

Session Notes

– *this document contains summarized notes from the session. The notes are based on comments made by participants that have not been independently validated. The notes have not been edited for grammar. Please share additional ideas, examples or comments through weldon@centerforbusinessmodels.com Thank You.*



“Looking Under the Rug”

A review of Issues and Solutions in Mammography Quality and Processes

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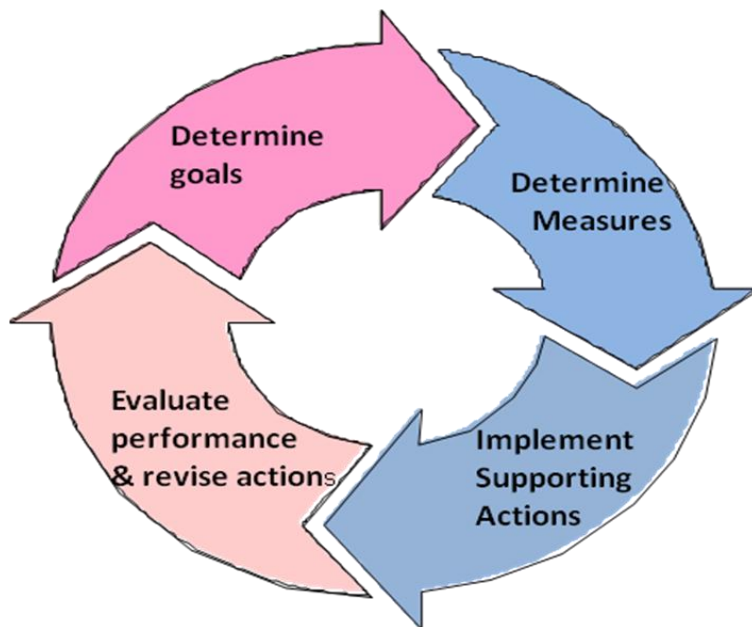
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Presentation Notes

Learning Objectives of Session Today

1. Assess how compression may impact the quality of a breast image and what situations/considerations may reduce optimal compression
2. Distinguish key factors that determine the number of views and/or type of equipment that will result in the most complete breast image
3. Describe what key information should be included in patient conversations to guide patient’s breast health

Rapid Cycle Improvement Process



Measures –Quality Mammography from 2009 Data Collection

- Appropriately detect abnormalities in a mammogram (Recall Rate).
~**25%** of facilities could NOT demonstrate
- Track patients with abnormal mammograms (Follow up) ~**65%** of facilities could NOT demonstrate
- Find Cancer (Cancer Detection Rate)
~**40%** of facilities could NOT demonstrate
- Find Cancer early (% early stage detected)
~**75%** of facilities could NOT demonstrate
- Find Cancer when it’s small (% minimal cancers detected)
~**70%** of facilities could NOT demonstrate

Measures –Quality Mammography Across Participating Environmental Scan Sites

Allow patient self referrals	14%
Walk-ins allowed	32%
Annual screening reminder sent from imaging center	76%
Calls patients to remind about all appointments	67%
Calls ALL no shows	16%
Calls patient to follow up for BIRADS 0,4,5 (beyond a letter)	52%
Offers screening mammograms on weekends?	44%
Pre-Register patients, proceed directly to radiology?	64%
Conducts outreach about breast screening	29%
Percentage of “returning” screening patients, who had past screening at site	Average across sites 69%
Standards for optimal and minimum compression – no consistent approach across sites	Need to determine measure
Views variable based on breast size / body habitus	73%

Discussion of Actions - Compression

What is considered Taut?

- When you touch the breast and it’s not a pillow effect, you can’t push it in.
- Springs back quickly

What is at risk if there is not enough compression?

- there might look like there are things there, pseudo masses because the breast tissue is not spread out
- patient being called back because that region needs to be investigated

What might you say to a patient about the importance of compression?

- talk with the patient, develop a relationship with the patient
- engage them, ask how they are doing while compressing the breast
- go over the history sheet
- talk/distract about things not related to the mammogram, some women are then able to take more compression than they realize.

- look at history sheet and refer information from that such as “oh, you’re

new to us, welcome"
- "Do you have kids?"

- explain why you have to do this level of compression
- when we do discharge calls after mammography and if they express that they will never have a mam again, we take time for service recovery and explain and the majority do come back.
- if they say a certain tech was more comfortable, they can request that tech

What to say to first time patients?

- tell them what we have to offer at the institution
- ask about self breast exams
- when you go to see your doctor, have them do an exam once a year because we find that a lot of doctors don't do that
- tell them that we are just one part of breast care, the physician and the patient have to be involved along with the mammography team

Ask what have you heard about mammograms?

- I'll say let us do yours and then you tell me what it was like and sometimes they will say it wasn't as bad as they thought it was going to be.
- when you develop a relationship with a patient, 9 times out of 10 they are more likely to come back. For some it is critical that they come back.

When one knows a patient might not come back:

- call on the tech that has the sensitive touch
- have the goal that no one falls through the cracks
- hold their hand and walk them through
- if you've done all you can, and they are just not going to come back, then you need to call their doctor, use a team approach
- even if you can get just 1 patient to come back who said they wouldn't, you've done well.

Inform patients about best time of month to get mammogram?

- tell them that if they come in right before their period, it will be more tender
- those who are on fertility treatment (wakes the breast up) have more sensitive breasts as well

How to help a woman tolerate compression:

- converse about other things, even the weather
- start with the pedal on the floor, but then use the hand dial compression, gentle it up, talking and taking it slow
- if very tentative, might tell the woman that she can do just one breast and see how that goes. Most of the time, you can get them to do the other.
- have another staff member come in and rub their back or offer help

We Compress Because We Care Poster

- An example of something that can be on display to aid in the explanation of the compression



Mammogram Documentation

- Screeners write a synopsis of what's happened during their patient contact so the radiologists know. It is then clear to the doctor that the patient couldn't tolerate the compression.
- this benefits the screener too to show that they tried everything they could to get a good screen
- this documentation helps the next year's screener with the patient
- can also use to document, even with a form with check offs, for patients who have tremors, in a wheel chair, couldn't tolerate compression, had radiation therapy, had rotator cup surgery, etc. Results in less call backs from the radiologists.
- any information that can be given to the radiologist is beneficial
- encourage screeners to sit down with their radiologists and ask them "what can we do on the patients side that will help you get a better interpretation to the doctor?" This info can then be related to the referring doctor.
- with the IBCCP program or an agency, this documentation getting back to the nurse case managers helps to minimize loss to follow up.

Breast Centers

- at one hospital, there are meetings with the radiologists and staff meetings with the technologists and discuss what will make our hospital a center of choice. Includes image quality, history sheets, how do we go about it, should we do scripting, review call backs and why they were called back.
- the aesthetics are becoming more spa like

Are there guidelines in terms of lbs (pounds) or daN (decaNewtons)?

- the minimum is 20lbs and making sure the breast is taut.
- between 20 -30 lbs
- some sites don't use any numbers, base on what the patient can tolerate
- other sites try to go to 40
- one uses 5-10lbs
- minimum of 10 - 11 decaNewtons, there is a huge difference of a mam at 5 or 6 decaNewtons verses 10 or 11 or take another one 15.
 - you won't see much difference at 10 - 15 on a fatty breast, you will see though a pseudo mass or potential lymphoma that you would not see on a 5.
- conversion from lbs to Newtons: # of lbs x .4448222
- radiologist recall rate is public information now, so doctors may start to say they want a specific amount of pressure
- need to apply the most compression a patient will tolerate to get the image and to get a really good image. Don't go beyond the standard.
- if a patient comes in saying they can feel something, mammography hasn't helped them one bit. Mammography goal is to find it on a screen. The power lies in the hands of the technologist to decide what kind of image is gotten so that the day doesn't come where a physician is telling a technologist how to do what they know how to do.
- some radiologists back from Xerox or GE 600's, they may say that if a mammogram was not at "this" number, it's no good, even if a good diagnostic can be given from the screen.

Previous Studies

- look at the previous technique and density, it will give the technologist a base of what you need to compress upon
- technologists are the most important part of the chain since they are the ones getting that image to be read. If the technologist does not do well, then they cannot read well.
- if it's a baseline, will be harder, make sure it's taut, are all the tissues where they need to be, is it compressed
- mammography is an art, it is not a science, it's how you position, it's what you know, it's when you look at that breast you know how it's going to lay, what to do if small or large, it's all based upon the technologist

Technologist Rating

- one hospital, when the radiologists are their volumes are down, issues a card for every single mammogram to the techs. They sit and evaluate with all the techs.
 - green card: great film, ACR quality
 - yellow card: could have been better
 - red card: not good
- techs appreciate this and like it because they know what the radiologist wants and what they are looking for to do a good read

Screening Views

- large breasted, if doing an anterior MLO, do as a 90 because if you do that extra picture, with a 90 at least you'll be able to use that if a patient gets called back for a diagnostic
- exaggerated cc's are also helpful if you can't get behind the dense breast tissue
- depends on what the radiologists set, talk with the radiologists ask what they would want you to do if the breast is large
- radiologists don't do positioning so making suggestions to them might be helpful
- some sites are only allowed to do 4 images, 2/breast. Surprise and sadness in the room for any site like this.
- a very large breasted woman, you're going to have to take one of the cc views and that might be 4 pictures

Suspicious Screens

- some sites can move through the same day to diagnostic after talking with the radiologist and calling the primary physician. If the primary care doctors allows, can do biopsy as well same day. If it's a Saturday, can't. But the techs know what views the radiologists like, so they try to get those on the same day.
- put them higher up on the pile for call backs
- hold 6 diagnostic slots, 3 in the morning/3 in the afternoon for new lumps, add-ons anything
- some sites using a CPT 76091 code for screening to diagnostic conversion to actually get appropriate reimbursement, not sure if correct
- talk to the billing department and see if there is a code to convert screens to diagnostic
- some need a referral for diagnostic 24 hours in advance unless the patient is willing to pay for the diagnostic mammogram and the breast ultrasound.
- some do run into insurance issues converting screen to diagnostic

First Time Patients

- have patients return to same site for future screens which allows for continuity of care
- tell them before (because if you tell them after, they may think the tech saw something) that most of the time they are going to come back for extra views. Tell them what that will entail:
 - they'll need to have another order from their doctor
 - it will take a little longer for the call back
 - they will feel better about it
- if first time to your facility, and they have had a mammogram before, at scheduling you ask them to bring their previous films for comparison which increases the sensitivity of the reading

- with first timers tell them there is nothing to compare to, so do not be alarmed if they get a call back
- explain that this will be their baseline exam. All future screens will be compared to this

Call Backs

- one site uses the name "Monica" called. Then when the patient calls back and said that Monica called, whoever answers the call knows immediately what the patient is calling about so they are able to handle the call appropriately
- nurse navigators makes that call
- think that the schedulers may be the ones who make them
- some do letters
- some expect the primary care givers to do the follow-ups
- Task Force is looking into a shared resource for follow ups especially for those that just get letters
- one site the techs make the call and it's done within 48 hours of the screen. Had the schedulers doing it, but found the techs can answer more questions and calm the patients fears more. This site has up to 15 per 48 hours.
- discharge calls are made to screeners, know then already if they are a call back. Will not get both calls, if a diagnostic is needed, will just call for a call back. Keep these separate from satisfaction calls.

Non-English Language Speaking Patients

- some sites will have an interpreter there on a specific day and try to schedule all patients needed this service
- some will have them there multiple days and schedule accordingly

Evaluate Performance and Revise Actions - What are some actions you may take?

- Ask the radiologist(s) you work with to share feedback on images: what is good, what is not as good, why?
Make adjustments based on feedback.
- Assess your approach to first time patients and make changes as needed
- Review your approach to compression
- Make a list of issues/challenges you encounter and share with co-workers (and task force), work together on solutions

Evaluate Performance and Revise Actions - What are some actions you may influence in your organization?

- Create plan for accepting self-referrals
- Pilot a time period each week for walk-in appointments
- Assess communication with patients: reminder calls, no show calls, calls to BIRADS 0-4-5

- Suggest pilot of extended hours, even if only 1 hour (weekday and weekend) to support patient's scheduling needs
- Review standard patient letters and identify improvements, test with patients. For example the word benign. Some patients need to see the word "normal" with it.
- Help your organization improve community interactions:
 - get to know your community around your hospital
 - getting to know the ladies in the community
 - get to know the city screening sites, share info when you hear information such as what the experience was with the last MQSA inspection, need to become each other's neighbors which will make it better for the patient.
 - staff meeting that the techs create the agendas
 - Go to the churches and get the word out about disparities and breast cancer and where to get screens
 - Outreach workers are doing the navigation through mammography but not doing mammography, need conversations between hospital and people who are doing the outreach. Some woman are afraid of hospitals
- Pin a Sister is a faith based outreach organizations. On their web site, you can request information packets:
<http://www.pinasister.com/>
- Community Outreach Programs by:
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