CPM Decision Making
(Contralateral Prophylactic Mastectomy)

DCIS Management
(Ductal Carcinoma In Situ)

AND

National Accreditation Program for Breast Centers

A Survey of NAPBC Physicians
May 2017

Please note: Your participation in this survey is voluntary – you may skip questions you do not wish to answer. By completing and returning the survey, you provide your permission for us to use the data. Your response is confidential, but the Survey Lab does use completion rate at the center level to guide reminder effort. This means the Survey Lab will track the total completes by center, but *not* by individual, and will *not* enter the names of centers with the survey answers. Center names will *not* be retained beyond the data collection phase, nor shared with Dr. Yao or other study analysts or sponsors. Neither your name nor the name of your center will be part of the data set used for analysis.

Please return survey to:

The University of Chicago Survey Lab
6030 S. Ellis Ave. Rm 152
Chicago IL 60637

A postage-paid envelope is provided with the survey for this purpose.

SECTION A. Contralateral Prophylactic Mastectomy (CPM)

First we ask for your feelings and opinions about CPM (contralateral prophylactic mastectomy).

A1. Do you favor or oppose insurance coverage for CPM in the following situations?

		Favor Coverage	Neutral	Oppose Coverage
A.	High operative risk.	①	②	③
B.	Average contralateral breast cancer risk.	①	②	③
C.	Higher than average contralateral breast cancer risk.	①	②	③
D.	Stage III or IV disease.	①	②	③
E.	Patient over 70 years old.	①	②	③
F.	In all cases.	①	②	③
G.	In no cases.	①	②	③

A2. Do you think *overall* rates of CPM should be added as a quality measure by …

	Definitely yes	Probably yes	Probably not	Definitely not	No Opinion
A. Hospitals.	①	②	③	④	□-2
B. Medical societies.	①	②	③	④	□-2
C. Insurance companies.	①	②	③	④	□-2

A3. Do you think *physician-specific* rates of CPM should be added as a quality measure by …

	Definitely yes	Probably yes	Probably not	Definitely not	No Opinion
A. Hospitals.	①	②	③	④	□-2
B. Medical societies.	①	②	③	④	□-2
C. Insurance companies.	①	②	③	④	□-2

A4. Has an insurance company ever denied coverage for CPM in one of your cases?

① Yes

② No

Next are some knowledge questions about CPM. Please make your best guess without looking up information.

A5. What is your best guess of the ten and twenty year <u>risks of contralateral breast cancer</u> in patients with …

IDC and no additional risk factors	**IDC and a first-degree relative with breast cancer**	**IDC and a BRCA gene mutation**
A. 10-year contralateral risk _____%	C. 10-year contralateral risk _____%	E. 10-year contralateral risk _____%
B. 20-year contralateral risk _____%	D. 20-year contralateral risk _____%	F. 20-year contralateral risk _____%

A6. For disease at the same stage, how do local recurrence risks compare across tumor types for lumpectomy or mastectomy?

	Lumpectomy carries higher local recurrence risk	**Same local recurrence risk for lumpectomy and mastectomy**	**Mastectomy carries higher local recurrence risk**	**Unsure**
A. Triple negative.	①	②	③	□-2
B. HER2neu positive.	①	②	③	□-2
C. ER positive.	①	②	③	□-2

Now are questions about when you believe CPM is indicated, should be discouraged, or neither.

A7. In these situations, would you say …

	CPM is strongly indicated	Neither	CPM should be discouraged	No idea
A. Patient desires CPM many years after the original breast surgery.	①	②	③	□-2
B. Patient wishes to avoid future mammograms or biopsies.	①	②	③	□-2
C. Patient has high cancer recurrence anxiety.	①	②	③	□-2
D. Patient has concerns about symmetry.	①	②	③	□-2

A8. For these patients, would you say …

	CPM is strongly indicated	Neither	CPM should be discouraged	No idea
A. Under age 40 with breast cancer.	①	②	③	□-2
B. With suspicious breast cancer family history.	①	②	③	□-2
C. BRCA carrier.	①	②	③	□-2
D. Tested negative for BRCA, but in a family of BRCA positive carriers.	①	②	③	□-4
E. Two-plus first-degree relatives with breast cancer.	①	②	③	□-2
F. Male breast cancer, including BRCA carriers.	①	②	③	□-2
G. Young with ER negative breast cancer.	①	②	③	□-2
H. With pathogenic mutations besides BRCA.	①	②	③	□-2
I. Average risk with unilateral breast cancer.	①	②	③	□-2
J. With locally advanced breast cancer.	①	②	③	□-2

Section B. Management of DCIS: Ductal Carcinoma in Situ

Now we turn to the management of DCIS.

B1. What do you call DCIS (ductal carcinoma in situ) during your consultations with patients? Check all that apply.

□1 Pre-cancer
□2 Cancer
□3 Non-invasive cancer
□4 High-risk lesion
□5 Intra-ductal breast cancer
□6 Indolent lesion of epithelial origin
□7 Other, specify _____

B2. There is currently some discussion about whether some DCIS might be over treated. What is your impression of the evidence to support initial observation for DCIS rather than immediate treatment?

① Strong evidence
② Moderate evidence
③ Weak and limited evidence
④ No evidence

B3. Regardless of current protocols, for what proportion of your DCIS patients do you think initial observation (no surgery, no radiation) has the potential to be as or more appropriate than immediate treatment?

① All
② Over 80 % (more than 4 in 5)
③ 61 – 80 % (between 3 & 4 in 5)
④ 41 – 60 % (Roughly half)
⑤ 21 – 40 % (between 1 & 2 in 5)
⑥ Less than 20 % (fewer than 1 in 5)
⑦ None

B4. Please rate your comfort level in initially observing rather than immediately treating the following patients with DCIS:

	Very comfortable	Pretty comfortable	Neutral	Somewhat *un*comfortable	Very *un*comfortable
A. High grade DCIS.	①	②	③	④	⑤
B. Low grade DCIS.	①	②	③	④	⑤
C. Patient over 70 years old with high or low grade DCIS.	①	②	③	④	⑤
D. DCIS greater than 3 cm.	①	②	③	④	⑤
E. DCIS patient under 40 years old.	①	②	③	④	⑤
F. ER negative DCIS.	①	②	③	④	⑤
G. ER positive DCIS.	①	②	③	④	⑤

B5. Do you think the paradigm shift to observe DCIS has been prompted by …

	Definitely yes	Probably yes	Probably not	Definitely not
A. A push for cost savings.	①	②	③	④
B. More data on over-diagnosis and over-treatment of breast cancer.	①	②	③	④
C. Data showing harm of DCIS treatment.	①	②	③	④
D. Data showing no survival advantage for treatment of DCIS.	①	②	③	④
E. Experience with active surveillance for prostate cancer.	①	②	③	④

B6. How easy or difficult do you anticipate it would be to recruit DCIS patients to a randomized clinical trial of initial observation of DCIS versus immediate treatment?

① Very easy – more than are typically interested in clinical trials.

② Fairly easy – as many as most clinical trials.

③ Somewhat difficult – fewer than in most clinical trials, but enough for the trial.

④ Very difficult – only a few patients would agree to this, maybe not enough for the trial to succeed.

⑤ Impossibly difficult – no patient would agree to this.

B7. Below are reasons why some doctors would not likely participate in a clinical trial of initial observation for DCIS. Which of these are reasons *you* might choose not to participate?

	Major reason	Minor reason	Not a reason
A. High risk of disease progression.	①	②	③
B. Patients would not consent.	①	②	③
C. Unsure of how to explain active surveillance to patients.	①	②	③
D. Medical center would not support observation of DCIS.	①	②	③
E. Going against standard of care.	①	②	③
F. Worry about tumor upstaging seen with surgery.	①	②	③
G. Other, please describe. _____ _____	①	②	③

Now are some knowledge questions about DCIS. Please make your best guess without looking up information.

B8. What is your best guess of the 10-year *local* recurrence risk for DCIS patients undergoing …

A. Lumpectomy without radiation? _____%

B. Lumpectomy with radiation? _____%

C. Mastectomy? _____%

B9. What is your best guess of the 10-year *distant* recurrence risk for DCIS patients undergoing …

A. Surgery? _____%

B. *No* treatment for DCIS _____%

Section C. National Accreditation Program for Breast Centers (NAPBC)

This section asks you to evaluate the NAPBC and your overall access to clinical trial information.

C1. Was the *first* time your center was ever accredited by the NAPBC …

① Before you started there

② During your tenure there

③ Unsure

C2. Does NAPBC accreditation enhance, hinder or have no effect on the following at *your center*?

Your *center's* …	Accreditation enhances	Neither	Accreditation hinders	No sense of this
A. Overall quality of patient care.	①	②	③	□-2
B. Effectiveness in allocating patient care resources.	①	②	③	□-2

C3. Is *your* ability to do the following enhanced or hindered by the NAPBC?

***Your* ability to …**	Accreditation enhances	Neither	Accreditation hinders	No sense of this
A. Attract patients.	①	②	③	□-2
B. Persuade your center's administration to devote or maintain resources within your program.	①	②	③	□-2
C. Stay current in your field.	①	②	③	□-2
D. Persuade colleagues to follow national guidelines and standards.	①	②	③	□-2
E. Assess where your center ranks relative to other cancer centers.	①	②	③	□-2
F. Understand the overall structure and process at your center from a top-down or organizational perspective.	①	②	③	□-2
G. Understand the patient's total center experience from a patient perspective.	①	②	③	□-2

C4. Are you supported in the following ways by your practice, institution or center?

	Yes	No	Unsure
A. Paid time off for continuing medical education events or activities.	①	②	□-2
B. *Un*limited funds for travel to meetings.	①	②	□-2
C. *Limited* funds for travel to meetings.	①	②	□-2
D. Journal subscriptions, textbooks, webinars or other educational materials.	①	②	□-2

C5. <u>Please rank,</u> from most (1) to least (9), how compelling you find the following ways of obtaining changing practice information. 1 is the most compelling and 9 the least compelling. Please use each number only once.

_____ National meetings

_____ Journal articles

_____ National guidelines

_____ Online video / streaming (from any source)

_____ Local tumor board

_____ Email blasts from national specialty organizations

_____ Email blasts from journals

_____ UpToDate (a subscription online resource for physicians)

_____ Social media such as Twitter, Facebook and similar

C6. How big a barrier are the following to implementing clinical trial findings in your practice?

	Large barrier	Medium barrier	Small barrier	Not a barrier
A. Fear of legal repercussions for changing practice patterns.	①	②	③	④
B. Strongly held beliefs by your partners/colleagues.	①	②	③	④
C. Lack of access to new trial information.	①	②	③	④
D. Difficulty interpreting published results.	①	②	③	④
E. Added time to discuss new practices with patients.	①	②	③	④
F. Patient preferences.	①	②	③	④
G. Trial findings are outdated.	①	②	③	④

C7. How often do the following external pressures prevent you from applying clinical trial findings to your patients?

	Always	Frequently	Sometimes	Rarely	Never
A. Lack of agreement from your multidisciplinary tumor board.	①	②	③	④	⑤
B. Risk of losing patients from your referring doctors.	①	②	③	④	⑤
C. Fear loss of reimbursement from payors, either government or private.	①	②	③	④	⑤
D. Resistance from clinical staff.	①	②	③	④	⑤
E. Possible reprimand from institutional quality committee.	①	②	③	④	⑤

C8. Have you found the NAPBC guidelines or requirements to *conflict* with any of the following?

	Yes	No	Don't Know
A. Some professional organization best practices or directives.	①	②	□-2
B. Other accreditation group guidelines or requirements.	①	②	□-2
C. Practices you have developed for care of your patients.	①	②	□-2

C9. Please provide examples of any conflicting guidelines, practices or requirements.

C10. Currently the NAPBC requires re-accreditation every 3 years. In your opinion, what would an ideal interval be for accreditation cycles? Every …

① 1 year
② 2 years
③ 3 years (current)
④ 4 years
⑤ 5 years

C11. Think of the time and effort required from you in the most recent NAPBC accreditation process. Would you say that for *you* …

① Benefit outweighed the cost
② Balanced cost and benefit
③ Cost outweighed the benefit
□-4 Does not apply – you have not yet been through this process.

C12. What one aspect of the accreditation process would you *add, change or omit*?

C13. If the accreditation process were revised, what one aspect of the process do you think would be most important *to preserve*?

Section D. Demographics

Finally, we have six questions to help us understand the data. Please remember that all response is confidential and not attached to your name. Center response rate information is kept separate from survey response and no person or center names will be attached or available for analysis.

D1. Do you practice medicine as a…

① Medical oncologist
② Radiation oncologist
③ Plastic or reconstructive surgeon
④ General surgeon
⑤ Surgical oncologist
⑥ Breast surgeon
⑦ Other, please describe _____

D2. What fellowships or additional training beyond residency have you completed? Please check all that apply.

☐1 Medical oncology
☐2 Radiation oncology
☐3 Plastic surgery
☐4 Surgical oncology
☐5 Breast surgery
☐6 Other, please describe _____

D3. What year did you begin practicing medicine as an attending?

Year: ___ ___ ___ ___

D4. Over the past 3 months, about how many different patients with <u>breast disease</u> did you see or treat?

① None
② 1-9 patients per week
③ 10-19 patients per week
④ 20-29 patients per week
⑤ 30-39 patients per week
⑥ 40-49 patients per week
⑦ 50-59 patients per week
⑧ 60-69 patients per week
⑨ 70-79 patients per week
⑩ 80-89 patients per week
⑪ 90-99 patients per week
⑫ 100+ patients per week

D5. Do you identify as …

① Male
② Female
③ Other

D6. What year were you born?

Year: ___ ___ ___ ___

***<u>THANK</u> <u>YOU</u>* very much for your help with this study.**
We greatly appreciate your time and input.

~ ~ ~ Please mail back your completed survey using the postage-paid envelope provided ~ ~ ~

Your responses are confidential – please do *<u>NOT</u>* add your name or return address.