

# Optimal Resources for Cancer Care 2020 Standards Webinars



Effective January 1, 2020

Review all information in the manual

- Address changes to Accreditation process
- New terms defined in glossary
- Specifications by category

Access the 2020 Standards and Resources page for more information on the standards and upcoming activities

<https://www.facs.org/quality-programs/cancer/coc/standards/2020>

5

# Patient Care: Expectations and Protocols



- Patient care expectations
  - **Psychosocial well-being**
  - **Quality of the cancer surgery**
    - **Operative Standards for Cancer Surgery**
  - **Completeness** of operative and pathologic reports



# 5.1 – CAP Synoptic Reporting

## Scope of the Standard

- Eligible cancer pathology reports
  - **90 percent** in synoptic reporting format
  - Contain all core data elements within the synoptic format.
- The **synoptic format** - structured format that includes all of the following:
  - All core elements reported (whether applicable or not)
  - Reported in a “diagnostic parameter pair” format
  - On a separate line or in tabular format to achieve visual separation
  - All core elements listed together in synoptic format in one location in the pathology report

90%

# 5.1 – CAP Synoptic Reporting

## Scope of the Standard

- Refer to the CAP Cancer Protocols for specific guidance and examples of core elements for the cancer site
- Eligible cancer pathology reports
  - Definitive surgical resection of primary invasive malignancies and ductal carcinoma in situ (DCIS), and
  - Definitive surgical resection in patients who have received neoadjuvant therapy AND who have residual tumor



# 5.1 – CAP Synoptic Reporting

- CAP Cancer Protocol **exceptions**:
  - Definitive surgical resection in which **no residual tumor** is present
  - **Additional surgical procedure** performed after definitive resection (for example, resection of positive margins or node biopsy/resection)
  - **Diagnostic biopsy, cytology specimens, or other diagnostic procedures** done before definitive surgical therapy
  - Surgical resection for **recurrent tumor**
  - **In situ carcinomas (except for DCIS)**
  - **Special studies** (for example, biomarker or prognostic testing)



# 5.1 – CAP Synoptic Reporting

- On-site documentation reviewed by site visit reviewer
  - Standardized **synoptic pathology reports** for eligible patients



## Compliance

During the accreditation cycle

1. 90% of eligible cancer pathology reports follow the synoptic format defined by CAP

AND

2. Contain all core data elements within the synoptic format



# 5.2 – Psychosocial Distress Screening

## Scope of the Standard

- Psychosocial services provided
  - On-site
  - By referral
- Cancer committee implements policy and procedure for providing and monitoring **psychosocial distress screening** and **referral for psychosocial care**.
- Process is:
  - Evaluated
  - Documented
  - Reported
- Services addressed
  - **Physical**
  - **Psychological**
  - **Social**
  - **Spiritual**
  - **Financial needs**



## 5.2 – Psychosocial Distress Screening

### Scope of the Standard

- The process identifies issues interfering with treatment and affect outcomes including
  - **Psychological**
  - **Social**
  - **Financial**
  - **Behavioral issues**
- Provide resources and/or referral for psychosocial needs
- Screened for distress **at least one time** during the patient's first course of treatment
- Additional screenings provided per cancer program or health care provider discretion, but not required



## 5.2 – Psychosocial Distress Screening

Psychosocial distress screening **exceptions**:

- **Biopsy only** or class of case “00” patients
- Patients who are admitted to the hospital with a **history of cancer**, but for non-cancer related issues
- Inpatients with a current diagnosis of cancer who are **treated for a non-cancer issue** and do not receive cancer treatment



## 5.2 – Psychosocial Distress Screening

### Scope of the Standard

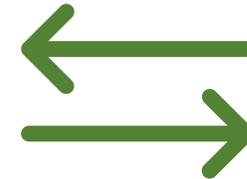
- **How administered?**
  - Determined by the cancer committee
  - Tailored to the workflow of the practice
- Administered by trained health care professionals
  - Medical staff
  - Medical assistants
  - Nurses
  - Social Workers
- The **policy and procedure** addresses
  - Screening sites, including CoC-accredited facility or designated providers
  - Includes process for assessment and treatment of distress



## 5.2 – Psychosocial Distress Screening

### Scope of the Standard

- The cancer committee selects and approves **the psychosocial distress screening tool** to be administered
  - Standardized, validated instruments or tools with established clinical cutoffs
  - Cancer committee sets **cutoff score** used to identify distressed patients
- Assess patient distress through direct patient contact
  - Direct contact means discussion of the results with the patient face-to-face, by telephone, or by telemedicine. This assessment confirms screening results and identifies the appropriate referrals as needed



## 5.2 – Psychosocial Distress Screening

### Scope of the Standard

- Policy and procedure addresses
  - **Screening process**
  - **Timing of screening**
  - **Identified tool**
  - **Distress level triggering a referral to services**
- The distress screening(s) results, referral for provision of care, and any follow-up are documented in the patient medical record to facilitate integrated, high-quality care
- The Psychosocial Services Coordinator oversees this activity and report to the cancer committee each year



## 5.2 – Psychosocial Distress Screening

- The annual psychosocial services summary must include, but is not limited to:



Number of patients screened



Number of patients referred for  
distress resources or further follow-up



Where patients were referred  
(on-site or by referral)

## 5.2 – Psychosocial Distress Screening

- **Pre-Review Questionnaire (PRQ) documentation:**
  - Patient access either on-site or by referral
  - The psychosocial distress screening **policy and procedure**
  - The annual **psychosocial services summary**



## 5.2 – Psychosocial Distress Screening

- **Compliance:**

1. Policies and procedures are in place to provide patient access to psychosocial services either on-site or by referral.
2. The cancer committee implements a policy and procedure that includes all requirements for providing and monitoring psychosocial distress screening and referral for psychosocial care.
3. Cancer patients are screened for psychosocial distress at least once during the first course of treatment.
4. The psychosocial distress screening process is evaluated, documented, and the findings are reported to the cancer committee by the Psychosocial Services Coordinator. The coordinator's report includes all required elements and is documented in the cancer committee minutes.

## 5.3 – Breast Sentinel Node Biopsy

### This is a phase-in Standard

- To ensure that sentinel lymph node mapping and sentinel lymphadenectomy provide accurate information for breast cancer staging, all sentinel nodes for breast cancer must be
  - **Identified**
  - **Removed**
  - **Subjected to pathologic analysis**
- Sentinel nodes are defined as
  - Nodes having uptake of a localization substrate (radioactive tracer and/or colored dye) that has been previously injected into the affected breast
  - A node to which an afferent colored lymphatic travels, or
  - Dominant lymph nodes that are suspicious as identified by the operating surgeon
- This standard is satisfied if a **diligent search** has been made for sentinel nodes, with those nodes removed when present, and documentation of those specifics

# 5.3 – Breast Sentinel Node Biopsy

- Synoptic Operative Report Requirements

Element	Response
Substrate(s) used for sentinel node biopsy in the non-neoadjuvant setting	Dye; Radiotracer; Clips; Dye and Radiotracer; Dye and Clips; Radiotracer and Clips; Dye, Radiotracer, and Clips; None; N/A.
Substrate(s) used for sentinel node biopsy in the neoadjuvant setting	Dye; Radiotracer; Clips; Dye and Radiotracer; Dye and Clips; Radiotracer and Clips; Dye, Radiotracer, and Clips; None; N/A.
All colored nodes or noncolored nodes present at the end of a dye filled lymphatic channel were removed, if dye was used as the substrate for localization.	Yes; No; N/A.
All significantly radioactive nodes were removed, if radionuclide was used as the substrate for localization.	Yes; No; N/A.
All palpably suspicious nodes were removed, if present.	Yes; No; N/A; If no, why.
If clips were placed in pathologically-involved nodes, those nodes were identified and removed.	Yes; No; N/A.

## 5.3 – Breast Sentinel Node Biopsy

- This standard applies to patients undergoing nodal staging in a curative setting for patients having breast cancers of epithelial origin

## 5.3 – Breast Sentinel Node Biopsy

On-site documentation reviewed by site visit reviewer

- The **standardized synoptic operative reports** for patients with breast cancer of epithelial origin who underwent nodal staging in a curative setting



## 5.3 – Breast Sentinel Node Biopsy

- **Compliance:**

1. All sentinel nodes for breast cancer are identified, removed, and subjected to pathologic analysis
2. Operative reports for patients undergoing breast sentinel node biopsy includes required minimum elements in synoptic format



# 5.4 – Breast Axillary Dissection

## This is a phase-in standard

- Axillary dissection for breast cancer constitutes removing level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall, and latissimus dorsi, while preserving key neurovascular structures
- Axillary lymph node dissection (ALND) is a staging and therapeutic procedure that serves two purposes:
  - (1) To provide important staging and prognostic information that can affect treatment decisions and determine prognosis
  - (2) Provides local control in certain settings where sentinel node biopsy, systemic and endocrine therapies, and radiotherapy, alone or combined, have not yet demonstrated adequate local control within the axilla

## 5.4 – Breast Axillary Dissection

- The standard has been satisfied if dissection to established axillary boundaries is complete and documented
- Level III nodes may be removed if clinically involved or suspicious at operation, although the benefit of their removal is isolated to local control, with limited data to support their removal
- Programs are encouraged to review the number of lymph nodes retrieved in patients who did not receive neoadjuvant therapy

## 5.4 – Breast Axillary Dissection

- Operative reports for patients undergoing axillary dissection must include the following minimum elements in synoptic format:

Element	Response
Resection was performed within the boundaries of the axillary vein, chest wall (serratus anterior), and latissimus dorsi.	Yes; No.
The long thoracic and thoracodorsal nerves were spared during dissection.	Yes; No; Not identified.
Attempts were made to spare the intercostobrachial nerves during dissection if possible.	Yes; No.
If one or more level III nodes is/are removed, then document why.	Yes; No; If yes, then why.

## 5.4 – Breast Axillary Dissection

- This standard applies to patients undergoing axillary dissection with diagnostic or therapeutic intent for patients having breast cancers of epithelial origin



## 5.4 – Breast Axillary Dissection

- On-site documentation reviewed by site visit reviewer
  - The **standardized synoptic operative reports** for patients with breast cancer of epithelial origin who underwent axillary dissection with diagnostic or therapeutic intent



# 5.4 – Breast Axillary Dissection

- **Compliance**

1. Axillary dissections for breast cancer remove level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall, and latissimus dorsi, while preserving key neurovascular structures.
2. Operative reports for patients undergoing axillary dissection include the required minimum elements in synoptic format.



# 5.5 – Primary Cutaneous Melanoma

## This is a phase-in standard

- Clinical margin width for wide local excision of invasive melanoma is
  - 1 cm for melanomas <1 mm thick
  - 1 to 2 cm for invasive melanomas 1 to 2 mm thick
  - 2 cm for invasive melanomas > 2 mm thick
- The clinical margin width for wide local excision of a melanoma in situ is at least 5 mm
- “The margin width for wide local excision of melanoma is based on the Breslow thickness of the primary tumor.... The margin is measured circumferentially at the level of the skin from either residual gross tumor and/or the previous biopsy scar.” Operative Standards for Cancer Surgery, Volume II, page 390



# 5.5 – Primary Cutaneous Melanoma

- Operative reports for patients undergoing a wide local excision of a primary cutaneous melanoma must include the following minimum elements in synoptic format:

Element	Response
Original Breslow thickness of the lesion	Melanoma in situ (MIS); Invasive (to the tenth of a millimeter).
Clinical margin from the edge of the lesion or the prior excision scar	0.5 cm; 1 cm; 2 cm; Other; __ cm due to cosmetic/anatomic concerns; Mohs micrographic surgery with __ cm initial margin
Depth down to the fascia; if not down to the fascia, then document why	Yes; No; If no, why.

# 5.5 – Primary Cutaneous Melanoma

- This standard applies to patients undergoing curative-intent wide local excision of a primary cutaneous melanoma lesion



# 5.5 – Primary Cutaneous Melanoma

- On-site documentation reviewed by site visit reviewer
  - The **standardized synoptic operative reports** for patients who underwent a curative-intent wide local excision for primary cutaneous melanoma



# 5.5 – Primary Cutaneous Melanoma

- **Compliance:**

1. Clinical margin width for wide local excision of invasive melanoma is 1 cm for melanomas less than 1 mm thick.
2. Clinical margin width for wide local excision of invasive melanoma is 1 to 2 cm for melanomas 1 to 2 mm thick.
3. Clinical margin width for wide local excision of invasive melanoma is 2 cm for melanomas greater than 2 mm thick.
4. The clinical margin width for wide local excision of a melanoma in situ is at least 5 mm.
5. Operative reports for patients undergoing a wide local excision of a primary cutaneous melanoma include the required minimum elements in synoptic format.



## This is a phase-in standard

- “Proximal vascular ligation with en bloc lymphadenectomy ensures complete resection of the associated lymph nodes for pathologic evaluation. The number of lymph nodes resected surgically and evaluated pathologically reflects the completeness of the lymphadenectomy and is an indicator of surgical quality and oncologic outcomes.” Operative Standards for Cancer Surgery Volume I, page 288

# 5.6 – Colon Resection

- Operative reports for patients undergoing resection for colon cancer must include the following minimum elements in synoptic format:

Element	Response	
Tumor location	Right colon; hepatic flexure; transverse colon; splenic flexure; descending colon; sigmoid colon	
Extent of lymphovascular resection	Tumor location	Proximal vascular ligation
	Right colon (cecum and ascending colon)	Ileocolic artery and vein and, if present, right colic artery and vein
	Hepatic flexure	Ileocolic artery and vein and, if present, right colic artery and vein and middle colic artery and vein
	Transverse colon	Middle colic artery and vein
	Splenic flexure	Middle colic artery and vein and ascending left colic artery and vein
	Descending colon	Inferior mesenteric artery and vein to include ascending left colic artery and vein
	Sigmoid colon	Inferior mesenteric artery and vein
If anatomic guidance other than listed above, document why	If yes, why.	
If patient is excluded, then document why	If yes, why.	

## 5.6 – Colon Resection

- This standard applies to all curative resections for colon cancer and applies to all operative approaches

## 5.6 – Colon Resection

- On-site documentation reviewed by site visit reviewer
  - The **standardized synoptic operative reports** for patients who underwent resection for colon cancer



- **Compliance:**

1. Resection of the tumor-bearing bowel segment and complete lymphadenectomy is performed en bloc with proximal vascular ligation at the origin of the primary feeding vessel(s)
2. Operative reports for patients undergoing resection for colon cancer include the required minimum elements in synoptic format



# 5.7 – Total Mesorectal Excision

## This is a phase-in standard

- “Total mesorectal excision (TME) of rectal cancer leverages existing tissue planes to perform a complete resection of the tumor and the associated draining lymph nodes
- By maintaining the intact fascia propria of the rectum and operating in the space between the mesorectum and the presacral fascia, the surgeon can achieve a resection with a negative margin, while simultaneously preserving neurovascular structures.” Operative Standards for Cancer Surgery Volume II, page 194



## 5.7 – Total Mesorectal Excision

- Per College of American Pathologists (CAP) cancer protocol template for rectal cancer resections, the quality of TME resection (complete, near complete, or incomplete) must be documented in curative resection of rectal adenocarcinoma pathology reports in synoptic format



## 5.7 – Total Mesorectal Excision

- This standard applies to operations for curative intent radical resections of rectal adenocarcinoma and excludes local excision approaches



# 5.7 – Total Mesorectal Excision

- On-site documentation reviewed by site visit reviewer
  - The **standardized synoptic pathology reports** for rectal cancer patients with middle and low rectal cancers



# 5.7 – Total Mesorectal Excision

- **Compliance**

1. Total mesorectal excision is performed for all patients undergoing radical surgical resection of mid and low rectal cancers and results in a complete or near complete mesorectal excision
2. The quality of TME resection (complete, near complete, or incomplete) is documented in curative resection of rectal adenocarcinoma pathology reports in synoptic format



# 5.8 – Pulmonary Resection

## This is a phase-in standard

- The surgical pathology report following any curative intent pulmonary resection for primary lung malignancy must contain
  - lymph nodes from at least one (named and/or numbered) hilar station
  - at least three distinct (named and/or numbered) mediastinal stations
  
- Per the College of American Pathologists (CAP) cancer protocol template for pulmonary resections, the nodal stations examined by the pathologist must be documented in curative pulmonary resection pathology reports in synoptic format. Surgeons are expected to identify on the histology requisition form the station from which each group of nodes has been taken



# 5.8 – Pulmonary Resection

- This standard applies to the primary surgical procedure for curative intent pulmonary resections for
  - Non-small cell lung cancer (NSCLC)
  - Small cell lung cancer (SCLC)
  - Carcinoid tumors of the lung
  
- This standard applies to all operative approaches

# 5.8 – Pulmonary Resection

- On-site documentation reviewed by site visit reviewer
  - The **standardized synoptic pathology reports** for curative intent pulmonary resections



- **Compliance**

1. The surgical pathology report following any curative intent pulmonary resection for primary lung malignancy must contain lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations
2. The nodal stations examined by the pathologist must be documented in curative pulmonary resection pathology reports in synoptic format



- Implementation leaders include, but are not limited to:
  - Cancer Committee Chair
  - Director of Surgery
  - Cancer Liaison Physician
  - Cancer Program Medical Director
  - Other physician leaders with knowledge of the surgeries covered in the standards
  
- Synoptic reporting templates are in development and will be available soon