Hereditary Breast Cancer (HBC) Quality Improvement (QI) Pilot Project

Family Medicine Education Consortium, Inc.

HBC Education for Family Physicians

- Susanna Evans, MD, FAAFP, QI Pilot Project Lead Family Physician
- Anya Karavanov, PhD, Public Health Consultant, National Association of Chronic Disease Directors

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Acknowledgements

Helping Families Communicate About Hereditary Breast or Ovarian Cancer project is supported by the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $450,000 with 100 percent funded by CDC/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CDC/HHS, or the U.S. Government.

In 2023/2024, FMEC received a subcontract from the National Association of Chronic Disease Directors (NACDD) to develop and implement this Hereditary Breast Cancer (HBC) Quality Improvement (QI) Pilot Project.

Required Trainings for Program Participants

This is one of three required trainings for family physicians and family physician residents with participating FMRPs to be eligible to claim Performance Improvement/Continuing Medical Education (PICME) credits for this pilot project.

Live Training Dates

1) Hereditary Breast Cancer Education/*Bring Your Brave* CDC Resources—January 17, 2024, 6-7 PM ET
2) Quality Improvement Basics—January 25, 2024, 6-7 PM ET
3) Pilot Project Structure, Timeline, Key Clinical Activities, Measures, and Data Collection Requirements—February 1, 2024, 6-7 PM ET

Project Credits for Family Physicians

The AAFP has reviewed Family Medicine Education Consortium (FMEC) Hereditary Breast Cancer Quality Improvement Pilot Project and deemed it acceptable for up to 20.00 Performance Improvement AAFP Prescribed credits. Term of Approval is from 12/01/2023 to 07/31/2024. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AAFP Prescribed credit is accepted by the American Medical Association as equivalent to *AMA PRA Category 1* credit(s)™ toward the AMA Physician's Recognition Award. When applying for the AMA PRA, Prescribed credit earned must be reported as Prescribed, not as Category 1.

Project Advisory Committee

- Susanna Evans, MD, Associate Professor and Chair of Family, Community, and Preventive Medicine Drexel University College of Medicine, and faculty with Temple Northwest Community Family Medicine Residency Program
- Tracey Conti, MD, Chair, Department of Medicine, University of Pittsburgh School of Medicine and UPMC
- Philip G. Day, PhD, Assistant Professor and Associate Director of Education, Department of Family Medicine and Community Health, UMass Medical School
- Adam E. Perrin, MD, Associate Professor of Family Medicine and Faculty Co-Director, Student Affairs, University of Connecticut School of Medicine (September to December 2023)

FMEC Staff: Rebecca Bouck, BS, Manager, Education and QI Programs; Scott Allen, MS, CEO
FMEC QI Consultant: Kathy Fredericks, MBA, PMP
NACDD Liaison: Anya Karavanov, PhD, NACDD

Today's Presenters

Susanna Evans, MD, FAAFP, Associate Professor and Chair of Family, Community, and Preventive Medicine Drexel University College of Medicine, and faculty with Temple Northwest Community Family Medicine Residency Program

Anya Karavanov, PhD, Public Health Consultant, National Association of Chronic Disease Directors

Disclosures

Dr. Susanna Evans and Dr. Anya Karavanov have no financial relationships with the manufacturer(s) of any commercial product(s) and/or provider of commercial services discussed in this activity.

None of the Project Advisory Committee members or anyone involved in the development of content for this training or for the pilot project has a financial commercial interest to disclose.

Welcome to 8 FMRP Participants with Assigned QI Coaches

Family Medicine Education Consortium, Inc. Hereditary Breast Cancer Quality Improvement Pilot Project
Program Participant Contact Information with Assigned QI Coaches

Name of FMRP/Clinic	Name of QI Project Leader	Address	Email	Assigned QI Coach and Email
Cornerstone Care Teaching Health Center FMRP	Jihad Irani, MD, Associate Program Director and DIO	120 Locust Ave Ext, Mt Morris, PA 15349	jirani@cornerstonecare.com	Tracey Conti, MD conttd@upmc.edu
Greater Lawrence Family Health Center/Lawrence FMRP	Elise LaFlamme, MD, Associate Program Director of Residency Program	34 Haverhill St, Lawrence, MA 01841	elaflam@glfhc.org	Scott Allen, MS Scott.allen@fmec.net
Heritage Valley FMRP	Lindsay Heiple, DO, Dir Osteopathic Curriculum, Assoc Director of RP	1125 7th Avenue, Beaver Falls, PA 15010	lheiple@hvhs.org	Rebecca Bouck, BS Rebecca.bouck@fmec.net
Indiana Regional Medical Center Rural FMRP	Arwen Bassler, MD, FMRP Core Residency Faculty	100 Neal Avenue, Marion Center, PA 15759	abassler@indianarmc.org	Kathy Fredericks, MBA, PMP Kathy.fredericks@fmec.net
Lewis Gale Community and Family Medicine GME FMRP	Julianna Snow, DO	4910 Valley View Blvd NW, 3rd Floor, Roanoke, VA 24012	Julianna.snow@hcahealthcare.com	Philip G. Day, PhD Philip.Day@umassmed.edu
New York Medical College at Saint Joseph's FMRP	Rodika Coloka-Kump, DO, Associate Program Director	81 S. Broadway, Yonkers, NY 10701	rcolokakump@saintjosephs.org	Kathy Fredericks, MBA, PMP Kathy.fredericks@fmec.net
St. Luke's Miners Rural Family Medicine Residency Program	Thomas C. McGinley, Jr., MD	34 S. Railroad Street, Tamaqua, PA 18252	Thomas.mcginley@sluhn.org	Susanna Evans, MD susanna.evans@tuhs.temple.edu
Univ of Pittsburgh Medical Center McKeesport FMRP	Jeff Jackson, MD, FMRP Program Director	2347 Fifth Avenue, McKeesport, PA 15732	Jacksonjk2@upmc.edu	Tracey Conti, MD conttd@upmc.edu

Family Medicine Education Consortium, Inc. Hereditary Breast Cancer Quality Improvement Pilot Project
Program Participant Information

Name of Family Medicine Residency Program (FMRP)/Clinic	Name of QI Project Leader	Location/Geographic Region	Program Descriptions (Year FMRP started, affiliation, community size)	Total # Residents as of July 2023	EMR	Does program have a coordinator for Cancer Screenings?	Does program screen for cancer risk? If yes, what tool?	Does program use HBC screening questionnaire?
Cornerstone Care Teaching Health Center FMRP	Jihad Irani, MD, Associate Program Director/DIO	120 Locust Ave Ext, Mt Morris, PA 15349 RURAL	2013 Community-based, med school; <30,000	12	NextGen	Yes	No	No
Greater Lawrence Family Health Center/Lawrence FMRP	Elise LaFlamme, MD, Associate Program Director of Residency Program	34 Haverhill St, Lawrence, MA 01841 URBAN, INNER CITY	1994 Community-based, med school;	44	Athena	No	Yes MyGeneHistory	Yes
Heritage Valley FMRP	Lindsay Heiple, DO, Dir Osteopathic Curriculum, Assoc Director of RP (Jaclyn Natalone, DO (PG-2)	1125 7th Avenue, Beaver Falls, PA 15010 SMALL TOWN	1979 Community-based, med school <30,000	18	Touchworks /Allscripts	No	No	No
Indiana Regional Medical Center Rural FMRP	Arwen Bassler, MD, FMRP Core Residency Faculty	100 Neal Avenue, Marion Center, PA 15759 RURAL	2022 Community-based, non-affiliated <30,000	12	Cerner	No	No	No

Name of Family Medicine Residency Program (FMRP)/Clinic	Name of QI Project Leader	Location/Geographic Region	Program Descriptions (Year FMRP started, affiliation, community size)	Total # Residents as of July 2023	EMR	Does program have a coordinator for Cancer Screenings?	Does program screen for cancer risk? If yes, what tool?	Does program use HBC screening questionnaire?
Lewis Gale Community and Family Medicine GME FMRP	Julianna Snow, DO	4910 Valley View Blvd NW, 3rd Floor, Roanoke, VA 24012 URBAN, NOT INNER CITY	2019 Community-based, med school 75,000 to 150,000	24	E Clinical Works (ECW)	No	No	No
New York Medical College at Saint Joseph's FMRP	Rodika Coloka-Kump, DO, Associate Program Director	81 S. Broadway, Yonkers, NY 10701 URBAN, INNER CITY	1974 Community-based, med school 150,000 to 500,000	30	Next Gen	Yes	No	No
St. Luke's Miners Rural FMRP	Thomas C. McGinley, Jr., MD	34 S Railroad Street, Tamaqua, PA 18252 RURAL	2017 Community-based, med school <30,000	12	EPIC	No	No	No
University of Pittsburgh Medical Center McKeesport FMRP	Jeff Jackson, MD, FMRP Program Director	2347 Fifth Avenue, McKeesport, PA 15732 URBAN, INNER CITY	1974 Community-based, med school 30,000 to 75,000	26	EPIC	No	Yes Breast History Questionnaire	Yes

HBC Education Learning Objectives/Overview

1. Understand the Risk and Incidence of Breast and Ovarian Cancers
2. Identify Breast Cancer Screening Tools and Ways to Incorporate them into Practice with Patients
3. Identify Benefits of Using Stories, Videos, etc. During Patient Visits-- CDC Bring Your Brave (BYB) Patient Education Materials
4. Be Comfortable in Discussing and Raising Awareness about Cancer Risk During Patient Annual Visits
5. Increase Knowledge of Genetic Counseling, Testing and Referral
6. Utilize Narrative Medicine as a Tool for Opening Communication with Patients

My Story

Dr. Evans, family physician QI leader for this pilot, shares her story and interest in addressing Hereditary Breast Cancer in everyday practice….

Early Onset Breast Cancer

Why is this important?

- 9% of breast cancers occur in women 45 and younger
- Women in this age group are more likely to have a hereditary breast cancer
- Breast cancer in this age group is found at a later stage when it is often more aggressive and difficult to treat
- Many young women do not know their risk for breast cancer and ways to manage the risk

Early Onset Breast Cancer

- As Family Physicians we need to identify women at higher risk for breast cancer and refer them for appropriate testing/screening
- According to CDC, only 41% of primary care physicians refer a woman with high risk for BC for genetic counseling or testing
- Fewer than one in five individuals with a history of BC or OC meeting select National Cancer Comprehensive Network criteria have undergone genetic testing. Most have never discussed testing with a health care provider. Large national efforts are warranted to address this unmet need. J Clin Oncol. 2018 February 1; 36(4): 432

Risk Factors for Early Onset Breast Cancer

- According to the American Cancer Society, women who are at high risk for early-onset breast cancer include those who
  - Have a known BRCA1 or BRCA2 gene mutation
  - **Have a first degree relative (parent, sibling, child), second-degree relative (aunts, uncles, nieces, or grandparents), or third-degree relative (first cousins), with a BRCA1 or BRCA2 gene mutation**
  - Have a lifetime risk of breast cancer of about 20-25% or greater according to risk assessment tools that are based mainly on family history
  - Had radiation therapy to the chest between the ages of 10 and 30 years
  - Have Li-Fraumeni syndrome, Cowden syndrome, or Bannayan-Riley-Ruvalcaba syndome, or have first-degree relatives with one of these syndromes

Tools to Assist with Family Breast Cancer History Collection and Assessment

Tools to Assist with Family Breast Cancer History and Assessment

This list of resources was created in December 2023 for the Family Medicine Education Consortium, Inc. (FMEC), Hereditary Breast Cancer Quality Improvement pilot project. This list is not comprehensive but represents tools assembled via a literature and Internet search. The FMEC, Inc. does not endorse a specific questionnaire, but rather is providing this information and links so participating Family Medicine Residency Programs can select a questionnaire that best fits with their program and clinic needs.

Type of Tool	Name of tool and/or Creator/ Sponsor of tool	Link to Tool	Additional Comments
Family history questionnaire and scoring guide	Ambry Genetics (A Konica Minolta Company)	https://www.ambrygen.com/file/material/view/1365/Hereditary%20Cancer%20Question	Paper form. Comprehensive for all cancer types. Provides a provider checklist to indicate when genetic testing may be appropriate
Breast Cancer Risk Assessment	Breast Cancer Now	https://breastcancernow.org/about-breast-cancer/awareness/breast-cancer-in-families/family-history-assessing-your-breast-cancer-risk/	This assessment will be able to tell you, based on your family history, what your risk of developing breast cancer may be. The risk assessment is carried out at a specialist family history clinic or a regional genetics center, depending on where you live. You will usually need to be referred by your GP.
Cancer Family History Questionnaire	Cancer.Net	https://www.cancer.net/sites/cancer.net/files/cancer_family_history_questionnaire.pdf	Paper form. Can be used for all cancer types.
Patient Facing Online Risk Calculator	Tyrer-Cuzick Risk Model (IBIS Breast Cancer Risk Evaluation Tool)	https://ibis-risk-calculator.magview.com/	The original link for the Tyrer-Cuzick Risk Model (IBIS Breast Cancer Risk Evaluation Tool) is no longer working (http://www.ems-trials.org/riskevaluator/). Here is a link to a website that uses the tool. It is a for-profit medical software company. The link is provided here so one can

Tools for Assessing Breast Cancer Risk Continued

- The Cuzick–Tyrer model
  - The Cuzick–Tyrer model was the most consistently accurate model for prediction of breast cancer. The Gail, Claus and BRCAPRO models all significantly underestimated risk, although with a manual approach the accuracy of Claus tables may be improved by making adjustments for other risk factors. Breast Cancer Res. 2007; 9(5): 213
- Gail Model (https://bcrisktool.cancer.gov)
- Bring Your Brave website resources
  - Genetics Risk Assessment Tool
    - Breast Cancer Genetics Referral Screening Tool (B-RST)
  - Breast Cancer Risk Assessment Tools
    - National Institutes of Health — Families SHARE: Sharing Health Assessment and Risk Evaluation
    - National Cancer Institute Breast Cancer Risk Assessment Tool

Visit the FMEC HBC QI Pilot Project Webpage to access a list of tools: https://www.fmec.net/breast-and-ovarian-cancer-phase-2

Genetic Counseling and Testing Guidelines

- **American Cancer Society** recommends genetic testing for women at high risk to look for mutations in the BRCA1 and BRCA2 genes (or less commonly in other genes such as PTEN or TP53)
  - While testing can be helpful in some situations, providers need to **weigh the pros and cons with the patient**
  - ACS strongly recommends that women first talk to a genetic counselor, nurse, or doctor who is qualified to explain and interpret the results of these tests
- **United States Preventive Services Task Force** recommends that women who have one or more family members with a known potentially harmful mutation in the BRCA1 or BRCA2 genes should be offered genetic counseling and testing
  - Women with an identified increased risk should be referred to a genetic counselor who can further evaluate the risk based on family history, discuss the pros and cons of testing, and arrange for BRCA testing if the patient is ready to proceed

Screening Guidelines

- National Comprehensive Cancer Network (NCCN)
  - Screen women with BRCA1 or BRCA2 mutation or with a first-degree relative with these mutations
  - High risk women should get mammogram and breast MRI yearly starting at age 25 to 40 (depending on the type of gene mutation and/or youngest age of breast cancer in the family)
  - Clinical breast exams every 6 to 12 months beginning at age 25
- ACS
  - Same recommendation for yearly mammogram and breast MRI
  - Begin screening at age 30 or an age recommended by their health care provider and continue for as long as they are in good health

The Power of Stories to Inspire Life-saving Conversations

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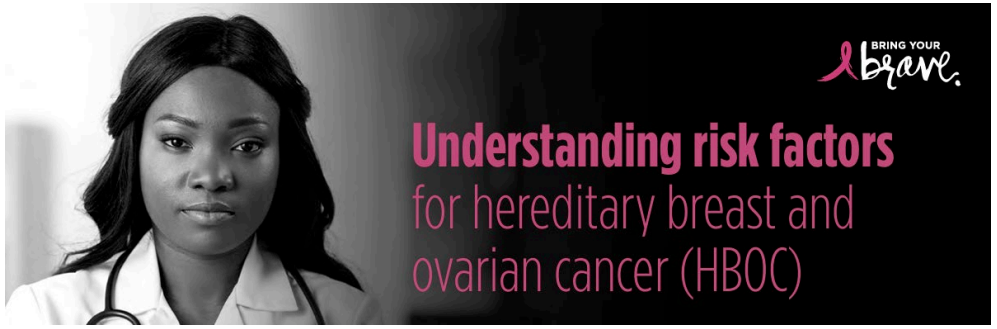
Bring Your Brave

- CDC launched Bring Your Brave in 2015 to provide information about breast cancer to women younger than age 45
- The campaign tells real stories about young women whose lives have been affected by breast cancer

Why is the Campaign Important?

- BRCA-related cancer risk can be reduced by 90% or more through preventive options (Cragun et al, 2017)
- Yet, only about 10% of those with BRCA mutations in the US are aware they carry a mutation.
- Primary care is the most opportune setting to conduct breast cancer risk assessment (Bellhouse et al, 2021)
- Among patients seen in primary care, less than a quarter of women at high risk of breast cancer were referred to BRCA 1/2 testing in accordance with the USPSTF recommendation. Three quarters of primary care physicians never referred a single patient for genetic testing (Linfield et al, 2022)



Challenge: Motivators and Barriers to Talking to Providers and Pursuing Genetic Testing

MOTIVATORS	BARRIERS
Knowledge of family history	Perceived cost
Knowledge of the right questions to ask	Lack of health insurance
Supportive family members	Lack of access to healthcare
Comfort with the topic	Fear
HCP prompts	Lack of information
	Lack of trust
	Provider attitudes

Strategy: Using Stories to Catalyze Conversations

- They make issues more ‘real’ and personally identifiable
- Emotions often drive action more effectively than straightforward education

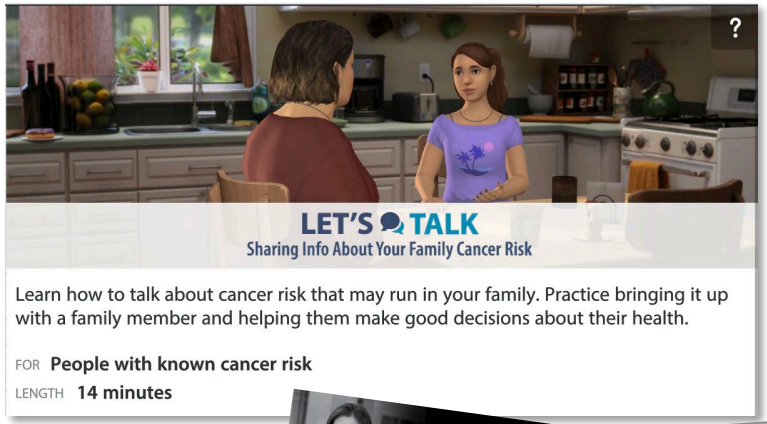
Narrative Medicine

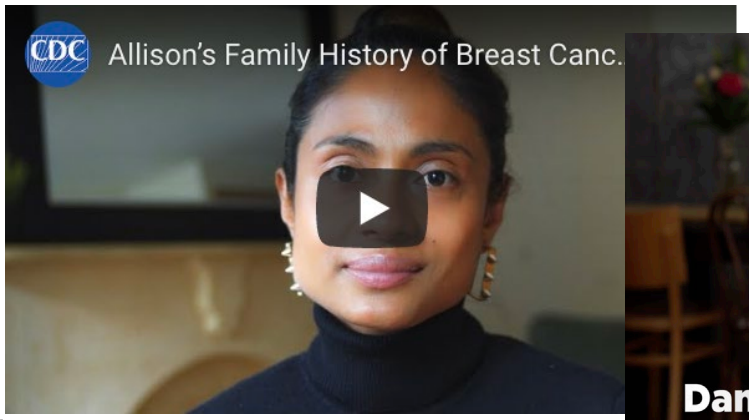
- Narrative-based medicine (NBM) is the application of narrative ideas to the practice of medicine
- NBM is “a fundamental tool to acquire, comprehend and integrate the different points of view of all the participants having a role in the illness experience” (Fioretti et al, 2016)

Narrative Medicine: Bridging Divides Between Doctors and Patients

- The relation to mortality
- The context of illness
- Beliefs about disease causality
- Shame, blame and fear

Using Stories to Catalyze Conversation

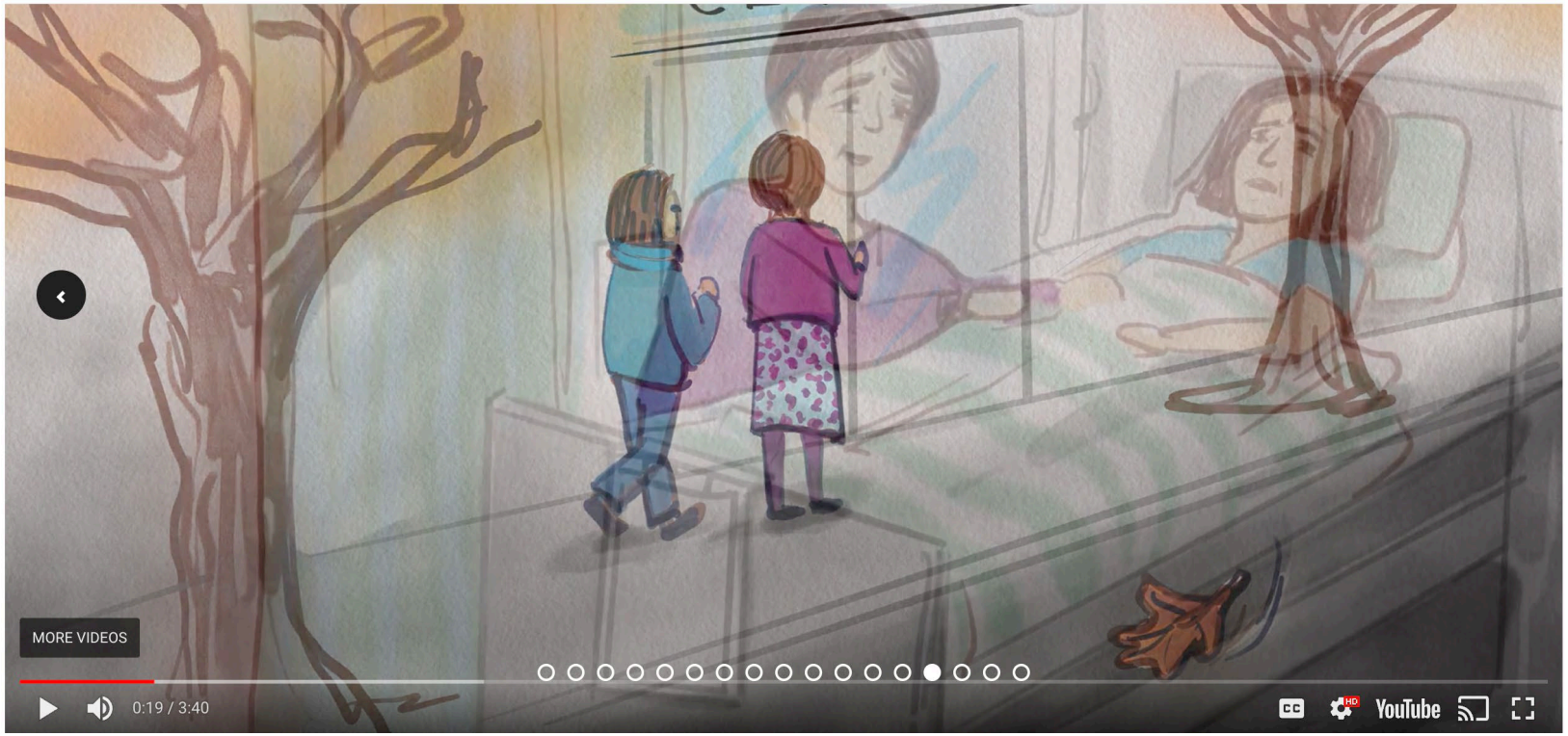




STORYCENTER
LISTEN DEEPLY. TELL STORIES

Arnaldo and Vanessa's Family History: Facing Breast Cancer Together

Best Laid Plans



How is the Campaign Different from Other Breast Cancer Initiatives?

The Bring Your Brave Campaign can Educate and Empower Patients and Healthcare Professionals

- In 2023, nine Family Medicine Medical Residency programs participated in Hereditary Breast Cancer/Narrative Medicine Learning Collaborative created in a partnership with the National Association of Chronic Disease Directors
- 100% of participating family medicine residency programs interviewed believe that the materials will have a positive impact on patient outcomes, either through:
  - increasing provider knowledge/comfort with the topic;
  - increasing empathy by providing insight into the patient experience; and/or
  - increasing motivation by learning from other physicians' experiences.

What Else Can Healthcare Providers Learn from Bring Your Brave?

Resources Available from the Bring Your Brave Campaign

- Assessing Risk in Young Patients
- Strategies for Managing Risk
- Early Onset Breast Cancer Provider Risk Assessment Tools
- Understanding Early Onset Breast Cancer **Continuing Education Courses**
  - Part I: Risk Factors
  - Part II: Engaging with Patients at Risk

The Importance of Genetic Testing

Let's talk about Genetic Testing

- Recent Learning Collaborative with Family Medicine Physicians Found
  - Only 25% of participants surveyed felt comfortable discussing genetic testing options with patients
  - Only 13% of participants surveyed felt comfortable discussing genetic testing results
  - 100% of participants surveyed agreed that improving provider education around genetic testing would increase comfort levels and subsequent frequency of hereditary cancer discussion with patients.

Genetic Testing Education Opportunities

- Video Presentation - Mylynda B. Massart, MD, PhD, “The Intersection of Genomics and Family Medicine”
- Cancer Genetics for Primary Care PowerPoint Presentation
- Genetic Information Nondiscrimination Act
- Direct-to-Consumer Genetic Testing FAQ Healthcare Professionals
- National Society of Genetic Counselors (NSGC) Find a Genetic Counselor
- NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) - Genetic/Familial High-Risk Assessment
- Does It Run In the Family? Online Tool

Gather Information and Tools to Navigate Hereditary Cancer Discussions with Patients

Be prepared for hereditary cancer conversations

Create a Resources Folder including guides, procedures, and resources for healthcare providers and for patients you can refer to

- For Healthcare Providers
  - Collect provider fact sheets and education materials
  - Compile a referral/resource list for providers to support patients
- For Patients
  - Identify local support resources available to patients (community group, social service agency, church program)
  - Identify options for providing patients access to the Bring Your Brave campaign

Get the Campaign Into the Hands of Your Community

Options for Helping Your Community Access Bring Your Brave Resources

- Creating handouts/business cards/QR codes to direct patients to the resources;
- Providing iPads in waiting rooms or exam rooms during wait periods for patients to watch the videos;
- Creating community connections with groups such as patient support groups or public libraries who could be educated about the resources and prepared to show them to patients after referral; and/or
- Playing videos on TV screens in the waiting rooms.
- Creating a system for follow-up calls with patients identified as high-risk to remind them about the resources; and/or
- Electronically sending active links within systems such as “My Chart.”
- Adding topic discussion to new patient/annual wellness visits;
- Adding discussion to well-woman exams;
- Scheduling dedicated follow-up appointments for patients identified as high-risk;
- Creating group medical appointments or providing information during established reoccurring group appointments;
- Attaching the videos at the end of already-developed family history surveys (in-office survey on iPad during the waiting period, ending on the video page);

Questions and Answers

Training Evaluation

Please complete a brief training evaluation online within one week of this session. In order to receive PICME credits for this QI activity, you must view and complete an evaluation for all three training presentations. Access the evaluation for the HBC Education training here:

https://www.surveymonkey.com/r/01-17-24-FMEC

For those who missed the live presentation, please view it on demand by January 31, 2024 and complete the evaluation using the link above.

To access the recorded presentation, visit the FMEC YouTube channel linked below and select the HBC Education Training presentation. The recording will be available within a few days of the live presentation.

https://www.youtube.com/@FMECInc/videos

Presenters' and Project Contact Information

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