient navigation services are organized either centrally at the network level or at the individual facilities within the network. In either case patient navigation services must meet compliance with this standard as written.

Documentation

Submitted with Pre-Review Questionnaire

- Required protocol
- BPLC meeting minutes documenting the required evaluation

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- A protocol is developed and implemented to address patient navigation throughout the patient journey.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each accreditation cycle.
- **Networks:** The required protocol must also document how patient navigation services are organized either centrally at the network level or at the individual facilities within the network.

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5.7 Function and Movement for Patients with Breast Cancer

Definition and Requirements

The NAPBC-accredited program must develop and implement a protocol to do the following:

- Screen for the physical functional status of patients with breast cancer
- Recommend/refer patients to appropriate movement programming to address physical function during and after active therapy

This must be considered for all patients with breast cancer who will be receiving active treatment, including surgical care, reconstructive surgery, medical oncology care, and radiation oncology care, at the NAPBC-accredited program. The screening can occur at any time during treatment, but it is recommended that the screening occur before the start of treatment.

Functional Screening

The functional screening may be performed by any member of the patient care team, including, but not limited to, medical assistants, physical therapists, occupational therapists, nurses, advanced practice providers, and physicians. The physical function screening is communicated to the treatment team. The program determines how this information is communicated. **For example**, the functional screening results may be included in the medical record or methods within the workflow that are visible to the treatment team.

The protocol for functional screening must include the following elements:

- Timing of the functional screening
- Method of functional screening utilized to assess patients with breast cancer

Functional screenings that meet compliance with this standard include:

- Objective testing (both upper and lower body tests must be done)
  Examples include, but are not limited to:
  - Upper body range of motion (ROM) testing
  - Timed "Up and Go" test

OR

- Patient surveys (survey[s] on both upper and lower body must be done)
  Examples include, but are not limited to:
  - QuickDASH survey for upper body function
  - Lower Extremity Function Scale

Eastern Cooperative Oncology Group (ECOG) Performance Status and similar scoring systems, such as Karnofsky Performance Status, may be used for lower body; however, upper body must still be screened using a different method.

Both the upper and lower body must be screened regardless of what tool is utilized.

If a patient had both an upper and lower body screening within six months of diagnosis of breast cancer, the assessment does not need to be repeated by the NAPBC-accredited program.

The following tables provide examples of thresholds for the functional screening to trigger recommendations for exercise or referral to physical or occupational therapy. Programs can set their own thresholds. If a patient has met the threshold for a physical or occupational therapy referral, the referral must be to physical or occupational therapy, even if other tests suggest recommendations for exercise. Referrals to physical or occupational therapy can be made onsite, online, or through community referrals and should occur during active treatment to address common symptoms and side effects.

Objective Testing Example Thresholds

	Physical/Occupational Therapy Referral	Exercise Recommendations
Upper Body ROM Testing	Shoulder elevation <120 degrees	Shoulder elevation ≥120 degrees
Timed Up and Go Test	≥12 seconds	<12 seconds

Survey Testing Example Thresholds

	Physical/Occupational Therapy Referral	Exercise Recommendations
QuickDASH	>25	≤25
Lower Extremity Function Test	≤60	>60

Movement
Exercise is recommended for all patients during active breast cancer therapy, per guidelines from the American Society of Clinical Oncology. At a minimum, the NAPBC-accredited program must provide educational materials regarding exercise recommendations. The NAPBC has developed an educational poster that can be used to meet this requirement. If the NAPBC-accredited program develops their own materials, they must include the same information as the NAPBC poster, at a minimum.

Evaluation by the BPLC
Each accreditation cycle, the BPLC must review and assess the following:
- The protocol for functional screening

The BPLC evaluation and discussion must be documented in the BPLC meeting minutes.

Requirements for Integrated Network Breast Programs

The INBP must meet compliance with this standard as written. The required protocol must also document how functional screening and movement recommendation services are organized either centrally at the network level or at the individual facilities within the network. In either case, functional screening services must meet compliance with this standard as written.

Documentation

Submitted with Pre-Review Questionnaire
- Required protocol

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:
- Functional screening must be considered for patients receiving active treatment for breast cancer.
- A protocol is developed and implemented to address functional screening and appropriate recommendations for exercise or referral to physical or occupational therapy.
- Educational materials regarding exercise recommendations are provided that include, at least, the same information as the NAPBC poster.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each accreditation cycle.
- **Networks:** The required protocol must also document how functional screening and movement referrals are organized either centrally at the network level or at the individual facilities within the network.

Resources

www.movingthroughcancer.org: Resource for identifying movement programs

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Phase-in standard required beginning January 2028

5.8 Lymphedema Assessment

Definition and Requirements

The NAPBC-accredited program must develop and implement a protocol to assess lymphedema in patients with breast cancer receiving treatment at the NAPBC-accredited program. Patients who undergo axillary lymph node dissection (ALND) or axillary radiation should undergo a lymphedema assessment. The timing of this assessment is at the discretion of the NAPBC-accredited program. Best practice is to perform this assessment prior to ALND surgery, when known, and again after surgery. Serial measurements after surgery should be done when possible. This lymphedema assessment may be performed by any member of the patient care team, including, but not limited to, medical assistants, physical therapists, occupational therapists, nurses, advanced practice providers, and physicians. The NAPBC-accredited program should also consider assessing other patients at elevated risk for lymphedema. The NAPBC-accredited program must define who is at elevated risk of lymphedema and should be included in this lymphedema assessment.

The protocol for lymphedema assessment must include the following elements:

- Definition of who is at elevated risk for lymphedema
- Timing of the lymphedema assessment during treatment, including a baseline assessment before treatment
- The method of lymphedema assessment utilized to assess patients with breast cancer who have been exposed to lymph node removal and/or radiation therapy
- Appropriate referrals to physical or occupational therapy, including assessment thresholds that will initiate referrals to physical or occupational therapy

Examples of lymphedema assessments that meet compliance with this standard include, but are not limited to:

- Objective testing
  - Bioelectrical impedance spectroscopy
  - Circumferential measurements of the affected and unaffected limb at 4 locations identified by bony landmarks (**for example**, just above ulnar styloid, 2 cm below olecranon process, 2 cm above the lateral epicondyle of the humerus, 2 cm below the acromion process)
- Patient surveys
  - Norman Lymphedema Survey
  - Lymphedema and Breast Cancer Survey

If a patient had a lymphedema assessment within six months of diagnosis of breast cancer, the assessment does not need to be repeated by the NAPBC-accredited program.

Evaluation by the BPLC
Each accreditation cycle, the BPLC must review and assess the following:

- The protocol for lymphedema assessment

The BPLC evaluation and discussion must be documented in the BPLC meeting minutes.

Documentation

Submitted with Pre-Review Questionnaire

- Required protocol

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- A protocol is developed and implemented to address lymphedema assessment and appropriate referrals to physical therapy.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each accreditation cycle.

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5.9 Breast Cancer Staging

Definition and Requirements

Pathological staging classification (after surgical treatment) or posttherapy pathological staging classification (after neoadjuvant therapy followed by surgical resection) must be reported by the managing physician according to the most recent AJCC system, which includes appropriate genomic testing to determine prognostic stage. If neoadjuvant therapy is given, the posttherapy clinical staging classification (after neoadjuvant therapy and prior to surgical resection) should be reported as part of the assessment prior to surgical resection. AJCC staging must be documented in the medical record and discussed with the patient.

Evaluation by the BPLC
Each accreditation cycle, the BPLC must review and assess:
- Documentation of clinical stage classification and either pathological stage classification or posttherapy pathological stage classification

The BPLC evaluation and discussion must be documented in the BPLC meeting minutes.

Documentation

Reviewed Onsite
- Preselected medical records to confirm compliance with this standard

Submitted with Pre-Review Questionnaire
- BPLC meeting minutes documenting the required evaluation

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:
- Pathological or posttherapy pathological stage classification must be reported by the managing physician and discussed with the patient, with documentation of both in the medical record.

The BPLC evaluation is completed and documented in the BPLC meeting minutes once each accreditation cycle.

Bibliography

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5.10 Surgical Care

Definition and Requirements

Patients with breast cancer must receive education and management as outlined in this standard when undergoing surgery for breast cancer:

- Guideline/evidence-based care with documentation in the patient medical record
  - **Examples** of guideline/evidence-based care include, but are not limited to:
    - The NAPBC-accredited program follows national guidelines provided by the American Society of Clinical Oncology (ASCO) for the management of locally advanced inflammatory and T2 triple-negative and HER2-positive breast cancer, and patients are referred for neoadjuvant systemic therapy.
    - The NAPBC-accredited program establishes a process for axillary management, including upfront sentinel node biopsy, upfront axillary dissection, and completion axillary dissection based on current literature.
- Preoperative and postoperative patient education, addressing preparation for surgery and postoperative recovery, with documentation in the patient medical record
- Utilization of Enhanced Recovery After Surgery (ERAS) and/or opioid-sparing multimodal pain management strategies to facilitate same-day discharge, with documentation in the patient medical record

Access to the pathology report is provided to the patient per the requirements of the CARES Act (Coronavirus Aid, Relief, and Economic Security Act). The pathology results must be discussed with the patient.

CoC Operative Standards
NAPBC-accredited programs that are not accredited by the CoC must demonstrate compliance with CoC Standard 5.3: Sentinel Node Biopsy for Breast Cancer and CoC Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer as outlined in *Optimal Resources for Cancer Care (2020 Standards).*

NAPBC-accredited programs that are also accredited by the CoC are not evaluated for compliance with CoC Standards 5.3 and 5.4 by the NAPBC.

Evaluation by the BPLC
Each accreditation cycle, the BPLC must review and assess:

- Preoperative and postoperative patient education

The BPLC evaluation and discussion must be documented in the BPLC meeting minutes.

Documentation

Reviewed Onsite

- Preselected medical records to confirm compliance with this standard

Submitted with Pre-Review Questionnaire

- Examples of preoperative and postoperative patient education
- BPLC meeting minutes documenting the required review of patient education materials

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- Patients undergoing surgery for breast cancer receive the following education and management with documentation in the patient medical record:
  - Care provided according to evidence-based guidelines
  - Preoperative and postoperative patient education
  - Utilization of ERAS and/or opioid-sparing multimodal pain management
  - Compliance with CoC Standards 5.3 and 5.4
- A copy of the definitive surgery pathology report is provided to and discussed with the patient.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each accreditation cycle.

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5.11 Reconstructive Surgery

Definition and Requirements

Patients with breast cancer must receive education and management as outlined in this standard when undergoing surgery for breast cancer.

- Appropriate patients undergoing mastectomy are offered a preoperative referral to a reconstructive/plastic surgeon, with documentation 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.
  - Reconstruction may also include assistance with oncoplastic reconstructions/reductions, symmetry procedures, and other related procedures/assistance.
- Multidisciplinary input on the impact of reconstruction on other treatment modalities is obtained preoperatively, with documentation in the patient medical record.

Surgeons must seek to maximize satisfaction of cosmesis within the limits of cancer care and patient factors.

Documentation

Reviewed Onsite

- Preselected medical records to confirm compliance with this standard

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- Patients with breast cancer receive the following education and management with documentation in the patient medical record:
  - Preoperative referral to a reconstructive/plastic surgeon for appropriate patients undergoing mastectomy
  - Multidisciplinary input on the impact of reconstruction on other treatment modalities

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5.12 Medical Oncology

Definition and Requirements

Patients with breast cancer must receive guideline/evidence-based care when receiving medical oncology treatment for breast cancer, with documentation in the patient medical record.

Examples of guideline/evidence-based care include, but are not limited to:

- Genomic tumor testing is considered in patients with endocrine responsive disease with 0-3 positive nodes.
- Appropriate patients with endocrine responsive disease are considered for endocrine therapy.
- Patients who are HER2 positive are considered for HER2-targeted therapy. If this is not administered, then there is documentation why it was not administered.
- Patients with triple-negative disease are considered for chemotherapy (neoadjuvant, when appropriate).
- Patients are provided with exercise recommendations (see Standard 5.7).

Examples of guideline/evidence-based resources include, but are not limited to, National Comprehensive Cancer Network (NCCN), ASCO, and Quality Oncology Practice Initiative (QOPI).

Patients falling outside of evidence-based guidelines are discussed at the MBCC or with multidisciplinary input.

Documentation

Reviewed Onsite

- Preselected medical records to confirm compliance with this standard

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- Patients with breast cancer receiving medical oncology treatment receive care according to evidence-based guidelines.
- Patients falling outside of evidence-based guidelines are evaluated with multidisciplinary input.

5.13 Radiation Oncology

Definition and Requirements

Patients with breast cancer must receive guideline/evidence-based care when receiving radiation oncology treatment for breast cancer, with documentation in the patient medical record.

Examples of guideline/evidence-based care include, but are not limited to:
- All lymph node-positive patients with breast cancer are evaluated by radiation oncology or discussed at the multidisciplinary breast care conference (MBCC).
- Patients who are candidates for breast conservation and postoperative radiation are discussed at MBCC or referred to a radiation oncologist.
- The majority of early stage patients with breast cancer having breast conservation surgery are treated with a form of hypofractionation.
- Patients are offered observation when appropriate.
- Patients are offered regional nodal radiation when appropriate.

Examples of guideline/evidence-based resources include, but are not limited to, NCCN and American Society for Radiation Oncology (ASTRO).

Patients falling outside of evidence-based guidelines are discussed at the MBCC or with multidisciplinary input.

Documentation

Reviewed Onsite
- Preselected medical records to confirm compliance with this standard

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:
- Patients with breast cancer receiving radiation oncology treatment receive care according to evidence-based guidelines.
- Patients falling outside of evidence-based guidelines are evaluated with multidisciplinary input.

5.14 Surgical Pathology

Definition and Requirements

The NAPBC-accredited program must document estrogen receptor, progesterone receptor, and HER2 study results in the synoptic pathology report for the definitive surgery. These biomarker studies are only required to be performed on one specimen (**for example**, the core biopsy). The biomarker results must be included in the synoptic pathology report for the definitive surgery regardless of where the biopsy was performed, including biopsies performed at an outside facility. Referring to prior pathology reports with the biomarker results instead of including the results in the synoptic pathology report does not meet the measure of compliance for this standard.

Documentation

Reviewed Onsite

- Preselected medical records to confirm compliance with this standard

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- Estrogen and progesterone receptors and HER2 studies are included in the synoptic pathology report for the definitive surgery

5.15 Return to Wellness

Definition and Requirements

The NAPBC-accredited program must use evidence-based guidelines to develop and implement a protocol addressing persistent symptoms, functional issues, and social and behavioral determinants of health for maximizing symptom management, physical function, and social well-being among patients who have completed their first course of treatment for breast cancer. Evidence-based guidelines include, but are not limited to, those provided by the American College of Sports Medicine (ACSM), American Physical Therapy Association (APTA), Oncology Nursing Society (ONS), American Cancer Society, NCCN, and ASCO.

Examples of evidence-based guidelines include, but are not limited to:

- Referral to local or online exercise programs
- Referral to a social worker if psychosocial distress remains elevated post-treatment
- Referral to outpatient rehabilitation if specific functional complaints arise
- Referral to outpatient rehabilitation for evaluation and treatment for lymphedema, as needed
- Use of a lymphedema prevention program, including regular symptom assessment and clinical evaluation using objective measurements of lymphedema, such as bioimpedance spectroscopy

The protocol must also address how patients with breast cancer are connected to evidence-based elements of breast cancer recovery. **For example**, patients with breast cancer receive referrals to exercise programming at follow-up appointments. For services that are not available onsite, the treatment team must help facilitate patient access to needed resources.

It is recommended, but not required, that a written summary of treatment and associated survivorship recommendations is provided to the patient and the patient's primary care provider.

Patients must be encouraged to maintain a relationship with their primary care provider, who is informed about the care the patient received and potential side effects the patient may encounter.

Evaluation by the BPLC

Each accreditation cycle, the BPLC must review and assess the following:

- The protocol for following evidence-based guidelines to address persistent symptoms, functional issues, and social and behavioral determinants of health for maximizing symptom management, physical function, and social well-being among patients with breast disease or breast cancer

The BPLC evaluation and discussion must be documented in the BPLC meeting minutes.

Requirements for Integrated Network Breast Programs

The required protocol must also document how return-to-wellness services are organized either centrally at the network level or at the individual facilities within the network. In either case, return-to-wellness services must meet compliance with this standard as written.

Documentation

Reviewed Onsite

- Preselected medical records to confirm compliance with this standard

Submitted with Pre-Review Questionnaire

- Required protocol
- BPLC meeting minutes documenting the required evaluation

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- A protocol is developed and implemented for following evidence-based guidelines for addressing persistent symptoms and maximizing physical function and social and behavioral health.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each accreditation cycle.
- **Networks:** The required protocol must also document how return-to-wellness services are organized at the network level or at the individual facilities within the network.

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5.16 Surveillance

Definition and Requirements

The NAPBC-accredited program must use evidence-based guidelines to develop and implement a protocol addressing how the following will occur:

- Appropriate clinical and imaging surveillance for disease progression or recurrence in patients with breast disease or breast cancer
  - **For example**, annual mammograms are performed to monitor for disease local recurrence
- Surveillance for long-term and late effects of disease and treatment
  - **For example**, assessing patients for depression, cardiotoxicity, lymphedema, sexual well-being, and sleep disturbance

For services that are not available onsite, the NAPBC-accredited program must facilitate access to the necessary resources and services.

Evaluation by the BPLC
Each accreditation cycle, the BPLC must review and assess the following:

- The protocol for following evidence-based guidelines for disease surveillance and long-term and late effects of disease and treatment in patients with breast disease or breast cancer

The BPLC evaluation and discussion must be documented in the BPLC meeting minutes.

Requirements for Integrated Network Breast Programs

The protocol must also document how surveillance services are organized either centrally at the network level or at the individual facilities within the network. In either case, surveillance services must meet compliance with this standard as written.

Documentation

Reviewed Onsite

- Preselected medical records to confirm compliance with this standard

Submitted with Pre-Review Questionnaire

- Required protocol
- BPLC meeting minutes documenting the required evaluation

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- A protocol is developed and implemented for following evidence-based guidelines for disease surveillance and long-term and late effects of treatment in patients with breast disease or breast cancer.
- Surveillance for disease and long-term and late effects is documented in the patient medical record.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each accreditation cycle.
- **Networks:** The required protocol must also document how surveillance services are organized at the network level or at the individual facilities within the network.

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Data Surveillance and Systems

Rationale

Submission to a NAPBC-specific database is not required by *Optimal Resources for Breast Care (2027 Standards)*; therefore, there are no Chapter 6 standards.

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Quality Improvement

Rationale

The Institute of Medicine outlines the following attributes as contributory to high-quality care: safe, timely, effective, efficient, equitable, and patient centric. NAPBC-accredited programs must embark on quality improvement initiatives that address these factors in order to continuously improve the quality of the care they deliver to patients with breast disease or breast cancer.

7.1 Not Currently Active

Quality Measures

Definition and Requirements

The NAPBC requires accredited programs to treat patients with breast disease or breast cancer in accordance with nationally accepted quality measures. The NAPBC approves such nationally accepted quality measures based on a determination of need for quality or accountability regarding a specific aspect of breast care.

The BPLC must monitor the accredited program's expected estimated performance rates (EPR) for quality measures selected by the NAPBC. The timeline for implementation and the expected compliance rate for all new quality measures is determined by the NAPBC.

If the NAPBC-accredited program is not meeting the expected EPR of a quality measure, an action plan must be developed and implemented to improve performance. The action plan must document how the NAPBC-accredited program will investigate the issue(s) for each quality measure with the goal of resolving all barriers and improving compliance.

Programs with no cases eligible for assessment in an approved quality measure are exempt from demonstrating compliance with the requirements for that individual quality measure.

Evaluation by the BPLC
Each calendar year, the BPLC must review and assess the following:

- Compliance with all required quality measures
- Development and implementation of action plans for all quality measures that fall below the expected rate of compliance

The BPLC evaluation and discussion must be documented in the BPLC meeting minutes.

Requirements for Integrated Network Breast Programs

The network BPLC must annually monitor expected EPRs for quality measures selected by the NAPBC for each individual facility within the network. If the EPR is not met by an individual facility, an action plan must be developed and implemented and reported to the network BPLC.

Documentation

Submitted with Pre-Review Questionnaire

- BPLC meeting minutes documenting the required evaluation

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- The BPLC monitors the program's expected EPRs for quality measures approved by the NAPBC.
- The BPLC develops and implements an action plan for any quality measure that falls below its expected EPR.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes once each calendar year.
- **Networks:** The network BPLC monitors EPRs for NAPBC-selected performance measures at each individual network facility and develops and implements an action plan when EPRs are not met.

7.2 Quality Improvement Initiative

Definition and Requirements

Under the guidance of the BPD and the BPLC, the NAPBC-accredited program must measure, evaluate, and improve its performance through at least one breast cancer–specific quality improvement (QI) initiative each accreditation cycle.

This QI initiative requires the NAPBC-accredited program to identify a problem, understand the root cause of the identified problem through use of a recognized performance improvement methodology, and implement a planned solution to the problem. Reports on the status of the QI initiative must be given to the BPLC at least twice each calendar year until the QI initiative is complete. The status reports must be documented in the BPLC meeting minutes.

Required Components for Quality Improvement Initiatives

1. **Review Data to Identify the Problem**
   The QI initiative must be focused on an already-identified, quality-related problem specific to the NAPBC-accredited program.

   The following may be used to identify the focus of the QI initiative:
   - Data-focused quality problems identified through a chart review of a specific cohort of patients in order to assess an area of specific concern, or to assess an area of care specified in nationally recognized guidelines
   - Data-focused quality problems identified through a physician, specialty-specific quality improvement program; **examples** include, but are not limited to, the American Society of Breast Surgeons' Mastery of Breast Surgery program, the American Society for Radiation Oncology's Radiation Oncology Incident Learning System (RO-ILS), or the American Society of Plastic Surgeons' Tracking Operations and Outcomes for Plastic Surgeons (TOPS) program
   - Data-focused quality problems identified through a specialty-based facility-specific quality improvement program; **examples** include, but are not limited to, the American College of Radiology's National Mammography Database (NMD) or the National Consortium of Breast Centers' National Quality Measures for Breast Centers program (NQMBC)
   - Data-focused quality problems identified through an internal institution-specific or health-system-specific database, which may include the entire cancer registry or a smaller established clinical database
   - Data-focused problems identified in a Standard 7.1 quality measure
   - Problems identified through review of National Cancer Database data, including Cancer Quality Improvement Program (CQIP) or Rapid Cancer Reporting System (RCRS) data
   - Problems identified through the review of data related to cultural competency, individualized shared decision-making, and the implementation of health equity interventions in the breast program
   - Any other data-focused, breast cancer-specific, quality-related problem determined by the BPLC

2. **Write the Problem Statement**
   The QI initiative must have a problem statement. The problem statement must outline:
   - A specific, already identified, quality-related problem that is specific to the NAPBC-accredited program to solve through the QI initiative
   - The baseline and goal metrics (must be numerical)
   - The anticipated timeline for completing the QI initiative and achieving the expected outcome

   The problem statement for the QI initiative cannot state that a study is being done to see if a problem exists. The problem must already be known to exist.

3. **Choose and Implement Performance Improvement Methodology and Metrics**
   The BPD and BPLC must identify the subject matter experts needed to execute the QI initiative. **For example**, if the QI initiative is focused on the time between pre-surgery chemotherapy and surgery, then at least one breast surgeon and one medical oncologist must be included on the QI initiative team.

   A recognized, standardized performance improvement methodology must be selected and implemented to conduct the QI initiative (**for example**, Lean, DMAIC, or PDCA/PDSA).

   In line with the quality improvement methodology selected, the team must conduct analysis to identify all factors contributing to the problem. This may involve literature review and/or root-cause analyses. Based on the results of this analysis, an intervention is developed that aims to fix the cause of the problem being studied.

   It is recommended to establish a project calendar, which includes the launch date of the QI initiative, when status updates will be given at BPLC meetings, and a project end date.

4. **Implement Intervention and Monitor Data**
   The intervention chosen in step three must be implemented. If oversight of the implementation suggests the intervention is not working, then the intervention must be modified.

5. **Present Quality Improvement Initiative Summary**
   Once the QI initiative has been completed, a document summarizing the initiative and the results must be presented and discussed with the BPLC and documented in the BPLC meeting minutes. The results of the QI initiative must be quantifiable, using outcomes data compared to the baseline data and the numerical goal metrics established in step two. The results of the QI initiative must also be compared with national benchmark data, whenever possible.

   The summary presentation must include:
   - Summary of the data reviewed to identify the problem
   - The problem statement
   - The QI initiative team members
   - Performance improvement methodology utilized
   - The implemented intervention
   - If applicable, any adjustments made to the intervention
   - Results of the implemented intervention

BPLC Reports
The BPD and/or the quality improvement team must provide updates to the BPLC on the QI initiative's status at least twice each calendar year until the QI initiative is complete. Status updates, at a minimum, indicate the current status of the QI initiative and any planned next steps. The final summary and results report may qualify as one of the required reports.

Requirements for Integrated Network Breast Programs

The INBP must conduct two quality improvement initiatives each accreditation cycle that include all required elements as outlined in Standard 7.2:
- One QI initiative that includes all facilities within the INBP
- One QI initiative that is relevant to one or more facilities within the network

Documentation

Reviewed Onsite
- Documentation of QI initiative team's work from throughout the initiative (**for example**, meeting minutes, literature review)

Submitted with Pre-Review Questionnaire
- Quality Improvement Initiative Template
- BPLC meeting minutes documenting required status updates and presentation of the QI initiative summary

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that NAPBC-accredited programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

The NAPBC-accredited program fulfills all compliance criteria:

- One breast cancer–specific quality improvement initiative based on an identified quality-related problem is initiated each accreditation cycle. The QI initiative documentation includes how it measured, evaluated, and improved performance through implementation of a recognized, standardized performance improvement methodology.
- Status updates are provided to the BPLC twice each calendar year until the QI initiative is complete. Reports are documented in the BPLC meeting minutes.
- A final presentation of a summary of the quality improvement initiative is presented after the QI initiative is complete. The summary presentation includes all required elements.
- **Networks:** The INBP must conduct two quality improvement initiatives each accreditation cycle that include all required elements as outlined in Standard 7.2.

Resources

ACS Quality Improvement Case Study Repository

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Education: Professional and Community Outreach

Rationale

NAPBC-accredited programs must strive to focus efforts on education about breast cancer prevention, healthy lifestyles, and screening awareness. Such education helps lessen the physical, emotional, and financial burdens of a potential cancer diagnosis by improving the odds of faster detection and faster treatment. Lifestyle modifications, such as achieving and maintaining a healthy body mass index and reducing alcohol intake, can reduce the risk for breast cancer.

8.1 Education, Prevention, and Early Detection Programs

NAPBC-accredited programs that are also accredited by the CoC are not evaluated for compliance with Standard 8.1 by the NAPBC.

NAPBC-accredited programs that are not accredited by the CoC must hold two events each calendar year that are compliant with CoC Standard 8.2: Cancer Prevention Event and/or Standard 8.3: Cancer Screening Event as outlined in *Optimal Resources for Cancer Care (2020 Standards)*. Programs may choose to hold two prevention events, two screening events, or one prevention event and one screening event. These events must focus on breast disease or breast cancer screening or prevention. The events may address multiple cancer sites, but at least one component of the event must be dedicated to breast disease or breast cancer.

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Research

Rationale

In order to advance medical science in service to patient care in every sense, it is important to learn as much as possible from patients who receive treatment. Accordingly, NAPBC-accredited programs must endeavor to enroll patients into scientific studies that may broaden the overall understanding of breast diseases.

9.1 Clinical Research Accrual

Definition and Requirements

The NAPBC-accredited program must enroll a minimum of 2% of its analytic breast cancer cases in clinical research studies. The clinical research studies must be related to breast disease or breast cancer. This requirement must be met each calendar year.

Cancer-Related Research Studies Eligible for Accrual
Clinical research studies eligible to count for accrual must meet the following requirements:

1. Related to breast disease or breast cancer
2. Approved by an internal or external Institutional Review Board (IRB) that is responsible for the review and oversight of the research study
3. Have informed, written, subject consent (unless consent is waived by the IRB)

Categories of breast disease or breast cancer–related clinical research studies eligible for accrual:

- Basic Science
- Device Feasibility
- Diagnostic
- Health Services Research
- Prevention
- Screening
- Supportive Care
- Treatment

Definitions for these categories may be found on the National Cancer Institute Clinical Trial Reporting Program User Guide (see Primary Purpose Value Definitions).

Additional categories of breast disease or breast cancer–related clinical research studies for accrual:

- Cancer-specific biorepositories or tissue banks
  - Such biobanks must collect samples for use in clinical trials and/or clinical research
- Economics of cancer care
  - Studies that assess the costs and effectiveness of cancer interventions and/or analyze the financial impact of cancer care on patients
- Genetic studies
  - Studies that examine contributing genes or how different exposures modify the effect of a gene mutation that may be at risk for cancer development
  - Studies that examine genetic polymorphisms and mutations for early risk assessment
- Patient registries with an underlying breast disease or breast cancer research focus
  - Such registries must be used in clinical trials and/or clinical research
- Epidemiological studies with an underlying breast disease or breast cancer research focus

Humanitarian Use Devices studies cannot be counted as an accrual under this standard.

Calculating Compliance
Compliance with this standard is calculated using the number of subjects with breast disease or breast cancer enrolled in eligible clinical research studies (numerator) and the total number of annual analytic breast cancer cases (denominator).

To count for accrual, subjects enrolled in eligible clinical research studies must fall into at least one of the following categories:

- Diagnosed and/or treated at your program and enrolled in a breast disease or breast cancer–related clinical research study within your program
- Diagnosed and/or treated at your program and enrolled in a breast disease or breast cancer–related clinical research study within a staff physician's office of your program
- Diagnosed and/or treated at the program, then referred by your program for enrollment onto a breast disease or breast cancer–related clinical research study through another program or facility
- Referred to your program for enrollment onto a breast disease or breast cancer–related clinical research study through another program or facility

Researchers and clinical trial investigators who accept referral of subjects from other programs for the purpose of participation in a breast disease or breast cancer–related clinical research study must cooperate with the data management team of the cancer program from which the patient was referred.

If one subject is enrolled in two different trials or studies, that subject may be counted twice for accrual. However, if one subject is enrolled in two arms of a protocol, or enrolled in a sub-study of a protocol, that subject only counts once for accrual.

If the clinical research is cancer related, but it is not specific to breast disease or breast cancer, subject accruals are allowed to count provided the study relates to breast disease or breast cancer. The subjects enrolled must still be patients with breast disease or breast cancer.

Evaluation by the BPLC
Each calendar year, the BPLC develops an annual report on clinical research activity. The annual report is presented during the first-quarter meeting of each calendar year and must include reporting data from the previous full calendar year. The annual report is documented in the BPLC meeting minutes.

The clinical research activity annual report must contain the following elements:
- The breast disease or breast cancer–specific clinical research studies where subjects were accrued, including the trial/study name and, when applicable, the clinicaltrials.gov trial number
- Number of subjects accrued to each individual breast disease or breast cancer–specific clinical research study
- Open breast disease or breast cancer–specific clinical research studies with identification of those nearing end date
- New breast disease or breast cancer–specific trials that will be added
- If the required accrual percentage is not met, the BPLC identifies contributing factors and identifies an action plan to address those factors

The BPLC report and analysis must be documented in the BPLC meeting minutes.

Requirements for Integrated Network Breast Programs

The INBP has a screening protocol to identify participant eligibility for clinical research studies and how to provide clinical trial information to patients across the network. These processes are assessed to identify and address barriers to enrollment and participation. Clinical research accrual percentages are calculated based on a cumulative accrual percentage met collectively across the network facilities. Within a network, individual patient accruals can only be counted once (if the patient is on a clinical trial but has been seen at more than one facility in the network, they can only be counted once).

Documentation

Reviewed Onsite
- Tracking documents that detail the number of subjects accrued to specific clinical research studies

Submitted with Pre-Review Questionnaire
- Clinical Research Template
- BPLC meeting minutes documenting the required evaluation
- **Networks:** Screening protocol for identifying participant eligibility for clinical research studies and providing clinical trial information to patients across the network

Documentation uploaded into the Pre-Review Questionnaire must have all protected health information removed.

It is expected that NAPBC-accredited programs follow local, state, and federal requirements related to patient privacy, risk management, and peer review for all standards of accreditation. These requirements vary state to state.

Measure of Compliance

Each calendar year, the NAPBC-accredited program fulfills all compliance criteria:
- The annual number of breast disease or breast cancer subjects accrued to breast disease or breast cancer–related clinical research studies meets or exceeds 2%.
- The BPLC evaluation is completed and documented in the BPLC meeting minutes.
- **Networks:** A screening protocol is in place for identifying participant eligibility for clinical research studies and providing clinical trial information to patients across the network.

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Resources and Examples for Individualized Shared Decision-Making (ISDM)

Resources and Examples for Individualized Shared Decision-Making

The NAPBC has retired all individualized shared decision-making (ISDM) requirements from its accreditation standards. However, the concepts are still strongly supported by the NAPBC. The following resources for ISDM remain in *Optimal Resources for Breast Care (2027 Standards)* as a reference for NAPBC programs.

Agency for Healthcare Research and Quality (AHRQ)
SHARE Curriculum Tools
- Resources for starting a shared decision-making dialogue with patients
- Communication tools for shared decision-making
- Implementation resources for shared decision-making
- Webinars on implementation and overcoming barriers to shared decision-making

Association of Community Cancer Centers (ACCC)
Shared Decision-Making: Practical Implementation for the Oncology Team
- Featured publication regarding methods for establishing patient engagement, with an emphasis on shared decision-making

National Cancer Institute (NCI)
Communication in Cancer Care – Models of Communication
- Models of communication
- Demographic and cultural considerations in cancer communication
- Education and training in cancer communication

Examples of Individualized Shared Decision-Making
- Training on cultural sensitivity
- Training on gender identity and gender expression
- Identifying patient values, goals, preferences, and priorities
- Incorporating patient values, goals, preferences, and priorities into treatment decision-making
- How to run a family meeting
- The role of families and caregivers in supporting treatment decision-making
- Coaching on communication of treatment risks and benefits to patients, families, and caregivers
- Conducting difficult conversations (discussing prognosis, bad news, and end of life)
- Use of evidence-based decision aids to guide conversations with providers and patients
- Basic training about shared decision-making and how it differs from informed consent

Examples of Individualized Shared Decision-Making in Clinical Scenarios
- A 72-year-old patient with triple-negative breast cancer, atrial fibrillation, and hypertension. The decision is made to provide a NeoPACT regimen (docetaxel/carboplatin + pembrolizumab), instead of neoadjuvant anthracycline.
- A postmenopausal patient with early stage ER+ breast cancer, genomic testing showing low risk, a strong family and personal history of osteoporosis, and concerns for bone fracture, chooses to start tamoxifen instead of an aromatase inhibitor.
- A young patient with four children, and a member of an Orthodox community with traditionally larger families, receives a referral to reproductive endocrinology to discuss fertility preservation before deciding whether or not to proceed with neoadjuvant chemotherapy.
- A patient who has avoided any systemic therapy due to fears associated with chemotherapy chooses to start HP+ endocrine therapy for a fungating triple-positive breast mass.

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Glossary, Acronyms, and Key Terms

A

ACCC: Association of Community Cancer Centers

Accreditation Report: Document released to NAPBC programs at the conclusion of their initial or reaccreditation site visit. The accreditation report includes compliance ratings for each applicable standard and may include specific comments regarding the program's performance. The accreditation report also states the assigned accreditation award and, if applicable, the corrective action due date.

Accredited Program(s): A single or multiple-location medical institution providing diagnostic services, treatment services, and comprehensive multidisciplinary care for patients with breast disease or breast cancer, which has achieved accreditation by the NAPBC. This also refers to initial applicant programs that are actively pursuing accreditation with the NAPBC.

ACS: The American College of Surgeons

ACS Cancer Programs: ACS's programs focused on improving care and treatment for patients with cancer, including Commission on Cancer, National Accreditation Program for Breast Centers, National Accreditation Program for Rectal Cancer, the National Cancer Database, American Joint Committee on Cancer, Cancer Surgery Standards Program, and the Clinical Research Program

ACR: American College of Radiology

ACSM: American College of Sports Medicine; ACSM Guidelines for Exercise and Cancer

ADH: Atypical ductal hyperplasia; a type of high-risk breast lesion

Adjuvant therapy: Additional treatment given after primary treatment (typically surgery) to reduce the risk of recurrence, e.g., systemic therapy or radiation therapy

AHRQ: Agency for Healthcare Research and Quality

AJCC: American Joint Committee on Cancer

ALH: Atypical lobular hyperplasia; a type of high-risk breast lesion

Analytic breast cancer case: Cases for which the hospital provided the initial diagnosis of cancer and/or for which the hospital contributed to first course treatment

Annually: Once each calendar year

AOCN: Advanced Oncology Certified Nurse

AOCNP: Advanced Oncology Certified Nurse Practitioner

AOCNS: Advanced Oncology Certified Clinical Nurse Specialist

Appeal: A part of the site visit process where the applicant program contests one or more of the findings of the site visit

APRN: Advanced practice registered nurse

APTA: American Physical Therapy Association

ASBrS: American Society of Breast Surgeons

ASCO: American Society of Clinical Oncology

ASTRO: American Society for Radiation Oncology

B

BICOE: Breast Imaging Center of Excellence. Retired terminology. See "CBIC".

Breast Care Team (BCT): See definition and requirements in Standard 2.3.

Breast Program Director (BPD): See definition and requirements in Standard 2.2.

Breast Program Leadership Committee (BPLC): See definition and requirements in Standard 2.1.

C

Calendar year: January 1 – December 31

Calendar year review: Compliance criteria requiring annual review must be completed at least once for each full calendar year (January 1 – December 31)

CBCN: Certified breast care nurse

CBIC: Comprehensive Breast Imaging Center designation from the American College of Radiology

CE: Continuing education

CEO or equivalent: A high-ranking member of hospital/institutional administration with the authority for high-level decision-making and resource allocation

CEU: Continuing education unit

CGRA: Cancer Genetic Risk Assessment Certification

Class of Case: Class of Case divides cases into two groups that reflect the program's primary responsibility in managing the cancer, analytic and non-analytic cases. More information on Class of Case is available in the Standards for Oncology Registry Entry (STORE).

CoC: The Commission on Cancer

Community representative: An individual who resides within the accredited program's service area

Compliance: The accredited program meets all the criteria required for a specific standard.

CQIP: Cancer Quality Improvement Program, a report provided to accredited programs by the National Cancer Database that includes short-term quality and outcome data and long-term data, including five-year survival rates for commonly treated malignancies

Corrective action: The process by which a cancer program shows they have met a standard(s) that was non-compliant at the time of the site visit

CTR(s): Certified Tumor Registrar. Retired terminology; see "ODS".

D

Definitive treatment: Neoadjuvant therapy, surgical resection, initiation of non-operative care, or initiation of palliative care

DMAIC: Acronym for Define, Measure, Analyze, Improve, and Control; DMAIC is a structured quality improvement methodology.

E

"Each accreditation cycle" review: Compliance criteria requiring review each accreditation cycle must be completed at least once every three years during the NAPBC-accredited program's accreditation cycle.

ER(+/-): Estrogen receptor (positive/negative)

ERAS: Enhanced Recovery After Surgery

G

Genetic Professional: The NAPBC defines genetic professionals as healthcare professionals who hold any of the qualifications outlined in Commission on Cancer Standard 4.4.

H

HER2: Human epidermal growth factor receptor 2

HR(+/-): Hormone receptor (positive/negative)

I

IRB: Institutional Review Board

L

LCIS: Lobular carcinoma in situ

M

MBCC: Multidisciplinary Breast Care Conference

Medical Records Review: The evaluation of patient medical records to determine compliance with specific standards

Monitor: Closely and consistently observe and evaluate a function or process.

MQSA: Mammography Quality Standards Act

MRI: Magnetic resonance imaging

N

NAPBC: National Accreditation Program for Breast Centers

NAPRC: National Accreditation Program for Rectal Cancer

NCCN: National Comprehensive Cancer Network

NCDB: National Cancer Database

NCI: National Cancer Institute

Neoadjuvant therapy: Treatment provided to initiate further treatment and/or reduce the size of the primary breast cancer before definitive treatment

Newly diagnosed: Patients who have received a breast cancer diagnosis at the NAPBC-accredited program or have received a diagnosis elsewhere and present for evaluation and/or treatment at the NAPBC-accredited program before receiving any treatment elsewhere

NMD: National Mammography Database

Non-compliance: The NAPBC-accredited program does not meet one or more of the compliance criteria required for a specific standard.

NQMBC: National Consortium of Breast Centers' National Quality Measures for Breast Centers Program

O

OCN: Oncology Certified nurse

ODS: Oncology Data Specialist

ONN-CG: Oncology Nurse Navigator-Certified Generalist

ONS: Oncology Nursing Society

Outside provider/Outside facility: Any individual or entity that is not part of the NAPBC-accredited program at a specific medical institution. These outside providers/facilities may or may not be involved in the treatment, testing, or evaluation of patients receiving care at the NAPBC-accredited program.

P

PA: Physician assistant

Patient representative: A current or former patient of a NAPBC-accredited program

PCP: Primary care physician

PDCA: Plan, Do, Check, Act; PDCA is a structured quality improvement methodology.

PDSA: Plan, Do, Study, Act; PDSA is a structured quality improvement methodology.

Policy and procedure: Retired terminology. See "Protocol".

PR(+/-): Progesterone receptor (positive/negative)

Pre-Review Questionnaire (PRQ): An online reporting tool that is utilized to demonstrate compliance with NAPBC standards. Formerly known as "Survey Application Record (SAR)".

Protocol: Previously referred to as "policies and procedures" in past versions of the NAPBC Standards, 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 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. **Please refer to the NAPBC 2027 Standards FAQ for guidelines and recommendations related to the development of protocols.**

PRQ: See "Pre-Review Questionnaire".

Q

QOPI: Quality Oncology Practice Initiative

R

RCRS: Rapid Cancer Reporting System

RDN: Registered dietitian nutritionist

Referred services: Diagnostic services, treatment services, and comprehensive care that are provided at another facility

RO-ILS: American Society for Radiation Oncology's Radiation Oncology Incident Learning System

S

Site Reviewer: NAPBC-trained physician who conducts site visits and reviews the compliance documentation of a NAPBC-accredited program. The site reviewer assists in verifying whether the accredited program meets compliance with the NAPBC Standards.

Site Visit: A virtual or in-person review of the NAPBC-accredited program by an NAPBC site reviewer to verify compliance with the NAPBC Standards and recommend an accreditation award. After initial accreditation, site visits occur once every three years.

Standard: Qualification criteria for NAPBC accreditation (not standard of care)

Survey/Surveyor: Retired terminology. See "Site Visit" and "Site Reviewer".

Synoptic format: A structured format that includes all of the following:

- All core elements must be reported (whether applicable or not)
- All core elements must be reported in a "diagnostic parameter pair" format, in other words, data element followed by its response (answer)
- Each diagnostic parameter pair must be listed on a separate line or in a tabular format to achieve visual separation
- All core elements must be listed together in a single location in the pathology or operative report

T

TOPS: American Society of Plastic Surgeons' Tracking Operations and Outcomes for Plastic Surgeons (TOPS) Program

V

VUS: Variants of uncertain significance

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American College of Surgeons
633 N Saint Clair St
Chicago, IL 60611-3295
facs.org