

# Operative Standards Success at the Site Visit: Making the Most of Preparation

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# Disclosures

Nothing FINANCIAL  
to Disclose



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# Perspective



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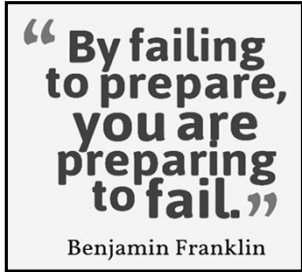
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### Operative Standards: Steps for Success

- Know the standard
- Implement the standard
- Assess performance
- Communicate with Site Reviewer
- Accreditation visit day




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### Operative Standards for Cancer Surgery



- Developed by ACS Clinical Research Division
- Evidence-based
- Break down the major cancer operations for each disease site into critical steps.
- Critical elements: perceived by teams of experts and stakeholders to have the most significant influence on outcomes.

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## Operative Standards for Cancer Surgery

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## Operative Standards

Standard	Disease Site	Procedure	Documentation
5.3	Breast	Sentinel node biopsy	Operative report
5.4	Breast	Axillary dissection	Operative report
5.5	Melanoma	Wide local excision	Operative report
5.6	Colon	Colectomy (any)	Operative report
5.7	Rectum	Mid/low resection (TME)	Pathology report (CAP)
5.8	Lung	Lung resection (any)	Pathology report (CAP)

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## Results of 2023 Accreditation Visits

As of 10/1/23

Standard	Compliant	N/A	Noncompliant	Grand Total
5.7	135	55	23	213
5.8	79	47	85	213

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## Operative Standards

Planning

Execution


Monitoring

Adjusting

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Performance

**OR**




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## Know the Standard

### 5.3 Pulmonary Resection

**Definition and Requirements:**

**Definition of Compliance:**

**Documentation and Requirements:**

**Operative Report:**


### 5.7 Total Mesorectal Excision

**Definition and Requirements:**

**Definition of Compliance:**

**Documentation and Requirements:**

**Operative Report:**



**Operative Standards for Cancer Surgery**

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## Operative Standards

Standard	Disease Site	Procedure	Documentation
5.3	Breast	Sentinel node biopsy	<b>Operative report</b>
5.4	Breast	Axillary dissection	<b>Operative report</b>
5.5	Melanoma	Wide local excision	<b>Operative report</b>
5.6	Colon	Colectomy (any)	<b>Operative report</b>
5.7	Rectum	Mid/low resection (TME)	Pathology report (CAP)
5.8	Lung	Lung resection (any)	Pathology report (CAP)

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### Know the Standard

<https://www.facs.org/quality-programs/cancer-programs/cancer-surgery-standards-program/cssp-operative-standards-toolkit/>

CAC Operative Standards and the Cancer Surgery Standards Program

CAC Accreditation, Compliance, and Site Review Process

Synoptic Operative Reporting

Standard S.5: Sentinel Lymph Node Biopsy for Breast Cancer

Guidelines for operators to identify eligible cases for Standard S.5 (PPI)

CSP #10104 as CAC Standard S.5 & S.4 for Breast Cancer (reimbursement from November 11, 2021 - 12/31/2022)

- Slides (PPI)
- Summary and FAQs (PPI)

Relevant pages from the Breast chapter in Operative Standards for Cancer Surgery, Volume 1 (PPI)

CAC Standard S.5: Requirements & Best Practices (Video - 5min)

Editorial on CAC Standards S.5 and S.4 in Surgery

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### Operative Standards: S5.7 & S5.8

Compliance and Site Reviews

2020

Communicate requirements & engage clinicians in implementation plans

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

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### 2023 Accreditation Visits: Noncompliance

S5.7 and S5.8:

- NOT SURPRISINGLY, FOR THE INITIAL ASSESSMENTS OF BRAND NEW STANDARDS UNLIKE ANY WE HAVE HAD PREVIOUSLY, THESE WERE THE TWO STANDARDS WITH WHICH PROGRAMS STRUGGLED THE MOST.
- WE ANTICIPATE SUBSTANTIAL IMPROVEMENT IN COMPLIANCE RATES BEGINNING IN 2025, WHEN PROGRAMS WILL BE ASSESSED FOR THE SECOND TIME ON S5.7-5.8.
- HOWEVER, WE CAN STILL LEARN FROM THESE EARLY EXPERIENCES.

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Noncompliance	Path Documentation	Technical	Both
S5.7	46%	38%	16%
S5.8	2%	73%	25%

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### Lack of Coordination: S5.7 & S5.8

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## Coordination: S5.3-S5.6

### Operative Standards Toolkit

Operative Standards Toolkit

Frequently Accessed Resources

- 2023 Site Visit Preparation Webinar Questions
- Quick Reference Guide - Standards S.3-S.6 Synoptic Reporting Requirements
- Overview of Compliance Requirements & Site Visit Process for CAC Operative Standards
- Frequently Asked Questions on the CAC Operative Standards
- Letter to Surgeons With Documentation Requirements for the CAC Operative Standards
- Visual Abstract of Synoptic Operative Reporting Information for Standards S.3-S.6



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## Operative Standards: S5.3-5.6

Element	Response Options	Element	Response Options	Element	Response Options
Operation performed with curative intent.	Yes No	Operation performed with curative intent.	Yes No	Tumor location	Cecum, Ascending colon, Hepatic flexure, Transverse colon, Splenic flexure, Descending colon, Sigmoid colon, Rectosigmoid junction, Rectum, NOS, Colon, NOS
Trajectory used to identify sentinel nodes in the upstom surgery (non-mesoadipose) setting (select all that apply).	Dye; Radioactive Superpara Other (with N/A)	Resection was performed within the boundaries of the axillary vein, chest wall (seratus anterior), and latissimus dorsi.	Yes No Median ... mm millimeter	Extent of colon and vascular resection	Right hemicolectomy - ileocolic, right colic (if present); Extended right hemicolectomy - ileocolic, right colic (if present), middle colic; Transverse colectomy - middle colic; Splenic flexure resection - middle and ascending left colic; Left hemicolectomy - inferior mesenteric; Sigmoid resection - inferior mesenteric; Total abdominal colectomy - ileocolic, right colic (if present), middle colic; Partial colectomy; Total abdominal colectomy with proctectomy - ileocolic, right colic (if present), middle colic, inferior mesenteric, superior and middle rectal; Other (with explanation).
Trajectory used to identify sentinel nodes in the mesoadipose setting (select all that apply).	Dye; Radioactive Superpara Other (with N/A)	Nerves identified and preserved during dissection (select all that apply).	Clinical margin width (measured from the edge of the lesion or the prior excision scar)	Depth of excision	Full-thickness subcuta to fascia Only ski subcuta (includes)
All nodes (colored or non-colored) present at the end of a dye-filled lymphatic channel were removed.	Yes No (with N/A)				
All significantly radioactive nodes were removed.	Yes No (with N/A)				
All palpably suspicious nodes marked with clips prior to chemotherapy were identified and removed.	Yes No (with N/A)	Level III nodes were removed.	expansions; No.		

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### Assess Performance: Communicate with Surgeons

**Lymphatic mapping and sentinel node biopsy synoptic report**  
 Surgery performed with curative intent (YES/NO/NA 1802: "YES")  
 Tracer(s) Non NACT (ADR/Nodes 2018)  
 Tracer(s) Dual NACT (ADR/Nodes 2018: "Yes & Radioactive")  
 All Dyed Nodes/Nodes adjacent to dyed lymphatics Removed (YES/NO/NA 1802)  
 All Radioactive >10% of labeled nodes Removed (YES/NO/NA 1802)  
 All Palpably Suspicious Nodes Removed (YES/NO/NA 1802)  
 All Nodes with Markers Removed (YES/NO/NA 1802)  
 Nodes: \*\*\* nodes removed, Ex vivo counts of \*\*\* and \*\*\* background counts of \*\*\*

**Axillary Lymphadenectomy synoptic report**  
 Surgery performed with curative intent (YES/NO 1802: "YES")  
 Resection performed within the boundaries of the axillary vein, serratus anterior muscle and latissimus dorsi muscle (YES/NO 1802: "YES")  
 Long Thoracic Nerve spared during dissection (YES/NO 1802: "YES")  
 Thoracodorsal Nerve spared during dissection (YES/NO 1802: "YES")  
 Attempt made to spare Intercostobrachial Nerve during dissection (YES/NO 1802: "YES")  
 Level III nodes removed (YES/NO/NA 1802)  
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### Assess Performance: Internal Audit



"In God we trust; all others bring data."  
 - W. Edwards Deming

"Without data, you're just another person with an opinion."  
 - W. Edwards Deming

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### Assess Performance: Internal Audit



ACTION PLAN TEMPLATE				
Goal 1	Action Step Descriptions	Party / Dept. Responsible	Date to Begin	Date Due
1. What are your intended goals?				
2. List Resources & Required Materials				
Goal 2	Action Step Descriptions	Party / Dept. Responsible	Date to Begin	Date Due
1. What are your intended goals?				
2. List Resources & Required Materials				
Goal 3	Action Step Descriptions	Party / Dept. Responsible	Date to Begin	Date Due
1. What are your intended goals?				
2. List Resources & Required Materials				

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### Benefits of Audit: S5.7 & S5.8 Coordination



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### Benefits of Audit: Recognizing Issues

**Measures of Compliance**

- Wide local excision of a melanoma** (based on the original Breslow thickness of the primary lesion, as indicated on the initial biopsy pathology report. The clinical margin width for wide local excision of invasive melanoma should be 1 cm for melanoma < 1 mm thick, 1 to 2 cm for invasive melanoma 1 to 2 mm thick, and 2 cm or more for invasive melanoma > 2 mm thick. The clinical margin width for wide local excision of a melanoma in situ should be at least 5 mm. Cosmetic concerns or anatomic limitations, particularly on the hands, feet, or face, may dictate narrower margins. If this is the case, the operative report must document the reason for this deviation.
- Operative report** (This standard applies to all curative intent wide local excisions of primary cutaneous melanoma lesions. Metastatic, ocular, and subungual melanoma are excluded.)

Element	Response Options
Operation performed with curative intent	Yes; No.
Original Breslow thickness of the lesion	Melanoma in situ (MIS); ... mm (to the tenth of a millimeter).
Clinical margin width (measured 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; Other (with explanation).
Depth of excision	Full-thickness skin/ subcutaneous tissue down to fascia (melanoma); Only skin and superficial subcutaneous fat; Other (with explanation).

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### Communicate with Site Reviewer

- Collaborate with the site reviewer to provide case lists in a TIMELY fashion
- Collaborate with the site reviewer to try and assure that there are **7 appropriate cases** for review for each standard
- Determine how the document review will be performed and when (pre-site visit or during)




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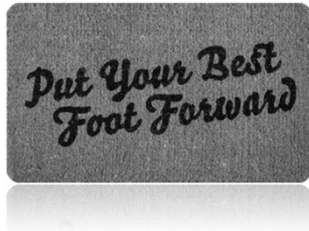
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### Assessing Compliance with Operative Standards




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### Assessing Compliance with Operative Standards

- S5.7 and S5.8 had the highest percentage of noncompliant assessments during the past two years, as mentioned previously
- However, because they are calculated results and because the assessment of compliance is objective and standardized, there were very few appeals

Year (2021)	Assessment Number	Assessment Standard	Assessment Result	Assessment Reviewer	Appeal Status	Comments
1	2021	Documentation of Value	Yes			
2	2021	Documentation of Value	Yes			
3	2021	Documentation of Value	Yes			
4	2021	Documentation of Value	Yes			
5	2021	Documentation of Value	Yes			
6	2021	Documentation of Value	Yes			
7	2021	Documentation of Value	Yes			
8	2021	Documentation of Value	Yes			
9	2021	Documentation of Value	Yes			
10	2021	Documentation of Value	Yes			

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### Attitude Towards the CoC Accreditation Site Visit



Year (2021)	Assessment Number	Assessment Standard	Assessment Result	Assessment Reviewer	Appeal Status	Comments
1	2021	Documentation of Value	Yes			
2	2021	Documentation of Value	Yes			
3	2021	Documentation of Value	Yes			
4	2021	Documentation of Value	Yes			
5	2021	Documentation of Value	Yes			
6	2021	Documentation of Value	Yes			
7	2021	Documentation of Value	Yes			
8	2021	Documentation of Value	Yes			
9	2021	Documentation of Value	Yes			
10	2021	Documentation of Value	Yes			

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### Key Takeaways

- Ask surgeons to READ standards S5.3-S5.8 appropriate to their practices AND optimally the Operative Standards text
- AUDIT your pathologists and surgeons to identify any issues in either documentation or technical performance
- DOCUMENT any action plans for deficiencies in the minutes
- COLLABORATE with the site reviewer to provide case lists in a timely fashion and to assure that there are 7 appropriate cases for review
- ENCOURAGE cancer committee members to approach site review as a learning opportunity



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**Thank you**

Questions will be addressed during the Q and A period at the end of the session.



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