

Breast Surgeon Quality Measurement

Purpose

To describe the principles of quality measurement and improvement endorsed by the American Society of Breast Surgeons (ASBrS)

Associated ASBrS Guidelines or Quality Measures

1. This Consensus Guideline replaces the ASBrS Position Statement on Breast Surgery Quality Measurement and Initiatives approved February 15, 2012
2. ASBrS Endorsed Quality Measures

Methods

1. Comprehensive, but not a complete systematic review of literature, for healthcare quality measurement
2. Comprehensive review of healthcare policy stakeholder recommendations for use of quality measures (QM) to identify quality gaps and aid quality improvement.
3. The ASBrS Patient Safety and Quality Committee developed a consensus document that was reviewed and approved by the ASBS Board of Directors.

Summary of Data Reviewed

1. Quality measurement policy recommendations of the Institute of Medicine, the National Quality Forum, the Agency for Healthcare Research and Quality, the Institute for Healthcare Improvement, The American College of Surgeons, the Commission on Cancer, the Surgical Quality Alliance, the American Society of Clinical Oncologists, the American Medical Association PCPI, the National Consortium of Breast Centers, the National Accreditation Program for Breast Centers, and the European Union of Breast Cancer Specialists.
2. Review of the National Quality Strategy, the National Quality Healthcare and Disparities Reports, and the ASCO report on “The State of Cancer Care in America 2015”
3. Publications regarding surgical and breast cancer quality measurement

Recommendations

1. **Breast surgeons should search for disparities, inequalities, and gaps in the quality of breast surgical care.** Gaps are identified when there is proof of variability of performance synchronous with evidence that good performance is possible; i.e. actual care does not match achievable care.
2. **Breast specific “quality measures” (QM) should be developed, then used for quality gap identification, peer performance comparison, and quality improvement initiatives.** QMs are an attempt to quantify quality of care in a specific domain of care. Post-operative general surgical morbidity and mortality outcome QM are important but not sufficient to measure breast surgical performance.
3. **QMs should be developed for multiple domains of care to include, but not limited to care structure, process of care, outcomes, patient experience, care coordination, affordability, access, and population health.**
4. **QMs require “specifications” - a specific numerator, denominator, exception and exclusion criteria.** These specifications improve fairness during peer comparisons because they differentiate between “quality” and “non-quality” reasons why performance for a specific QM was “not met.”
5. **New QMs should have “desirable attributes.”** These include relevancy, importance (gap between desired and actual care), scientific soundness, and feasibility of measurement.
6. **Peer performance comparison requires appropriate statistical risk adjustment for accuracy and fairness.**
7. **Programs designed for breast-specific QM reporting and peer performance comparison should be accessible for both general and breast specialty surgeons.** Attempts should be made to develop programs that limit the surgeon burden of data entry.
8. **Providers of care should not be expected to achieve 100% compliance with every QM.** There are justifiable reasons why performance may not be achieved to include patient refusal, significant co-morbidities, and limited life expectancy. In addition, performance for some QM can be dependent on multiple care providers and cannot be solely “attributed” to the surgeon.
9. **The developers of QM and improvement initiatives should seek multi-stakeholder input to include patients, payers, and policymakers, in addition to the providers of care and their professional organizations.**
10. **Programs that intend to use breast cancer QM for “accountability” should not be developed without breast surgeon stakeholder representation.** Accountability use includes public transparency, linking provider performance to financial compensation

(or penalty), patient steerage (eligibility to see a patient), and licensing or credentialing activities.

11. **QM program data should be reviewed periodically for effectiveness and contemporary relevancy.** The results will drive decisions to continue, modify, or retire specific QM or the entire program.
12. **The stewards of quality measurement must anticipate and monitor for unintended outcomes because quality initiatives may cause unintended and adverse consequences such as provider “risk aversion” to care for a patient or change their choice of procedure to meet a “performance requirement” of a QM.**
13. **Since there is ample evidence that variability of surgical care exists, all surgeons should participate in quality measurement and improvement activities at some level to determine their level of performance.**

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