

The Provincial Breast Health Strategy

Working together to improve breast cancer prevention, screening & diagnosis in BC

Clinical Pathway Team: Input from Summit Participants

Provincial Breast Health Strategy Objective (#1):

To improve quality and consistency in the clinical pathway from screening to initiation of treatment

- Develop a provincial framework, clinical pathway and standards to guide breast health in BC and ensure that there is ongoing measurement and coordination of services.
- Redesign, standardize and streamline existing clinical pathways to ensure that women receive high quality services in a timely manner regardless of where they live.
- Increase the integration of screening and full service diagnostic programs.

Themes from Summit Breakout Group Discussions:

The role of the GP and the role of the navigator

- There needs to be some “Fed Ex” type of overall tracking system to follow women and stop them from falling through the cracks.
- We need a well coordinated system in every HA to facilitate patients through the breast journey pathway that does not rely on the GP to navigate and make the necessary appointments for patients. (The draft clinical pathway map does not make provision for women without GPs.)
- Women without GPs considered to be a big challenge overall, and many thought that women without GP could not access SMPBC (there are workarounds, including some walk-in clinics)
- Role of the GP in breast screening, diagnosis needs clarification – many variables now – but important to keep lines of communication open so that GPs know what happens to patients
- The System/Pathway needs change, but still a need for case management in changed system.
- We ultimately need a system that works and has enough resources to enable any navigator model to work well - need to establish principles, elements of care then design role around these needs

The “hub and spoke” model

(How could a “hub and spoke” model work to create screening centres, community (private) diagnostic clinics and full-service breast health (imaging) centres to provide a streamlined pathway for women?

What services should a full service breast health centre provide?)

- It’s desirable to connect community diagnostic imaging centres (that do mammography and ultrasound) to full service centres that perform biopsies (The full service centre would most likely need to be in the hospital for access to Pathology/Surgery)
- Recommended components of a Regional Breast Imaging Centre: screening (not critical) diagnostic mammography, US, US-guided core biopsy, stereotactic core biopsy, breast MRI, MRI-guided biopsy, fine-wire localization, possibly GP or NP (for patients without GP and/or in need of physical exam), Navigator and/or Regional Coordinator
- There are long waitlists in some Regional Diagnostic Imaging Clinics, particularly those that do core biopsies, but some of these centres could do more if they had more operating dollars.
- Community Imaging Clinics should be required to be affiliated with a Regional Breast Imaging Centre where they can refer patient with abnormal results and notify GP
- MSP fees need to be revised, especially for biopsies and for patients who need two or more procedures in same visit (to make centres more efficient)

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Accreditation

(Accreditation: What type of accreditation standards should be applied to breast imaging clinics? What should be the acceptable standards (i.e. for wait times) at each stage in the diagnostic pathway?)

- Note that screening centres are accredited by the Canadian Association of Radiologists (CAR), but there is need to explore whether diagnostic centres should also be accredited.
- Meeting the CAR standards for diagnostic centres could require a strict division of labour among radiologists and limit the attraction of breast screening/ diagnosis.
- The standards are harder to meet outside the Lower Mainland where radiologists and MRTs wear many hats. Should/could there be tailoring of standards? NB Alta and Sask clinics are accredited.

Wait times (acceptable standards for each stage in the diagnostic process)

- Some viewed screening to diagnosis in 21 days is acceptable but not ideal ...you should be able to get this done in a couple of days.
- Ideas for more efficiency included having the radiologist (who has done woman's imaging) go ahead and perform the core biopsy rather than referring back to the GP; more flexible referrals (e.g. the radiologist referring women to her next step, or referral by nurse clinician)