Addressing Staging Documentation Challenges in our Breast Program

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Background

- National Accreditation Programs for Breast Centers (NAPBC) requires documentation of clinical staging for breast cancer in the patient's medical record prior to first line treatment.
- Previous practice for documentation of clinical staging in breast cancer, prior to first line treatment, was inconsistent at best.

Objective

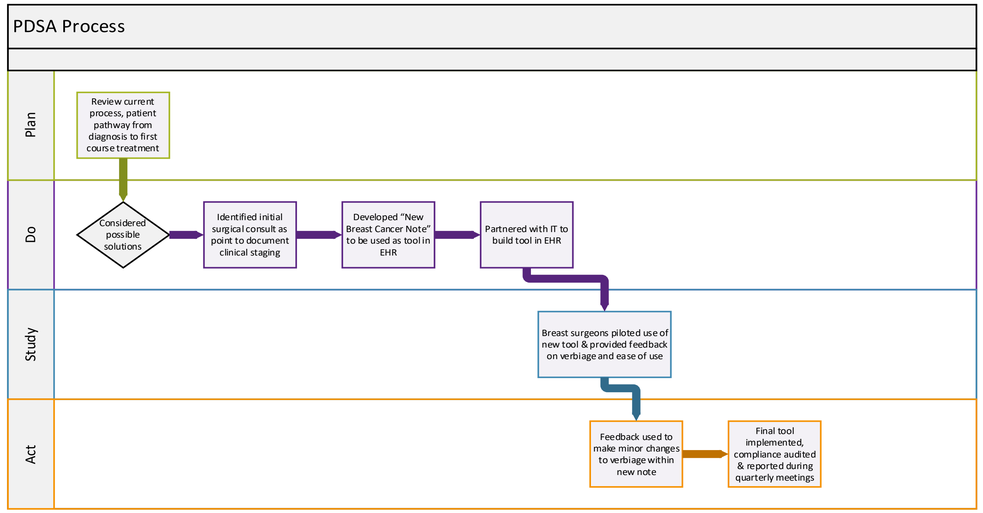
- The Breast Program aimed to develop and implement a process to ensure consistent documentation of clinical staging for new breast cancers, prior to the first course of treatment.

Method

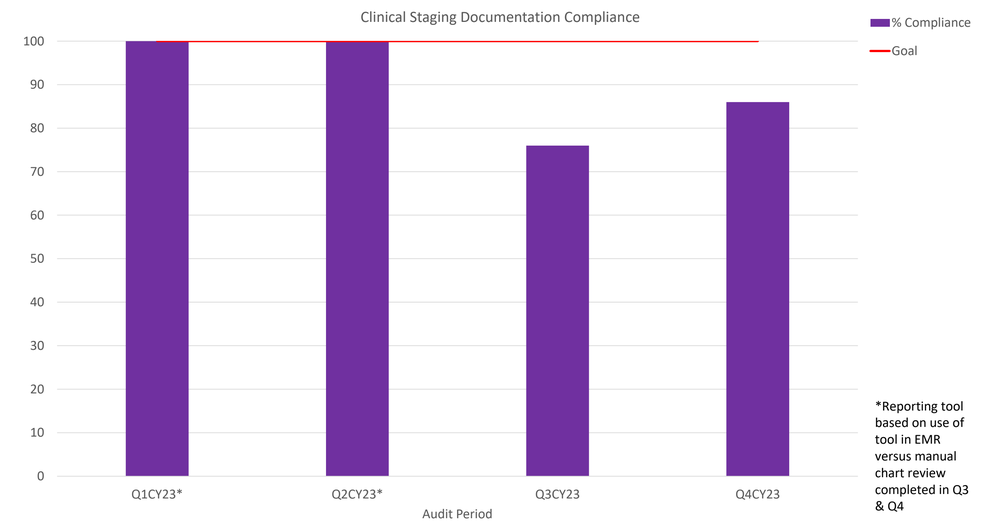
Using the PDSA method:

- A multidisciplinary breast program leadership team, consisting of both nursing and physicians, collaborated to review current processes, the patient pathway from diagnosis to first line treatment, and potential solutions to meeting documentation requirements.
- The multidisciplinary team identified the initial breast surgery consult as the ideal point for breast cancer clinical staging documentation to occur within the medical record.

Implementation Process



Compliance Audit Results



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Results

- While compliance appears to have decreased from quarters 1 & 2 to quarter 3, it was identified the initial report logic was based on use of the tool, therefore it only pulled charts with staging documentation. Manual review and audit of all new breast consults began in quarter 3.
- Compliance with clinical staging documentation continues to improve within our breast program through use of this simple-to-use electronic health record (EHR)-based tool. Compliance will continue to be monitored.

Discussion

- This new EHR-based tool includes the required clinical staging documentation with cascading of additional components based on documented staging. For example, if stage I or II is documented, the note automatically cascades a component addressing reconstructive surgery referral and sentinel lymph node biopsy recommendations, whether both were offered as appropriate options; if not, why, and if so, whether the patient agreed to or declined the recommendation and referral.
- This EHR-based tool can easily be adapted to fit any cancer site or program need to assist with meeting accreditation documentation requirements.

References

1. Wolters Kluwer, Health (2022). Five ways to improve clinical documentation and bridge the gap between coders and physicians. Retrieved from: https://www.wolterskluwer.com/en/expert-insights/five-ways-improve-clinical-documentation.
2. Ebbers, T., Kool, R. B., Smeele, L. E., Dirven, R., den Besten, C. A., Karssemakers, L. H. E., Verhoeven, T., Herruer, J. M., van den Broek, G. B., & Takes, R. P. (2022). The Impact of Structured and Standardized Documentation on Documentation Quality; a Multicenter, Retrospective Study. *Journal of medical systems*, *46*(7), 46. https://doi.org/10.1007/s10916-022-01837-9