What Currently Defines a Breast Center? Initial Data From the National Accreditation Program for Breast Centers

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Abstract

Purpose: The definition of a “breast center” varies significantly, ranging from hospital-based or free-standing comprehensive programs to private subspecialty practices with patient resources in close proximity. This study analyzes the 2-year data of the National Accreditation Program for Breast Centers (NAPBC) to assess the demographics of the types of programs seeking breast center (BC) accreditation. The results of a postaccreditation survey are also analyzed.

Materials and Methods: All data (ie, Survey Application Record, on-site surveyors’ reports, postaccreditation survey) for programs applying for accreditation between October 31, 2008, and October 31, 2010, were entered into a database at the American College of Surgeons headquarters. Analysis was conducted with SPSS v.19 and Microsoft Excel 2007.

Results: During the initial 2-year period, 238 centers were surveyed across 41 states. With regard to the 27 standards and

17 BC components, 68% of centers had no deficiencies, 28% had $\leq 10\%$ deficiencies, 3% had deficiencies in 11% to 29% of standards, and 2% had $\geq 30\%$ deficiencies. The most common standards with noncompliance were accreditation for ultrasound-guided biopsy (standard 11), stereotactic biopsy (standard 10), and accrual onto clinical trials (standard 3.2). The only BC component found to be absent was survivorship program (1%). Descriptive categories were as follows: 81.5% were hospital-based centers, 13.5% were free-standing facilities, 2.5% were group practices, and 3% were “other.” There were no significant associations between descriptive category and full accreditation versus contingency or failure, or deficiencies in any one standard (all P s $> .05$). On the basis of responses to the postaccreditation survey, 76% admitted making significant changes before the survey process.

Conclusion: This initial analysis of the NAPBC 2-year data suggests that a wide variety of BC models adequately provide a high level of care and services for patients across the nation.

Introduction

The first breast center in the United States was a free-standing, comprehensive facility with multidisciplinary, coordinated care under one roof,¹ conceived in the 1970s to reduce fragmented care for women with breast diseases. Subsequently, innumerable “breast centers” have been established across the nation, with expansion of the original prototype to include a wide variety of breast center models. Though the public, media, and medical profession have embraced this multidisciplinary concept over the years, the diversity of each center has generated confusion for patients and referring physicians.

Recognizing the lack of a national registry or accreditation process for breast health care, the American College of Surgeons established a multidisciplinary accreditation process for breast centers in 2005.² This program, named the National Accreditation Program for Breast Centers (NAPBC), was developed by a multidisciplinary group of stakeholders (patient advocacy representatives, surgeons, pathologists, medical and radiation oncologists, social workers, nurses, tumor registrars, and others) who combined their expertise in breast health care to develop a validation process for breast programs. The NAPBC Board of Directors,³ representing 20 national organizations, has defined standards and structural components considered essential for a

breast center (Appendix, online only). On-site surveys with chart reviews, attendance at interdisciplinary breast conference, and facility inspections are conducted to ensure availability of components and compliance with standards. In addition to annual data submission, reaccreditation is mandated every 3 years. Although individual physicians’ practices within a center are not monitored, the NAPBC endorses nationally recognized quality improvement programs**and incorporates these initiatives into their standards; these efforts are intended to raise the level of care by fostering competent breast health care delivery in conjunction with the efforts of professional organizations that award individual certification to their subspecialists. Finally, the NAPBC accreditation allows for patients, referring physicians, and payers to easily identify programs that are delivering proficient care with comprehensive, multidisciplinary breast health care.

The goal of this study was to analyze the data accrued over the first 2-year experience of the NAPBC to evaluate the current landscape of the breast programs receiving accreditation and to review compliance with components and standards at these programs. In addition, the results of a postaccreditation survey, designed to provide insight into the perceptions regarding accreditation, the preparation process, and changes made before accreditation, are reported in this article.

Materials and Methods

All data were stored at the NAPBC Staff Office at the American College of Surgeons' headquarters in Chicago, IL. This included parameters from the mandatory on-line application (Survey Application Record [SAR]), records of the on-site surveyors' reports, and the results of a postaccreditation survey (distributed to all sites achieving accreditation). The study period was the initial 2 years of the NAPBC (10/31/2008-10/31/2010). Data were analyzed with SPSS v.19 and Excel Microsoft 2007.

Definitions

The NAPBC Board of Directors has defined 17 program components required to qualify as a breast center. In addition, 27 standards have been developed, three of which are mandatory for accreditation. The details of the program components and standards are available in Appendix 1 (online only).

The 17 components include imaging, needle biopsy, pathology, interdisciplinary breast conference, patient navigation, genetic evaluation and management, surgery, reconstruction, nursing, medical and radiation oncology, data management, research, education/support/rehabilitation, outreach, quality improvement, and survivorship program. The surveyor confirms the presence of each component at the time of the survey. Each component may be provided within the center or referred off-site (component available in close proximity to the center), or a combination of the above, for the purposes of the survey accreditation.

Of the 27 standards for accreditation, each is rated as compliant or noncompliant. The three mandatory standards pertain to the existence of (1) breast program leadership that is held accountable for center (standard 1.1), (2) multidisciplinary breast cancer tumor boards (standard 1.2), and (3) documentation of evidence-based breast care evaluation and management guidelines (standard 2.1). Full 3-year accreditation is granted to a program that meets more than 90% ($n \geq 24$ of 27) of the standards. All deficient standards must be resolved, documented, and submitted within 1 year of the survey date. A 3-year contingency accreditation is granted if a center meets between 71% and 90% ($n = 20$ -23 of 27) of the standards with the same 1-year requirement for resolution of deficiencies; full accreditation is withheld until documentation is submitted. Centers meeting less than 70% ($n < 20$ of 27) of the standards do not receive accreditation but are provided feedback on the deficiencies and are permitted to reapply within 1 year for re-survey.

Other categorical variables obtained from the SAR include (1) hospital based versus nonhospital based (freestanding, group practice, etc), (2) medical school affiliated versus non-medical school affiliated, (3) training programs present versus not present. For purposes of this analysis, a center was defined as an academic center if it met the following three criteria: (1) hospital based, (2) medical school affiliated, and (3) presence of at least one residency/fellowship training program. On the basis of the on-site survey results, the breast center components were

categorized as "provided" or "referred" versus "absent," and the standards as "compliant" or "noncompliant."

Postaccreditation Survey

In the fall of 2010, all accredited centers were asked to voluntarily complete a postaccreditation survey. The online survey consisted of multiple-choice questions regarding the accreditation process and perceptions. It was administered to centers that had received full accreditation, full accreditation with three or fewer deficiencies, or contingency accreditation.

Data Analysis

The data from the SARs, the on-site survey, and the postaccreditation survey were analyzed using descriptive statistical methods. Exploratory analysis to determine any significant associations between breast center model parameters and (1) final accreditation received, (2) compliance rating of each standard, (3) presence or absence of each breast center component, (4) provided versus referred for each of the components was conducted using Pearson χ^2 analysis and Fisher's exact test (when indicated).

Results

Centers and Deficiencies

During the initial 2-year study period, 238 centers were surveyed across 41 US states. From these surveys, 161 centers (68%) centers received full 3-year accreditation with no deficiencies, an additional six (28%) received full accreditation with more than 90% of standards met (full ≤ 3), six (3%) received contingency accreditation for meeting only 70% to 90% of the standards, and five (2%) were found to have critical deficiencies ($< 70\%$ of standards met). Of the 27 NAPBC standards (Table 1, Appendix 1), the most common deficiencies were (1) accreditation through the American College of Radiology (ACR)⁶ or American Society of Breast Surgeons (ASBS)⁷ for ultrasound-guided biopsy (standard 2.10, $n = 24$ centers); (2) accreditation through ACR or ASBS for stereotactic core needle biopsy (standard 2.11, $n = 17$ centers); (3) accrual requirements onto clinical trials (standard 3.2, $n = 11$ centers); (4) compliance with staging documentation (standard 2.6, $n = 10$ centers); and (5) compliance with College of American Pathologists guidelines for pathology documentation (standard 2.7, $n = 10$ centers). Figure 1 illustrates the numbers of centers with deficiencies in standards from the study period.

Components: Provided or Referred Versus Absent

When assessing whether necessary components of a breast program were provided, the Survivorship Program component was the only component found to be absent in three of the surveyed centers (one academic and two nonacademic programs). Analysis of provided versus referred for each of the 17 required components revealed that the vast majority of centers provided the mandatory components on site, with the remaining centers also providing the necessary components by referral to providers in proximity to the center. The top three most common

Table 1. Synopsis of Standards

1.1 Existence/documentation of structured program leadership
1.2 Existence of a dedicated breast tumor board
1.3 Documentation of evidence-based evaluation/management guidelines
2.1 Documentation of multidisciplinary patient management
2.2 Existence of a dedicated breast patient navigator
2.3 Documentation of > 50% breast conservation for early-stage breast cancer
2.4 Availability and appropriate use of sentinel lymph node biopsy
2.5 Appropriate documentation for follow-up surveillance of patients
2.6 Documentation of AJCC breast cancer staging
2.7 Pathology reports utilizing CAP guidelines
2.8 Availability of MQSA-certified mammography
2.9 Documentation of appropriate use of needle (not open) biopsy as initial diagnostic approach
2.10 Availability of ultrasound-guided biopsy by ACR/ASBS-certified MDs
2.11 Availability of stereotactic needle biopsy by ACR/ACoS/ASBS-certified MDs
2.12 Availability of board-certified, ACR/ASTRO-accredited radiation oncology
2.13 Availability of board-certified medical oncology
2.14 Availability of nurses with documented expertise in breast diseases
2.15 Availability of supportive and rehabilitation services
2.16 Availability of genetic risk assessment, counseling, and testing services
2.17 Availability of multilingual patient educational resources
2.18 Availability board-certified reconstructive surgeons
2.19 Documentation of evaluation and management benign breast disease
3.1 Availability of clinical trials
3.2 Annual accrual onto clinical trials of $\geq 2\%$ of breast center volume
4.1 Documentation of community education/prevention and early-detection programs
5.1 Documentation of staff education programs
6.1 Documentation of development and results for two or more outcomes studies

Abbreviations: ACoS, American College of Surgeons; ACR, American College of Radiology; AJCC, American Joint Committee on Cancer; ASBS, American Society of Breast Surgeons; ASTRO, American Society for Radiation Oncology; CAP, College of American Pathologists; MQSA, Mammography Quality Standards Act.

components that were referred (provided off site) were genetic evaluation and management (17%), plastic surgery consultation (16%), and survivorship (11%). The remaining 14 components were provided on site by more than 93% of the centers surveyed.

Breast Center Models

Of the 238 centers surveyed, 81.5% ($n = 194$) were hospital-based centers, 11% ($n = 25$) were free standing facilities with a hospital affiliation, 2.5% ($n = 6$) were free-standing without a hospital affiliation, 2.5% ($n = 6$) were group practices, and 3% ($n = 7$) were defined as “other.” On the basis of the SARs, 46% ($n = 110$) of the surveyed centers reported an affiliation with a medical school, and 40% ($n = 95$) had training (residency and/or fellowship) programs, but only 17% ($n = 40$) were classified as academic programs. The relationships of the various descriptive center model parameters are shown in Figure 2.

Associations

Exploratory analysis revealed no significant correlation between type of center (hospital-based, free-standing, group/other, medical school affiliated, academic) and receipt of full accreditation versus contingency or failure (all $P > .05$). Furthermore, when analyzing the deficiencies of each of the 27 standards as a function of descriptive parameters, there were no significant associations (all $P > .05$).

When analyzing components as provided versus referred as a function of program structure, hospital-based programs were significantly more likely to provide a patient navigator compared with non-hospital-based programs (100% *v* 96%, respectively; $P = .034$), and academic programs were more likely to provide on-site survivorship and/or surveillance programs compared with nonacademic centers (100% *v* 88%, $P = .018$). Medical oncology was provided more often in medical school-affiliated programs than in non-medical school-affiliated programs (100% *v* 90%, respectively; $P = .018$).

Of the centers that received contingency accreditation or failed to pass accreditation, exploratory analysis revealed no significant patterns for noncompliance with any specific standards. Specifically, of these 11 centers, the most common standards to have noncompliance were standard 6.1, documentation of quality measurements and/or quality improvement ($n = 4$) and standard 1.2, the breast tumor board requirement ($n = 3$).

Medical and Radiation Oncology Participation

Data collection regarding participation of radiation and medical oncologists in subspecialty-based quality initiative programs (from SARs) revealed that 45% of the 238 surveyed centers reported having three to five radiation oncologists affiliated with their breast program, 39% reported having one to two radiation oncologists, 12% reported six to nine radiation oncologists, and only 4% reported 10 or more radiation oncologists on staff. Of the 838 board certified/board-eligible radiation oncologists reported to be affiliated with these breast programs nationally, only 16% ($n = 135$) reported participation in the Performance Assessment for the Advancement of Radiation Oncology Treatment (PAAROT) program.⁴ Within medical oncology, of the 238 centers surveyed, the numbers of oncologists associated with the breast programs were as follows: one to two, 10% of centers; three to five, 35%; six to nine, 29%; and 10 or more, 26%. Of the 1,486 board certified or board-eligible medical oncologists affiliated with surveyed breast programs, approximately one third ($n = 509$; 34%) reported participation in the Quality Oncology Practice Initiative (QOPI).⁵

Postaccreditation Survey for Fully Accredited Centers

The overall response rate for the postaccreditation survey was 88.5% ($n = 201$ of 227). The largest challenges in preparation for the accreditation process are reported in Appendix Table A1 (online only). Data collection for the SARs was obtained from

Figure 1. National Accreditation Program for Breast Centers (NAPBC) standards, standard numbers, and numbers of centers rated as deficient over the initial 2-year period.

tumor registry, 88% ($n = 176$); chart review, 30% ($n = 59$); internal breast cancer database, 21% ($n = 42$); more than one of the three sources, 30%. Of the 201 breast centers responding to the survey, 73% ($n = 147$) responded that they had subsequently developed an improved way to obtain data for future reaccreditation and quality improvement studies after going through the accreditation process. The preparation time required for accreditation was 2 to 6 months for 43%, 7 to 9 months for 38%, greater than 9 months for 14%; only 5% required less than 1 month for survey preparation.

When asked whether preparation for the accreditation process enhanced the quality of their program overall, 92% ($n = 184$) responded yes. Of the 201 respondents, 76% ($n = 152$) admitted making significant changes before the accreditation survey process. The most common changes were development of, and/or improvements to, the critical components of breast tumor board (14%), breast program leadership (9%), tracking and documentation of clinical data.⁷ Details regarding the specific categories of changes made before accreditation are shown in Appendix Table A1.

Discussion

This study reports the initial 2-year analysis from the NAPBC, the first accreditation program to comprehensively establish guidelines and standards for breast centers across all disciplines (ie, surgery, radiology, pathology, medical and radiation oncology, etc). To date, the number and types of breast center models in existence across the country remains unknown. Since the NAPBC launch, 238 breast programs across 41 states have undergone survey for accreditation.

The goal of the current analysis was to evaluate the current landscape of the breast programs receiving accreditation in this

initial period of the program, to review our experience of compliance with the accreditation requirements, and to report the responses of the postaccreditation survey regarding changes made before accreditation and perceptions regarding the accreditation process. We acknowledge that, given that this is our initial report, the programs applying for accreditation may be a somewhat skewed sample of centers that were highly motivated to obtain accreditation and centers that believed their programs were qualified. Nevertheless, the responses from the postaccreditation survey suggest that the majority of these programs admittedly underwent significant preparation over many months, and implemented major changes to enhance their programs before undergoing survey. This may explain why the vast majority of these centers received full or contingency accreditation.

It is encouraging that the 27 standards and 17 program components necessary for accreditation were achievable irrespective of the breast center descriptive category (academic, medical school affiliated, training program present, hospital based, hospital affiliated, group or solo practice, other). In addition, it is important to highlight that receipt of full accreditation (as opposed to contingency accreditation or failure) was not correlated with any specific descriptive program category. These findings highlight that the level of breast care currently delivered at the accredited programs exceeds the NAPBC-established threshold and is independent of program type or center model. These data challenge the notion that high-quality care and resources are available solely in hospital-based or academic programs and underscore the evolution of the original breast center concept of a comprehensive center with all resources under one roof to now include a wide variety of models, many of which are “centers without walls” that deliver high-quality, comprehensive care.

Figure 2. Venn diagrams depicting the relationships between the various descriptive models of breast center programs.

With respect to the 17 program components required for NAPBC accreditation, the only component that was found to be not provided/not available was the survivorship program component (absent: $n = 3$ programs, 1%). The remaining 16 components were either provided within each facility or referred to providers in proximity to the center. Interestingly, a relatively large number of centers referred patients outside of their program for the survivorship program component ($n = 43$ programs, 18%). This may be due to the recent and rapid evolution of survivorship programs and the controversies surrounding what exactly defines such programs.

The most common breast center components referred off site were genetics evaluation and management in 17% and reconstruction consultation and treatment in 16% of surveyed programs. These findings are not surprising and parallel the two standards to ensure availability of certified genetics experts and preoperative plastic surgery consultation by board-certified plastic surgeons at all accredited breast programs.

The most difficult standards for preparation of accreditation were reported as requirements for additional accreditation for ultrasound-guided biopsy (standard 2.10) and stereotactic biopsy (standard 2.11) through the American College of Radiology (ACR)⁶ or American Society of Breast Surgeons (ASBS).⁷ Eleven centers reported that obtaining these accreditations were part of their preparation for NAPBC accreditation. It is important to note that although various accreditation programs for the other subspecialties also exist (eg, for radiation oncology

accreditation, American College of Radiation Oncology or ACR/American Society of Radiation Oncology programs) and participation is encouraged by the NAPBC, currently, ultrasound and stereotactic biopsy accreditation through ACR or ASBS for radiologists and/or surgeons are the only compulsory NAPBC accreditation requirements. These mandatory diagnostic accreditation standards were established to raise the bar and ensure a high level of quality in the diagnosis of breast diseases for all accredited breast programs, analogous to the Mammography Quality Standards Act passed in 1992 by the US Congress, which federally mandated standards for all mammography facilities in order to perform mammography.⁸

As a result of the NAPBC standard for subspecialty-specific accreditation for ultrasound-guided and stereotactic biopsy, the number of certified centers performing these procedures across the country should gradually increase. Of 202 postsurvey respondents, 11 centers reported undertaking the accreditation for ultrasound and/or stereotactic biopsy as part of their preparation for NAPBC survey. An additional 11% and 7% had deficiencies in these two standards at the time of survey and are required to pursue accreditation within a year to achieve full certification. Furthermore, with additional programs applying for NAPBC accreditation as our program continues to mature, we anticipate a further gradual increase in centers attaining ACR or ASBS accreditation in ultrasound and stereotactic biopsy across the nation.

In contrast, the NAPBC has not, to date, established standards for individual physician participation involvement in subspecialty quality initiative programs such as PAAROT and QOPI.^{4,5} While we are collecting these data at present and may, in the future, mandate participation, it is compelling that the current percentage of physicians participating in their subspecialty organization quality improvement programs (as a baseline) is so low. One can foresee that if the NAPBC mandated participation in these quality initiative programs, the participation would likely increase within each subspecialty, similar to the phenomena that has occurred with biopsy accreditation requirements. However, it is essential that all of these quality measures be integrated without excess burden on physicians and centers.

Last, despite best hopes and intentions to improve the quality of care delivered, we recognize that these data are preliminary and that we have yet to demonstrate the program's effects on quality measures and patient outcomes. The NAPBC, recognizing this limitation, has begun requiring submission of quality and outcome measures, with the intention of establishing benchmarks and evaluating changes over time. These data should allow for the analysis of whether implementation of this program ultimately translates into improved quality of care for patients.

In summary, the NAPBC has attempted to standardize what is expected of a breast center program in the United States by developing guidelines and required program components. We recognize the need to assess how patient outcomes and quality measures are affected as this program matures, and plan to report these data in the future. Given the variety of breast center

models that have achieved NAPBC accreditation, without one model type surpassing another in terms of proficiencies in standards or components available, we conclude that the term “breast center” has significantly evolved over the last several decades. The initial prototype of a free-standing comprehensive center has given way to the current landscape, in which a wide variety of models provide a high level of care and service for breast patients across the nation.

Authors' Disclosures of Potential Conflicts of Interest

Although all authors completed the disclosure declaration, the following author(s) and/or an author's immediate family member(s) indicated a financial or other interest that is relevant to the subject matter under consideration in this article. Certain relationships marked with a “U” are those for which no compensation was received; those relationships marked with a “C” were compensated. For a detailed description of the disclosure categories, or for more information about ASCO's conflict of interest policy, please refer to the Author Disclosure Declaration and the Disclosures of Potential Conflicts of Interest section in Information for Contributors.

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Appendix

Appendix 1: Details of the 17 Breast Center Components and 27 Standards for Accreditation.

1. Center Leadership

Purpose: The standard establishes the medical director and/or codirectors, or interdisciplinary steering committee, as the Breast Program Leadership (BPL) responsible and accountable for breast center activities.

Standard 1.1: Level of responsibility and accountability. The organizational structure of the breast center gives the BPL responsibility and accountability for provided breast center services.

Standard 1.2: Interdisciplinary breast cancer conference. The BPL establishes, monitors, and evaluates the interdisciplinary breast cancer conference frequency, multidisciplinary and individual attendance, prospective case presentation, and total case presentation annually, including American Joint Committee on Cancer (AJCC) staging and discussion of nationally accepted guidelines.

Standard 1.3: Evaluation and management guidelines. The BPL identifies and references evidence-based breast care evaluation and management guidelines.

2. Clinical Management

Purpose: The standards identify the scope of clinical services needed to provide quality breast care to patients. The managing physician is essential to coordinating a multidisciplinary team approach to patient care.

Standard 2.1: Interdisciplinary patient management. After a diagnosis of breast cancer, the patient management is conducted by an interdisciplinary team.

Standard 2.2: Patient navigation. A patient navigation process is in place to guide the patient with a breast abnormality through provided or referred services.

Standard 2.3: Breast conservation. A proportion of at least fifty percent (50%) of all patients diagnosed with early-stage breast cancer (stage 0, I, II) are treated with breast-conserving surgery, and compliance is evaluated annually by the BPL.

Standard 2.4: Sentinel node biopsy. Axillary sentinel lymph node biopsy is considered or performed for patients with early breast cancer (clinical stage I, II), and compliance is evaluated annually by the BPL.

Standard 2.5: Breast cancer surveillance. A plan is in place for ensuring follow-up surveillance of patients with breast cancer.

Standard 2.6: Breast cancer staging. The BPL develops a process to monitor physician use of AJCC staging in treatment planning for breast cancer patients. The process and results of such monitoring are discussed among the BPL and breast center staff, and the findings are documented annually.

Standard 2.7: Pathology reports. The College of American Pathologists (CAP) Cancer Committee guidelines are followed for all breast cancers, including estrogen and progesterone receptors, and HER2 status for all invasive breast cancer. Estrogen and progesterone receptors are recommended for ductal carcinoma in situ (but not required by CAP).

Standard 2.8: Diagnostic imaging. Screening mammography and diagnostic mammography are performed at Mammography Quality Standards Act (MQSA)-certified facilities and interpreted by MQSA-certified physicians.

Standard 2.9: Needle biopsy. Palpation-guided or image-guided needle biopsy is the initial diagnostic approach rather than open biopsy.

Standard 2.10: Ultrasonography. Diagnostic ultrasound and/or ultrasound-guided needle biopsy is performed at an American College of Radiology (ACR)-accredited facility or by an American Society of Breast Surgeons (ASBS)-certified surgeon.

Standard 2.11: Stereotactic core needle biopsy. Stereotactic core needle biopsy is performed at an ACR-accredited facility, by surgeons under the standards and requirements developed by the ACR and the American College of Surgeons, or by an ASBS-certified surgeon.

Standard 2.12: Radiation oncology. Radiation oncology treatment services are provided by or referred to radiation oncologists who are board certified or in the process of board certification, the center has been accredited by the ACR/American Society for Radiation Oncology Accreditation Program or has a quality assurance program in place, and the breast cancer quality measures endorsed by the National Quality Forum (NQF) for radiation therapy are utilized.

Standard 2.13: Medical oncology. Medical oncology treatment services are provided by or referred to medical oncologists who are board certified or in the process of board certification, and the breast cancer quality measures endorsed by the NQF for medical oncology are utilized.

Standard 2.14: Nursing. Nursing care is provided by or referred to nurses with specialized knowledge and skills in diseases of the breast. Nursing assessment and interventions are guided by evidence-based standards of practice and symptom management.

Standard 2.15: Support and rehabilitation. Support and rehabilitation services are provided by or referred to clinicians with specialized knowledge of diseases of the breast.

Standard 2.16: Genetic evaluation and management. Genetic risk assessment, genetic counseling, and genetic testing services are provided or referred.

Standard 2.17: Educational resources. Culturally appropriate educational resources are available for patients, along with a process to provide them. The materials provided are reviewed on an annual basis and adjusted for the patient population.

Standard 2.18 Reconstructive surgery. All appropriate patients undergoing mastectomy are offered a preoperative referral to a reconstructive/plastic surgeon. Reconstructive surgery is provided by or referred to reconstructive/plastic surgeons who are board certified or in the process of board certification. Compliance is evaluated annually by the BPL.

Standard 2.19: Evaluation and management of benign breast disease. Evaluation and management of benign breast disease follows nationally recognized guidelines.

3. Research

Purpose: The standards promote advancement in prevention, early diagnosis and treatment through the provision of clinical trial information, and patient accrual to breast cancer–related clinical trials and research protocols.

Standard 3.1: Clinical trial information. Information about the availability of breast cancer–related clinical trials is provided to patients through a formal mechanism.

Standard 3.2: Clinical trial accrual. Two percent or more of all eligible patients with breast cancer are accrued to treatment-related breast cancer clinical trials and/or research protocols annually.

4. Community Outreach

Purpose: The standards ensure that breast cancer education, prevention, and early detection opportunities are provided to the community, patients, and their families.

Standard 4.1: Education, prevention and early detection programs. Each year, two or more breast cancer education, prevention, and/or early detection programs are provided on site or coordinated with other facilities or local agencies targeted to the community, and follow-up is provided to patients with positive findings.

5. Professional Education

Purpose: The standard promotes increased knowledge of breast center staff through participation in local, regional, or national educational activities.

Standard 5.1: Breast center staff education. Professionally certified/credentialed members of the breast center participate in local (in addition to breast cancer conference attendance), state, regional, or national breast-specific educational programs annually.

6. Quality Improvement

Purpose: The standard ensures that breast services, care, and patient outcomes are evaluated and improved continuously.

Standard 6.1: Quality and outcomes. Each year, the breast program leadership conducts or participates in two or more studies that measure quality and/or outcomes, and the findings are communicated and discussed with the breast center staff, participants of the interdisciplinary conference, or the cancer committee, where applicable.

Breast Center Components

1. Imaging
2. Needle biopsy
3. Pathology
4. Interdisciplinary conference
5. Patient navigation
6. Genetic evaluation and management
7. Surgical care
8. Plastic surgery consultation and treatment
9. Nursing
10. Medical oncology consultation and treatment
11. Radiation oncology consultation and treatment
12. Data management
13. Research
14. Education, support, and rehabilitation
15. Outreach and education
16. Quality improvement
17. Survivorship program

Table A1. Changes in Programs Made Prior to Survey for NAPBC Accreditation (from postaccreditation survey)

	No.	%
Largest challenges for accreditation		
Completing the SAR	62	31
CME tracking	59	29
Preparing for survey day	31	15
Meeting research requirements	30	15
Accreditation for stereotactic biopsy	29	14
Accreditation for breast ultrasound	26	13
Organizing breast program leadership	26	13
Conducting quality initiative studies	23	11
Meeting tumor board requirements	17	9
Significant changes made to program		
None	48	23.9
Unspecified	20	10.0
Development of a breast tumor board	28	13.9
Development of breast program leadership	18	9.0
Development of a method for documentation/data tracking	14	7.0
Initiating quality initiative studies	13	6.5
Undergoing additional accreditation (ultrasound/stereotactic biopsy)	11	5.5
Development of algorithms for patient follow-up and surveillance, designation of a breast navigation, development of a survivorship program	11	5.5
Staff education	9	4.5
Development of a genetics program	5	2.5
Development of a rehabilitation/lymphedema program	4	2.0
Establishing MD requirements for breast center participation (ie, specified CME requirements, tumor board attendance, breast cases per year, etc)	4	2.0
Retrospective collection of staging data	4	2.0
Improving timelines (ie, time from biopsy to definitive surgery, etc)	3	1.5
Implementation of CAP pathology guidelines	3	1.5
Increasing clinical trial accrual	2	1.0
Development of benign breast disease management algorithms	2	1.0
Development of a multidisciplinary clinic	2	1.0
Total	201	100.0

Abbreviations: CAP, College of American Pathologists; CME, continuing medical education; NAPBC, National Accreditation Program for Breast Centers; SAR, Survey Application Record.