2023 CoC Site Visit Preparation for Operative Standards 5.3-5.8

October 4, 2022 @ 5pm CT
Webinar Logistics

• All participants are muted during the webinar

• Questions – including technical issues you may be experiencing – should be submitted through the question pane

• Questions will be answered as time permits

• Please complete the post-webinar evaluation you will receive via email
Moderator

Anthony Villano, MD
Surgical Oncologist
Fox Chase Cancer Center
Site Visit Requirements for 2023

• Compliance with the required CoC elements/responses in synoptic format for Operative Standards 5.7 and 5.8
• Implementation plan for the required CoC elements/responses in synoptic format for Operative Standards 5.3-5.6
Agenda

• Operative standards & compliance overview
• Site review process
• What if a site is found non-compliant?
• Opportunities for improvement & lessons learned
• Available resources
Panelists

James B. Harris, MD, FACS
Western Surgical Group
Chair, CoC Accreditation Committee

Mediget Teshome, MD, FACS
MD Anderson Cancer Center
Chair, CSSP Education Committee

Matthew H.G. Katz, MD, FACS
MD Anderson Cancer Center
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Accreditation Senior Manager
ACS Cancer Programs

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Newark Beth Israel Medical Center
Operative Standards and Compliance Overview
## The CoC Operative Standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>Disease Site</th>
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<td>Lung</td>
<td>Lung resection (any)</td>
<td>Pathology report (CAP)</td>
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Implementation Timeline for Standards 5.7 & 5.8

- **2020**: Communicate requirements & engage clinicians in implementation plans
- **2021**: Measure compliance with synoptic pathology reports and assure high reliability at 70% compliance
- **2022**: Site Visits review 2021 pathology reports for 70% compliance
- **2023**: Site Visits review 2021 & 2022 pathology reports for 80% compliance
- **2024**: Site Visits review 2021, 2022, and 2023 pathology reports for 80% compliance

Steps to Achieve Compliance
Measures of Compliance

Standard 5.7: Total Mesorectal Excision

• Total mesorectal excision is performed for patients undergoing radical surgical resections of mid & low rectal cancers, resulting in complete or near-complete total mesorectal excision

• Pathology reports for resections of rectal adenocarcinoma document the quality of TME resection in synoptic format

Standard 5.8: Pulmonary Resection

• Pulmonary resections for primary lung malignancy include lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations

• Pathology reports for curative pulmonary resection document the nodal stations examined by the pathologist in synoptic format
CAP Definition of Synoptic Reporting

- **CAP’s website** provides definitions and guidelines for ensuring compliance with synoptic reporting requirements.
- Each CAP protocol also summarizes these requirements in the first few pages under “Synoptic Reporting”
### The CoC Operative Standards

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Timeline for Standards 5.3-5.6

- **Plan for implementation, educate/train surgeons & registrars**
- **Document final plan for implementation and conduct audits**
- **Begin compliance with Standards 5.3-5.6**

- **2020**
  - Introduction of operative standards

- **2021**
  - Site Visits
  - Plan for implementation, educate/train surgeons & registrars

- **2022**
  - Site Visits review documentation of final plans for compliance
  - Document final plan for implementation and conduct audits

- **2023**
  - Begin compliance with Standards 5.3-5.6
  - Site Visits review 2023 operative reports for 70% compliance

- **2024**
  - Site Visits review 2023 & 2024 operative reports for 80% compliance

- **2025**
Measures of Compliance

Standard 5.3: Sentinel Node Biopsy for Breast Cancer

- All sentinel nodes for breast cancer are identified using tracers or palpation, removed, and subjected to pathologic analysis.
- Operative reports for sentinel node biopsies for breast cancer document the required elements in synoptic format.

Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer

- Axillary lymph node dissections for breast cancer include removal of Level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall (serratus anterior), and latissimus dorsi, with preservation of the main nerves in the axilla.
- Operative reports for axillary lymph node dissections for breast cancer document the required elements in synoptic format.
Measures of Compliance

Standard 5.5: Wide Local Excision for Primary Cutaneous Melanoma

- Wide local excisions for melanoma include the skin and all underlying subcutaneous tissue down to the fascia (for invasive melanoma) or the skin and the superficial subcutaneous fat (for in situ disease). Clinical margin width is selected based on original Breslow thickness

- Operative reports for wide local excisions of primary cutaneous melanomas document the required elements in synoptic format

Standard 5.6: Colon Resection

- 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)

- Operative reports for resections for colon cancer document the required elements in synoptic format
Definition of Synoptic Reporting

Standardized data elements organized as a structured checklist or template

Each data element’s value is “filled in” using a pre-specified format to ensure interoperability of information

- The information being sought is standardized
- The options for each variable are constrained to a pre-defined set of responses

Synoptic reports allow information to be easily collected, stored, and retrieved
Synoptic Format vs. Narrative Format

• Synoptic reporting presents information in a paired “data element: response” format.
  • Example:
    Procedure: Total thyroidectomy
    Tumor focality: Single focus

• Narrative reporting presents information in a prose format that can be read as phrases or sentences.
  • Example:
    No lymph nodes submitted, adrenal gland uninvolved, lymphatic invasion present.
Timeline & Compliance Requirements for Standards 5.3-5.6

• In 2022, CoC-accredited programs will need to document their final plan for how they will meet the requirements of Standards 5.3-5.6 starting on January 1, 2023

• This documentation will be reviewed at site visits in 2023, 2024, and 2025.

• Starting with site visits in 2024, site reviewers will assess 7 operative reports for each standard.

• Each report must meet both the technical and documentation requirements for the standard to be found compliant.
## Compliance Levels for 5.3-5.8

<table>
<thead>
<tr>
<th>Visit Year</th>
<th>Standard</th>
<th>Materials Assessed</th>
<th>Requirement</th>
</tr>
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<tbody>
<tr>
<td><strong>2023</strong></td>
<td>5.3-5.6</td>
<td>Implementation plan for Standards 5.3-5.6</td>
<td>Plan documented in 2022</td>
</tr>
<tr>
<td></td>
<td>5.7</td>
<td>7 pathology reports from 2021-2022</td>
<td>80% compliance</td>
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<td>5.3-5.6</td>
<td>7 operative reports, per standard, from 2023</td>
<td>70% compliance</td>
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Guidelines for Implementation Plan for Standards 5.3-5.6

- How the cancer committee reviewed Standards 5.3-5.6, their intent, and the requirements
- All education and training activities
- Any internal audit process undertaken or planned prior to the site review
- The processes planned or in place to facilitate synoptic operative reporting and data collection
- Outline the approach for synoptic reporting and the proposed timeline for implementation
Site Review Process
Site Visit Process-Chart Review for Applicable Standards

- Programs generate list of eligible cases
- Site reviewers select 7 cases to assess for each standard
- Programs confirm case eligibility for selected cases
- Site reviewers assess each case for all measures of compliance
- Site reviewers select a rating for each standard based on whether the threshold compliance level has been met
Compliant vs. Noncompliant Reports – Technical Requirements

Original Breslow thickness of the lesion: 0.7 mm

Clinical margin width (measured from the edge of the lesion or the prior excision scar): 0.5 cm

Noncompliant ✗

Original Breslow thickness of the lesion: 0.7 mm

Clinical margin width (measured from the edge of the lesion or the prior excision scar): 1 cm

Compliant ✓
Compliant vs. Noncompliant Reports – Formatting Requirements

Narrative Format
Dissection was carried down posteriorly to the level of the long thoracic nerve which was identified. Care was taken to preserve the long thoracic nerve. The thoracodorsal neurovascular bundle was encountered, and care was taken to avoid injury. The intercostobrachial nerves were also identified and preserved.

Synoptic Format
Nerves identified and preserved during dissection (select all that apply): Long thoracic nerve, Thoracodorsal nerve, Branches of the intercostobrachial nerves

Noncompliant × Compliant ✓
Examples of Compliant vs. Noncompliant Pathology Reports

Compliant ✅
Specify nodal station(s) examined: 4R, 7, 9R, 11R
Nodal Site(s) Examined:
5 Subaortic
6 Para-aortic
7 Subcarinal
10L Hilar

Noncompliant ❌
Specify nodal station(s) examined: 2R, 4R, 7, 9R
“5 lymph node stations were examined.”
← Does not meet technical requirement
← Not in synoptic format
Integrated Network Cancer Programs

• Each hospital in an Integrated Network Program (INCP) will have 7 charts assessed per standard. The INCP will then be rated cumulatively.

• Example: For an INCP with 10 hospitals, 70 reports will be reviewed per standard (7 reports × 10 hospitals).
  • 49 of the 70 charts assessed would need to meet all requirements to achieve 70% compliance for that standard.
What if a Program has Fewer than 7 Cases for Standards 5.3-5.8?

• If a program has fewer than 7 cases that meet the criteria for a specific standard, then all cases meeting the criteria will be reviewed by the site reviewer
  • The threshold compliance level will be at 100% starting with charts assessed at 2023 site visits

• If a program has NO cases that meet the criteria for a specific standard, they are exempt from that standard
  • Programs should make a comment in the PRQ to indicate that the operation is not performed at their institution. Site reviewers will discuss with the program and assign a “Not Applicable” rating for that standard
Amended/Addended Reports

- Amended/addended operative reports can meet the requirements of Standards 5.3-5.6. Likewise, amended or addended pathology reports can meet the requirements of Standards 5.7 and 5.8

- Reports should only be corrected when the change will affect clinical care
What if My Site is Found to be Non-Compliant with the CoC Operative Standards?
What if a Program is Deemed Noncompliant for Standards 5.7-5.8?

• If a program does not meet the compliance threshold, the program must complete a random audit of 10 reports eligible for the noncompliant standard to determine whether the synoptic reporting format and technical requirements were met.
  • The cancer committee should designate who should conduct the audit.
  • If a program has less than 10 cases in this time period, the audit should include all applicable cases

• The audit must be documented in the cancer committee minutes. The number of reports reviewed and the number that were compliant must be documented. The outcome must meet the original threshold of compliance to resolve the standard.
  • The reports reviewed for the deficiency resolution must be from procedures occurring after the period reviewed during the site visit.
What if a Program is Deemed Noncompliant for Standards 5.3-5.6?

• If a program does not have an implementation plan in place, the program will be non-compliant with Standards 5.3, 5.4, 5.5, and 5.6 individually

• To resolve the deficiency, the program must document their plan and discuss it with the cancer committee

• Cancer committee minutes reflecting the plan must then be submitted through the Corrective Action PRQ

• Programs have one year from the date of the accreditation report to resolve the deficiency
Opportunities for Improvement and Lessons Learned from Prior Site Visits
Opportunities for Improvement Identified During Site Visits

Standard 5.7 (Total Mesorectal Excision)

- Facilities not using most recent version of CAP report (missing TME completeness)
- Incomplete excision of the mesorectum
- Location and evaluation of mesorectum missing
- Pathology reports did not address the intactness of mesorectum
Opportunities for Improvement Identified During Site Visits

Standard 5.8 (Pulmonary Resection)

- Failure of surgeons to remove/identify required nodal stations
- Inadequate number of nodes from required stations (either no nodes removed, or fewer stations than required for mediastinal and/or hilar nodes)
- Stations not listed in pulmonary resection synoptic pathology reports
- Nodes grouped rather than named by site
- Information included not in synoptic format
Lessons Learned

Strategies for achieving compliance with operative standards 5.7 and 5.8

• Performing internal audits in preparation for the site visit
• Education, awareness, communication with surgeons/pathologists (share CSSP resources, STS webinar, etc.)
• Ensure thoracic and colorectal representation at tumor board
• Use most recent versions of CAP reports
• Create an internal review process to track reports
• Provide a checklist for staff in OR to use and remind surgeons of the need for mediastinal sampling and TME completeness as necessary
Available Resources
Resources for CoC-Accredited Programs

- Introduction to the CoC Operative Standards
- Comprehensive FAQ on Standards 5.3-5.8 and Synoptic Reporting
- Quick Reference Guide Synoptic Operative Reporting Requirements
- Guidelines for Implementation Plan for Standards 5.3-5.6
- Visual Abstracts on Standards 5.3, 5.4, 5.5, 5.7 and 5.8
- Guidelines for registrars to identify eligible cases for Standards 5.3, 5.4, 5.5, 5.6, 5.7 & 5.8

All resources can be found on the Operative Standards Toolkit, organized by topic.
# Compliance Requirements & Site Visit Visual Abstract

**Commission on Cancer Operative Standards**

## Compliance Requirements & Site Visit Process Overview

<table>
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<tr>
<th>Requirements</th>
<th>Review Process</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>A reviewed case must meet both the <a href="#">technical requirement</a> AND the <a href="#">synoptic documentation requirement</a> to be compliant</td>
<td>Programs generate list of eligible cases</td>
<td>2021&lt;br&gt;Standards 5.7 &amp; 5.8 take effect</td>
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<td>Operative reports are reviewed for Standards 5.3–5.6</td>
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[Technical requirement](#) [Synoptic documentation requirement](#) [FACS.org/opstandardscompliance](http://facs.org/opstandardscompliance)
Standard 5.7 & 5.8 Visual Abstracts

**Standard 5.7: Total Mesorectal Excision**

**Operation**
- Total mesorectal excision (TME) is performed for mid and low rectal tumors, resulting in complete or near-complete TME.

**Maintain the ‘Holy Plane’**
- Keep fascia propria of rectum intact, operate in plane between rectum and presacral fascia.
- Ensures negative margins.
- Protects neurovascular structures.

**Pathology Documentation**
- Quality of TME documented in synoptic report.
  - Complete
  - Near-Complete
  - Incomplete

**When?**
- 2021: Implementation
- 2022 site visits: 70% Compliance

**Standard 5.8: Pulmonary Resection**

**Operation**
- For any primary pulmonary resection performed with curative intent (including non-restorative parenchymal-sparing resections).
- Resect nodes from:
  - Mediastinum (Stations 2-9) ≥3 distinct stations
  - Hilum (Stations 10-14) ≥1 station

**Pathology Documentation**
- Synoptic report documents lymph nodes from:
  - Mediastinum (Stations 2-9) ≥3 distinct stations
  - Hilum (Stations 10-14) ≥1 station
  - With names and/or numbers of stations

**When?**
- 2021: Implementation
- 2022 site visits: 70% Compliance
Resources for CoC-Accredited Programs

Webinars

- Implementation Strategies for Synoptic Operative Reporting (recording, slides, summary)
- Best Practices for Compliance with CoC Standards 5.7 & 5.8 (recording, slides, summary)
- CoC Standard 5.3 & 5.4: Sentinel Node Biopsy and Axillary Lymph Node Dissection for Breast Cancer (recording, slides, summary)
- CoC Standard 5.5: Wide Local Excision for Primary Cutaneous Melanoma (recording, slides, summary)
- CoC Standard 5.6: Colon Resection (recording, slides, summary)
- CoC Standard 5.7: Total Mesorectal Excision (recording, slides, summary)
- CoC Standard 5.8: Pulmonary Resection (recording, slides, summary)

All resources can be found on the Operative Standards Toolkit, organized by topic.
Q&A
Upcoming CSSP Webinar

• Implementing Synoptic Requirements for CoC Operative Standards
  • Thursday, November 3rd @ 3pm CT
  • Registration link will be available shortly
For general questions about Site Visits, please contact coc@facs.org
For questions related to CoC Operative Standards 5.3-5.8, please contact cssp@facs.org
Special Thanks

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**CSSP Leadership & Staff:**
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CSSP Vice-Chair: Kelly K. Hunt, MD, FACS
CSSP Senior Manager: Amanda Francescatti, MS
CSSP Administrator: Linda Zheng
CSSP Program Coordinator: Clarissa Orr, MS

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