

# New York



## Monitoring Clinical Outcomes to Ensure High-Quality Breast Cancer Screenings

### Public Health Problem

A mammography screening facility in the Bronx, New York, has provided more than 11,000 breast cancer screenings through the New York State Breast and Cervical Cancer Early Detection Program since 1995. Given the number of screenings, a diagnosis of approximately 60 cases of breast cancer would have been expected. Yet only 15 cases were detected—less than 25% of the expected cases of breast cancer. Furthermore, among women with normal mammograms, only 0.1% of clinical breast examinations reported from the facility showed a suspicious finding that warranted further evaluation. This rate was much lower than rates reported by other providers in the state program. These findings indicated that clinical breast examinations were not being performed or that they were of poor quality.

### Program Example

These unusual findings at the Bronx screening facility prompted the New York State Department of Health to contact a random sample of 50 clients from the facility who were reported as having had a clinical breast examination in 1999. Only 3 of the 31 women interviewed reported that they had actually received a clinical breast examination during their visit. An emergency rescreening initiative was needed because the evidence indicated that women seen at this private radiology facility had received inadequate clinical care. CDC contributed emergency funding to the New York State Department of Health to conduct this large-scale rescreening effort. Beginning on June 1, 2000, more than 100 staff and volunteers attempted to contact by mail and telephone each of the 9,094 women seen at this facility since 1995 and found to be in potential need of a repeat comprehensive breast cancer screening. More than 25,000 telephone calls were logged as part of this process. Women received a minimum of 3 telephone contact attempts and as many as 10 calls in total.

### Implications and Impact

Of the more than 9,000 women contacted, 3,125 were rescreened for breast cancer (8 of these women were found to have breast cancer). The remaining women were not rescreened for various reasons. For example, 1,160 of the women had already received another breast cancer screening at a different facility (15 of these women were found to have breast cancer). As a result of these findings at the Bronx facility, the attending physician's medical license was suspended for 1 year, and he was required to receive additional training in breast cancer screening, including reestablishing his mammography qualifications. The creation of an interdisciplinary quality assurance team to monitor clinical outcomes is essential to help ensure that women receive high-quality screening services. In addition, certain data must be collected to ensure there are no problems with the quality of clinical services that are provided at screening facilities. The ongoing analysis of clinical outcome data can result in the discovery and exploration of reasons for unusual data patterns. Ultimately, such analysis can help a program address any clinical deficiencies or data reporting problems in a timely manner.

### Contact Information

New York State Department of Health • Breast and Cervical Cancer Early Detection Program  
Corning Tower Building, Empire State Plaza, Room 780 • Albany, New York 12237-0620  
Phone: (518) 474-1222 • Fax: (518) 473-0642  
Web site: <http://www.health.state.ny.us/nysdoh/cancer/center/cancerhome.htm>