The Challenge of Quality in Breast Care: Beyond Accreditation

By *Stephen B. Edge, MD, FACS*

The diagnosis and treatment of cancer, particularly breast cancer, requires the coordination of professionals from multiple disciplines. Lack of coordination often results in missed or inappropriate care that is wasteful and harmful. Efforts to improve breast cancer care have led to the development of alliances of specialists in “breast centers.” The first breast centers emerged in the 1970s pioneered by Wende Logan-Young in Rochester, NY, and Melvin Silverstein in Van Nuys, CA.^{1,2} Since then, the term “breast center” has been applied to practices of many shapes and sizes, ranging from large tertiary centers to individual physician practices.

The proliferation of breast centers with no oversight to assure the public of a quality product led David P. Winchester, the Medical Director of the Commission on Cancer (CoC) of the American College of Surgeons, to propose a coordinated effort by professional breast care organizations to set national standards for breast centers that, like CoC cancer program accreditation, would raise the level of care. In 2005, leaders of these organizations began developing a set of 27 standards and a breast center accreditation program that would meet these standards.³ This National Accreditation Program for Breast Centers (NAPBC) began accrediting centers in 2008.

In the article that accompanies this commentary, the NAPBC provided an overview of its standards and reported its initial experience with breast center accreditation.⁴ In just 2 years, the NAPBC attracted applications from, and completed accreditation of, 238 centers. As of this writing, 450 have received accreditation. This remarkable achievement underscores the relevance of the program and the desire of providers and centers to provide coordinated quality care and to receive community recognition for their efforts.

Quality assessment and improvement are generally considered through the prism of the Donabedian triad of structure, process, and outcome.⁵ Although improving outcomes is clearly the goal, assessing outcomes may be difficult because of the long time frame needed to achieve improvement and other factors besides quality that affect outcome (eg, cancer biology). Most quality improvement therefore involves measures of the organization or structure of programs and services, and assessment of whether care is provided in accordance with accepted standards or processes.

The current NAPBC standards are primarily structural. They specify programmatic leadership and organization, as well as the types of services that must be provided by the center – either directly on site or by referral to other providers in the center’s community. The NAPBC also includes two performance standards: the center must achieve a breast-conserving

surgery rate of at least 50% for women with early-stage cancer, and enroll 4% of women onto clinical trials.

It is intuitive that coordinated medical care with programmatic oversight plus psychosocial support, education, genetics, physical therapy, and other services is better quality than disjointed care overseen by an individual doctor. However, despite the perceived value of multidisciplinary program accreditation, it is hard to show that accreditation and structural standards result in higher quality, a fact the authors readily acknowledge. Indeed, recent evidence challenges the accepted notion that multidisciplinary tumor boards enhance quality of care.⁶

To further ensure quality, the NAPBC standards also require submission of data to a national breast disease registry to allow measurement of care processes. However, as of this writing, this registry has not been established. This system would likely to be similar to the CoC registry-based quality monitoring program.⁷ Because most NAPBC centers are at CoC accredited cancer programs, the NAPBC program may use new measures under development by the CoC, and may include other new process measures including those from other NAPBC members such as the National Consortium of Breast Centers, the American Society of Breast Surgeons, and others.

However, most accepted and endorsed process measures assess only process standards that are at the level of practice basics, such as administration of chemotherapy with hormone receptor-negative cancer and endocrine therapy with receptor-positive cancer. Although a high level of performance on such measures is a necessary component of good care, the best evidence is that for women who have access to care, concordance with these measures is high. Therefore, while meeting such standards is a requisite for quality care, achieving good performance on panels of process measures may not be a reliable indicator of high quality.

More important, current programs provide only retrospective evaluation of care. There is growing recognition of the need to evaluate the patient perspective, and to monitor care to ensure ongoing delivery of quality care rather than evaluate past quality. In any business, the customer’s perception affects business performance and success; in health care, it may affect treatment outcomes. In my everyday practice, I see women who are offered and receive guideline-adherent optimal medical care but who have poor-quality care because of untoward experiences with providers or the care system. In many cases, these negative experiences affect receipt of proper care. A key example in breast cancer is compliance with the recommended course of endocrine therapy: women who receive care in a patient-centered care model, with better provider-patient communication, are

more likely to complete the full course of this life-saving treatment.^{8,9}

Similarly, prospective care monitoring rather than retrospective quality review has real potential to improve quality and outcome. There is clear evidence of variability in care associated with factors such as social and emotional status and access to care. Prospective monitoring of key care processes may allow interventions to ensure delivery of care when a patient is “falling through the cracks.” Tracking systems have been tested and demonstrated to increase access to care and reduce disparities in care.¹⁰

There are many efforts underway in these domains. The CMS measures the patient perspective on hospital inpatient care using the Hospital Care Quality Information from the Consumer Perspective, with results available to the public on the HospitalCompare Web site. Systems to collect data symptom data directly from patients are also under development.¹¹ Similarly, the Rapid Quality Reporting System (RQRS), a national system for care tracking based on endorsed quality measures, was implemented by the CoC in 2011.¹² In addition to the RQRS, practice guideline-based clinical decision support tools and pathways by National Comprehensive Cancer Network, Eviti, and others may help improve care monitoring. There are now also systems to coordinate care directly among providers and patients with medical homes and with medical social networking systems. The dream of interactive data systems that allow the patient, specialty provider, and primary physician to view and enter data while monitoring care and adverse effects can now be realized.

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Establishing coordinated care monitoring and quality review systems that assist providers in patient care is a daunting task, and some may consider it outside the purview of an accreditation body such as NABPC. However the mission of NABPC is to improve breast care, a discipline that crosses between many providers and health systems, and meaningful enhancement of quality in this practice setting will likely involve such systems. That the NAPBC has not yet established its quality monitoring infrastructure gives the organization a unique opportunity to develop such systems. Doing so would provide its accredited programs with quality support tools that go beyond largely outmoded systems that assess quality primarily by retrospective evaluation of standards adherence.

The NAPBC is to be lauded for its huge accomplishment in such a short time. Building on this track record of success—and with its small, nimble size—the NAPBC should now seize the moment and lead the nation in redefining and broadly implementing new patient-centered models of quality assessment and care.

Author's Disclosures of Potential Conflicts of Interest

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