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
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

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Chair, CoC Accreditation Committee

Mediget Teshome, MD, FACS
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Chair, CSSP Education Committee

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Newark Beth Israel Medical Center

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Accreditation Senior Manager
ACS Cancer Programs
Operative Standards and Compliance Overview
## The CoC Operative Standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>Disease Site</th>
<th>Procedure</th>
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**Implementation Timeline for Standards 5.7 & 5.8**

**Compliance and Site Visits**

- **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

- **2020**: Introduction of operative standards
- **2021**: Plan for implementation, educate/train surgeons & registrars
- **2022**: Document final plan for implementation and conduct audits
- **2023**: Begin compliance with Standards 5.3-5.6
  - Site Visits review documentation of final plans for compliance
- **2024**: Site Visits review 2023 operative reports for 70% compliance
- **2025**: Site Visits review 2023 & 2024 operative reports for 80% compliance

Steps to Achieve Compliance
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>
</thead>
<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 rectal 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 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

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

Noncompliant ✗
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.
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?
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>
</tr>
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<tbody>
<tr>
<td>A reviewed case must meet both the technical requirement AND the synoptic documentation requirement to be compliant</td>
<td>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</td>
<td>2021 Standards 5.7 &amp; 5.8 take effect 2022 Site visits begin reviewing pathology reports 2023 Standards 5.3-5.6 take effect 2024 Site visits begin reviewing operative reports</td>
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</table>

Operative reports are reviewed for Standards 5.3-5.6 Pathology reports are reviewed for Standards 5.7-5.8

For more compliance information, visit facs.org/opstandardcompliance
**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.
- **Pathology Documentation**: Quality of TME documented in synoptic report.
- **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-surgical parenchymal-sparing resections).
- **Pathology Documentation**: Synoptic report documents lymph nodes from:
  - Mediastinum (Stations 2-10) ≥3 distinct stations
  - Hilum (Stations 10-14) ≥1 station
- **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

Moderator:
Anthony Villano, MD

Panelists:
James B. Harris, MD, FACS
Matthew H.G. Katz, MD, FACS
Mediget Teshome, MD, FACS
Timothy Vreeland, MD, FACS
Nadine Walker, MS, CTR

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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Committee Vice-Chair: Timothy J. Vreeland, MD, FACS

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Senior Manager, Education & Training: Asa Carter
Administrator, Education & Training: Chantel Ellis