MCCMH Preventive Care Guidelines to Promote Early Detection of Breast Cancer

I. Purpose:

a. To provide all, in and out of network providers, with recommendations that can assist them to educate their persons served and their guardians on the importance of creating awareness about the importance of early detection of breast cancer.

b. To guide the providers in becoming critical advocates in creating awareness about the important role they must play in assisting our persons served and their guardians in following appropriate preventive care guidelines. It is via the dissemination of guidelines that MCCMH wants to empower the providers to create their own processes to achieve awareness.

c. To mitigate the risk of occurrence or recurrence of certain medical conditions by educating their persons served and their guardians in the need to remain proactive with preventive care practices.

II. Overview:

The American Cancer Society has provided a series of recommendations for women at average breast cancer risk. Early breast cancer detection, when the cancer is small, facilitate the early action with treatment and increases the chances of successful treatment outcomes. Similar recommendations have come from other nationally recognized organizations such as the American College of Obstetricians and Gynecologists, American Academy of Family physicians, etc. This document follows American Cancer Society, CDC and United States Prevent Services Task Force recommendations.

Although it is rare, men are also at risk for breast cancer. Per the CDC, about 1 out of every 100 breast cancers diagnosed in the United States is found in a man. The most common kinds of breast cancer in men **are the same** kinds as in women.

Breast Cancer Screening Recommendations:

The United States Preventive Services Task Force recommends that women who are 50 to 74 years old and are at average risk for breast cancer get a mammogram every two years. Women who are 40 to 49 years are advised to discuss with their PCP or Women's Health provider about when to start and how often to get a mammogram or imaging study as it may apply. Women should weigh the benefits and risks of screening tests when deciding whether to begin getting mammograms before age 50. For more detailed information https://www.uspreventiveservicestaskforce.org/uspstf/

***It is important we assist our persons served and guardians in knowing about these recommendations and the factors that deemed them or their loved one at high risk vs average risk so that with the help of their health care provider appropriate steps are taken to get proper follow up.

Breast Cancer Screening Tests Include:

- Mammogram
- Breast MRI

- Other exams: These include clinical Breast exam performed **ONLY** by the PCP or their licensed designee and/or patient breast self-examination. The individuals' PCP or their licensed designed (i.e RN, NP, PA) are the appropriate professional authorities to teach and individual how to perform self-breast examinations.

More extended information on the subject visit:
https://www.cdc.gov/cancer/breast/basic_info/screening.htm

When discussing with our persons served preventive screening steps, it is important to know who fall in the category of average risk vs high risk.

a. **Women at average risk are those who:**
   - Don't have a personal history of breast cancer, a strong family history of breast cancer, or a genetic mutation known to increase risk of breast cancer (such as in a BRCA gene) and;
   - Had not had chest radiation therapy before the age of 30.

   <u>For Women at Average Risk the Recommendations Are:</u>

   - Women between 40 and 44 have the option to start screening with a mammogram every year.
   - Women 45 to 54 should get mammograms every year.
   - Women 55 and older can switch to a mammogram every other year, or they can choose to continue yearly mammograms. Screening should continue as long as a woman is in good health and is expected to live at least 10 more years.
   - All women should understand what to expect when getting a mammogram for breast cancer screening – what the test can and cannot do.

b. **Women at high risk are those who:**
   - Have a known BRCA1 or BRCA2 gene mutation (based on having had genetic testing).
   - Have a first-degree relative (parent, brother, sister, or child) with a BRCA1 or BRCA2 gene mutation and have not had genetic testing themselves.
   - Had radiation therapy to the chest when they were between the ages of 10 and 30 years.
   - Have been diagnosed with Li-Fraumeni Syndrome, Cowden Syndrome, or Bannayan-Riley-Ruvalcaba Syndrome, or have first-degree relatives with one of these syndromes.

   <u>For Women at High Risk the Recommendations Are:</u>

   - Women should get a breast MRI and a mammogram every year, typically starting at age 30.
   - If MRI is used, it should be in addition to, not instead of, a screening mammogram. This is because although an MRI is more likely to detect cancer than a mammogram, it may still miss some cancers that a mammogram would detect.
   - The CDC in their website provides a Breast Cancer Screening Chart in pdf file that compares recommendations from several nationally recognized leading

organizations. All women need to be informed by their health care provider about the best screening options for them.

- The PDF may be found via this link https://www.cdc.gov/cancer/breast/pdf/BreastCancerScreeningGuidelines.pdf which

c. **Men at high risk:** Those who may have any of the listed in **b** and/or below:

- Men who have strong family history of breast cancer, ovarian cancer, pancreatic cancer, testicular and or prostate cancer
- Known diagnosis of Klinefelter Syndrome
- Conditions that affect testicles (injury, swelling or surgery to remove testicles)
- Liver disease (cirrhosis can lower androgen levels and raise estrogen levels in men, increasing their risk)
- Heavy drinking.
- Men who are undergoing estrogen related treatment
- For more information visit https://www.cdc.gov/cancer/breast/men/index.htm

For Men at High Risk the Recommendations Are:

- Screening men for breast cancer has not been studied to know if it is helpful, and mammography (x-rays of the breast) and ultrasound is usually only done if a lump is found.
- Men who are at high risk for breast cancer should discuss how to manage their risk with their doctor.
- For more information visit https://www.cancer.org/cancer/breast-cancer-in-men/detection-diagnosis-staging.html

Other Resources:

https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html

https://www.mayoclinic.org/healthy-lifestyle/womens-health/in-depth/breast-cancer-prevention/art-20044676

MCCMH Preventive Care Guidelines and Provider Expectations:

Based on the information provided above and in concurrence with the American Breast Cancer Association, CDC and the United States Preventive Services Task Force, as it pertains to the goal of promoting early detection of breast cancer among our persons served, it is the recommendation from the Chief Medical Office to all of in-network and out-of-network providers that:

A. Providers develop a process to educate their direct care staff on the most up to date guidelines and resources related best breast cancer preventive recommendations as above described.

B. It is to the discretion of the provider to develop a process that guarantees how persons served and their guardians are being provided education on the subject.

C. Providers may opt to use the *"MCCMH Preventive Care Guidelines to Promote Early Detection of Breast Cancer"* here attached as handouts to their staff, persons served and their guardians as part of their efforts to create awareness on the subject. The use of the 2019-2020 MCCMH educational handout disseminated along with these recommendations is purely optional; however, the expectation of the role they must play on providing this education is not. Providers may develop their own educational materials to achieve this awareness goal always abiding by the appropriate most up to date guidelines from well recognized national organizations and authorities in the field.

D. It is the provider's responsibility to update their educational materials as the American Cancer Society and United States Preventive Services Task Force guidelines among others publish new revised guidelines.

E. Providers should remain aware of the importance of these guidelines and encourage their persons served and their guardians to, at least yearly or during the persons served annual physical exam appointment, consult with their health care providers about what screening options based on their age, family history, and health history, they would need to be aware of and consider.

F. Providers and direct care staff must know that only the persons served medical health care provider is the *ultimate authority* in determining when a given screening test type is deemed to be appropriate or contraindicated based on having a full understanding of the individual's medical history and family history. It is of paramount importance that the persons' served and their guardians also understand this and that they always follow and abide by their health care provider's recommendations.

G. **At no time is an MCCMH direct or contracted provider or any of their staff to conduct any kind of self-breast examination screenings on any person served. This is solely to be performed or taught to the person served by his/her primary care physician, OB-GYN physician, or professional licensed staff (i.e RN, NP, PA) designated by them.**

H. As part of being integrated care advocates, it is important that providers yearly encourage our persons served to stay up to date with their yearly physicals and breast screening test as recommended by their PCP. Providers must have their staff (i.e. supports coordinator) work collaboratively with the individual's medical provider to coordinate that, at minimum yearly, a discussion about this occurs with the individual/guardian.

I. Providers must develop a process for their direct care staff or supports coordinator to document in the record the instances in which education related to the issue was provided.

J. Granted all of the above occur, if a person/guardian were to exercise his/her right to decline the above recommendation, the provider must develop a process for their staff or supports coordinator to not only thoroughly date and document the efforts made to educate and encourage the person's served/their guardian on addressing the issue but also document the stated reason for the person's/guardian's decline.

a. Some appropriate documentation parameters to consider at minimum should include date, name and credentials of the staff providing the education/encouragement. And, when applicable, the reason stated by the person served and/or their guardian in the event they choose to decline the education or recommendations from their health care provider.

b. In the event a medical contraindication/s is/are the reason for a person served to not be a good candidate for continued screening, the provider should make sure they implement a process for

their staff or supports coordinator to document those. It is the expectation those instances are clearly documented in the record at the time they are due to revisit each year.

K. In cases of persons served whose cause of death are related to Breast Cancer diagnosis or possible complications secondary to it, the documentation of such becomes especially important and necessary when submitting Death Reports or Root Cause Analysis for the review of CRMC.

L. In the event those are not initially submitted by the provider, the CRMC Committee reserves the right to request the provider for this information when conducting the review of a case in which this is deemed to be pertinent and/or critically relevant for the review