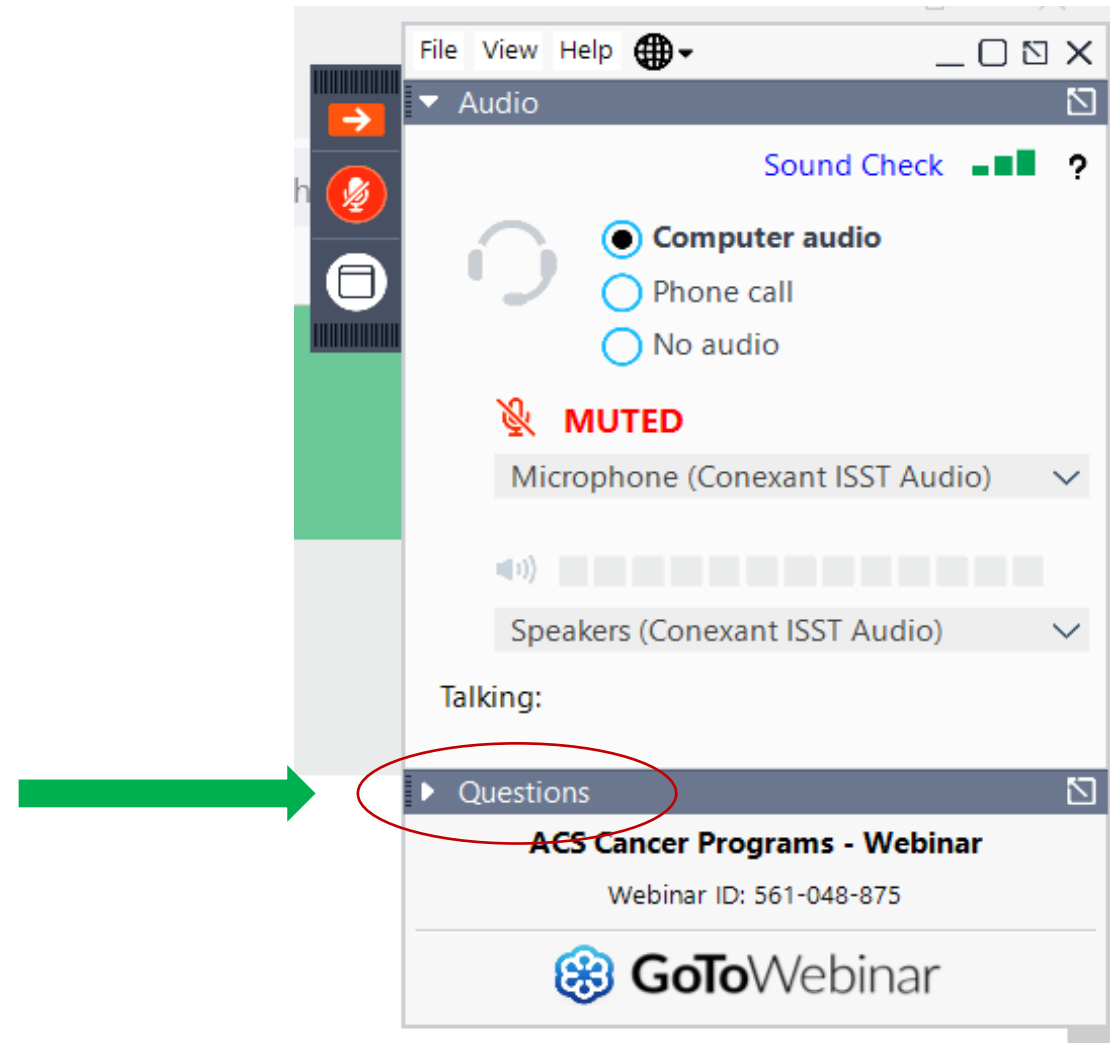


Implementing Synoptic Requirements for CoC Operative Standards 5.3-5.6

November 3, 2022
3:00-4:00pm CT

Webinar Logistics

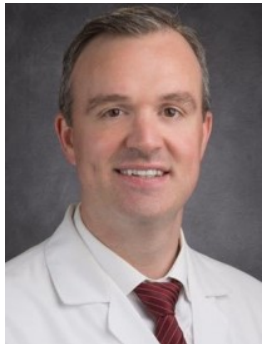
- All participants are muted during the webinar
- Questions – including technical issues you may be experiencing – should be submitted through the question pane
- Questions will be answered as time permits; additional questions and answers will be posted on the website
- Please complete the post-webinar evaluation you will receive via email



Moderators



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



Timothy J. Vreeland, MD FACS
Brooke Army Medical Center
Vice-Chair, CSSP Education
Committee

Speaker



Chantal Reyna, MD FACS
Crozer Health

Panelists



Tara M. Breslin, MD FACS
Trinity Health IHA Medical Group
Cancer Liaison Physician



Megan Buchanan
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Cancer Programs Coordinator



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Jill A. Mathison, RRT/RCP, CPHQ
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Panelists



Rogerio I. Neves, MD, PhD FACS, FSSO
Senior Member, Cutaneous Oncology
Department
Moffit Cancer Center



Lawrence Wagman, MD FACS
San Antonio Regional Hospital
Cancer Liaison Physician



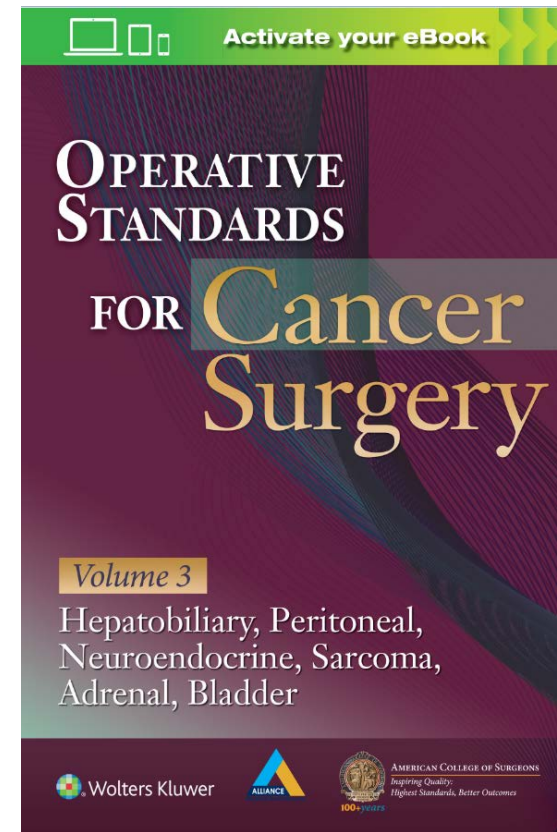
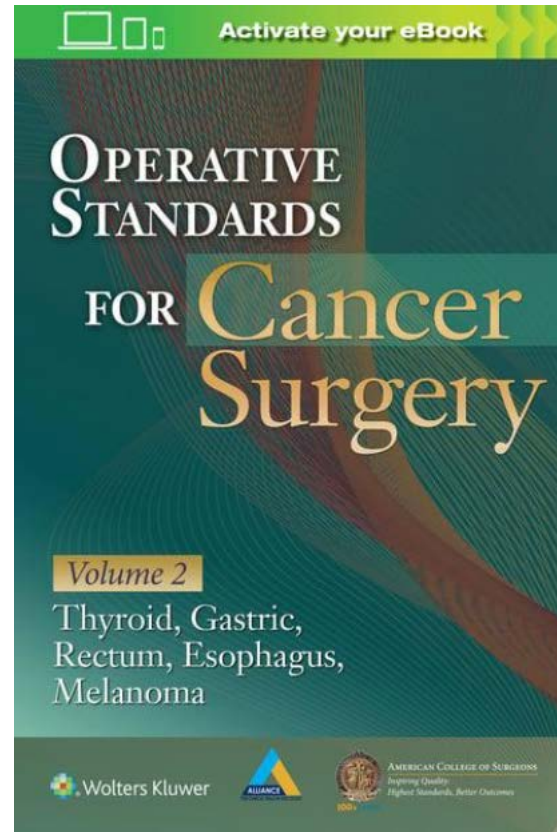
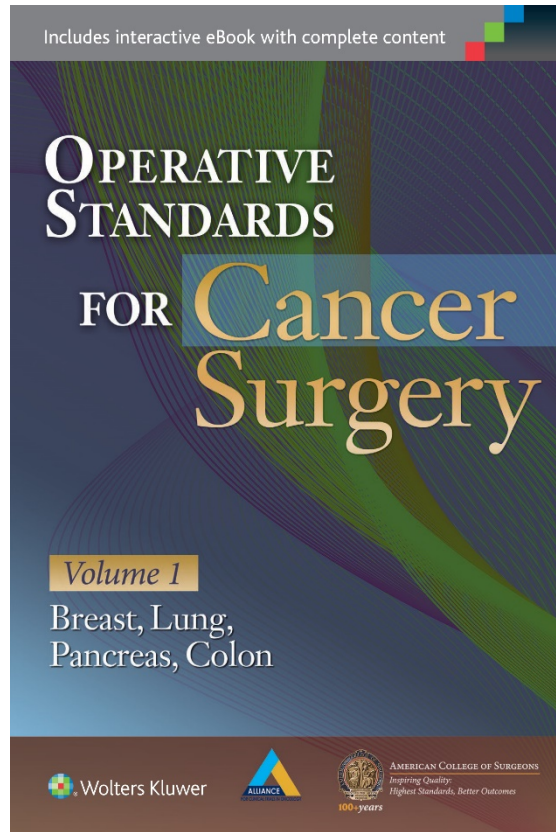
Michael D. Sarap, MD FACS
Southeastern Ohio Physicians Inc
Ohio CoC Co-Chair

Introduction: Synoptic Operative Reporting

Mediget Teshome, MD FACS

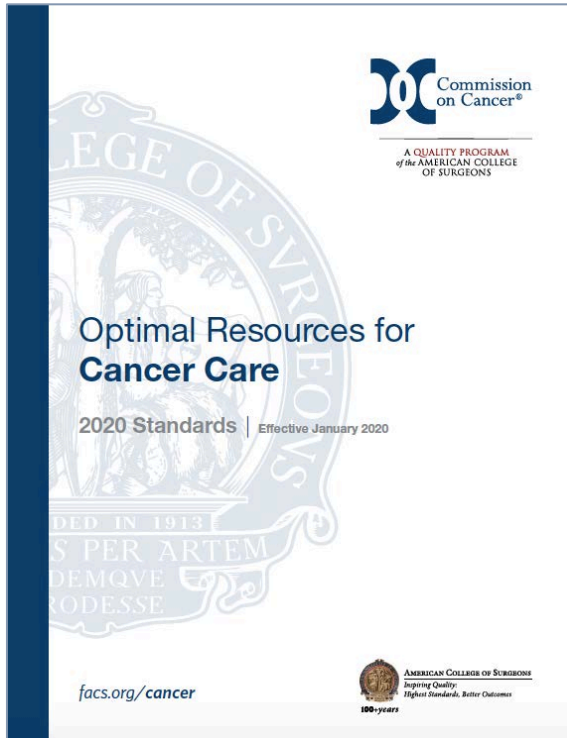
Timothy Vreeland, MD FACS

Operative Standards for Cancer Surgery



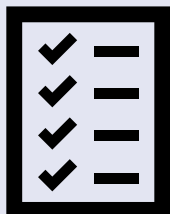
Just Released!

The CoC Operative Standards

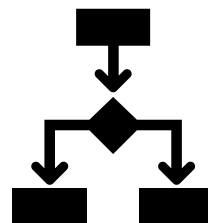


Standard	Disease Site	Procedure	Documentation
5.3	Breast	Sentinel node biopsy	Operative report
5.4	Breast	Axillary dissection	Operative report
5.5	Melanoma	Wide local excision	Operative report
5.6	Colon	Colectomy (any)	Operative report
5.7	Rectum	Mid/low resection (TME)	Pathology report (CAP)
5.8	Lung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

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**

Timeline for Standards 5.3-5.6



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

Survey Results: Implementation of CoC-Required Synoptic Elements in Operative Reports

Survey on Implementation of CoC- Required Synoptic Elements in Operative Reports (SORs)

- Survey open to CoC-accredited cancer programs July 14th – August 1st
- Seeking information about sites' synoptic operative reporting solution and implementation experience
- 120 responses total

SOR Implementation Survey Results: Demographics

Respondent Role

- 31% Certified Tumor Registrars
- 24% Cancer Liaison Physicians
- 20% Surgeons
- 19% Cancer Program Administrators
- 10% Cancer Committee Chairs

EMR Used

- 54% Epic
- 18% Cerner
- 13% Meditech
- 15% Other

Type of Institution

- 33% Comprehensive Community Cancer Program
- 23% Community Cancer Program
- 16% Integrated Network Cancer Program
- 14% Academic Comprehensive Cancer Program
- 4% NCI-Designated Comprehensive Cancer Center Program
- 10% Other

SOR Implementation Survey Results: In Practice

Disease Sites Covered

- Breast
- Colon
- Skin (Melanoma)
- Lung
- Rectum
- Thyroid

Solutions

- 62% Internally-developed checklist using auto-text
 - smart phrase/smart list
- 23% Other
 - dictation
 - digital form
 - checklist
- 12% Required elements/responses integrated from Epic Foundation
- 4% Third party application

SOR Implementation Survey Results: Education

- Email/written communications to surgeons including special communications to surgeons from CLPs, surgical specialty leads, department chairs
- Presented during tumor board/cancer committee meetings, at surgical grand rounds, and department of surgery meetings
- Scheduled separate training sessions
- Shared resources from Operative Standards Toolkit

SOR Implementation Survey Results: Barriers

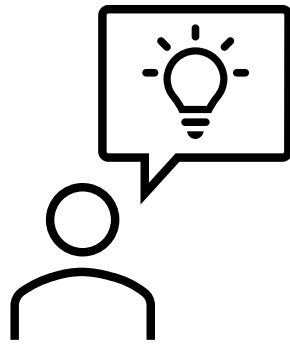
- Surgeon Buy-In
 - Initial surgeon buy-in (e.g., to synoptic reporting or importance of the CoC Operative Standards)
 - Consistent use of synoptic operative reporting tools by surgeons
- General lack of awareness
 - (e.g., of synoptic reporting or of the CoC Operative Standards)
- Consistent use of synoptic operative reporting tools by surgeons
- IT issues
 - Limited local IT resources/bandwidth
 - Challenges with EMR software integration
- Lack of clarity on synoptic reporting implementation options

Current Options for Implementing the Required CoC Elements/Responses

Chantal Reyna, MD FACS

Current Options for Implementing CoC Required Elements/Responses (1 of 3)

Create Your Own Basic Synoptic Templates



- Use required elements and responses from the CoC 2020 Standards manual
- Can be done using smart phrases/smart tools to supplement a traditional narrative operative report
- Can be integrated into an existing smartform or synoptic report within EMR
- Reporting format must be uniform across all surgeons at the facility

Current Options for Implementing CoC Required Elements/Responses (2 of 3)

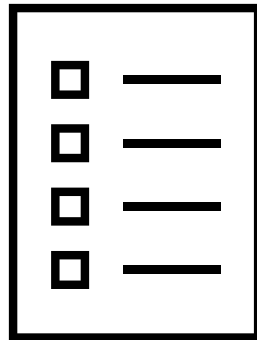
License Third-Party Vendor Tools



- Includes all data elements and responses from comprehensive CSSP synoptic operative reporting templates, including elements required for CoC accreditation
- Fully developed tool supported by vendor
- Current vendor list available on ACS website

Current Options for Implementing CoC Required Elements/Responses (3 of 3)

Use Fillable PDF Forms



- Includes only the required elements and responses from the CoC 2020 Standards manual
- Downloads as blank PDF from the Standards Resource Library
- Supplements a traditional narrative operative report
- Stop-gap measure to allow programs to ensure compliance with synoptic formatting requirements

**Cancer
Surgery
Standards**
PROGRAM

AMERICAN COLLEGE OF SURGEONS

Panel Session



Tara M. Breslin, MD FACS
Trinity Health IHA Medical Group
Cancer Liaison Physician

Trinity Health IHA Medical Group

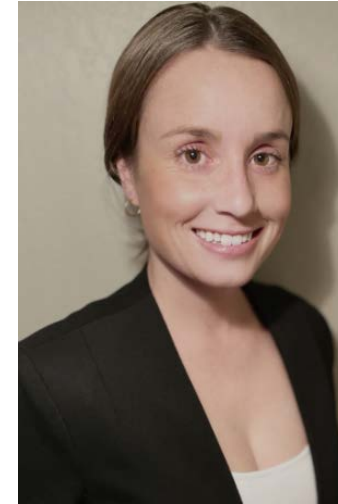
- Category of cancer program: INCP
- Number of surgeons: 5
- Caseload: 600/year
- Synoptic operative reporting solution: Epic

Opportunities & Challenges

- Opportunities:
 - Epic smart list provides a consistent approach to surgical procedure documentation
 - Once implemented, this approach is simple to automate
 - Opportunity to streamline processes between health system and practices and between our Epic Support and Clinical Informatics
- Challenges:
 - Epic smart list was implemented without education at the local level
 - Although we have a single EHR for all of our practices, the surgical case request process varies. As a result, the synoptic smart list does not always populate our operative note templates.



Madison Deutsch CCS, CDIP
Marshall Medical Center
Clinical Documentation
Improvement Coordinator



Megan Buchanan
Marshall Medical Center
Cancer Programs Coordinator



MARSHALL

MEDICAL CENTER

It's about you

- Category of cancer program: Community Cancer Program
- Number of surgeons: 3 General Surgeons
- Caseload: Approximately 86 sentinel node biopsy, axillary node biopsy, colon resection, wide local excision procedures performed in 2021.
- Synoptic operative reporting solution:
 - Development of smartphrases
 - Customization of operative report templates to include CoC smartphrases
 - Concurrent review prior to bill drop
 - Retrospective review post bill drop
 - Peer to Peer education provided by the Cancer Committee Primary Surgeon when fall out occur

SmartPhrase Development

- The Clinical Documentation Improvement (CDI) Department developed smartphrases in the EMR that prompt providers to address synoptic reporting standards.
- Smartphrases were customized to include specific criteria for each procedure.

- **Sentinel node biopsy for breast cancer**
 - Smartphrase name: CoCSentinelNodeBreastCancer
- **Axillary lymph node dissection for breast cancer**
 - Smartphrase name: CoCAxillaryNodeBreastCancer
- **Wide local excision for primary cutaneous**
 - Smartphrase name: CoCMelanomaCutaneous
- **Colon resection**
 - Smartphrase name: CoCColonCancer

SmartPhrase Documentation Requirements (example): Axillary Lymph Node Dissection

CoCAxillaryNodeBreastCancer: Axillary Lymph Node Dissection for Breast Cancer

Synoptic Operative Report Requirements: Operative reports for patients undergoing axillary lymph node dissection must include the following elements in synoptic format:

Operation performed with curative intent. {YES/NO:11306}

Original Breslow thickness of the lesion {BCABreslowThickness:27377}

Clinical margin width (measured from the edge) of the lesion or the prior excision scar {BCAMarginWidth:27378}

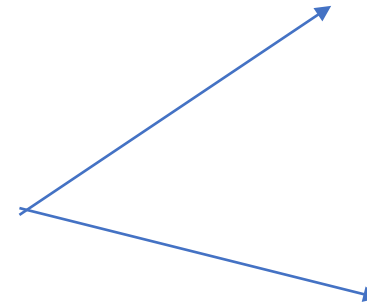
Depth of excision {BCADepthExcision:27379}

EMR Coding Validation

EMR flags specific PCS codes that may fall into synoptic reporting criteria. Coder is directed to send the case to the Clinical Documentation Improvement (CDI) work queue.



CDI reviews case to ensure synoptic reporting compliance when applicable.



If synoptic reporting criteria is met, CDI sends the case back to Coding for bill drop.

If synoptic reporting criteria is not met, the Cancer Committee's Primary Surgeon will perform a peer to peer review and educate as needed

Retrospective Auditing

- A separate data collection system (Midas) interfaces with our EMR and cases that are coded with specific ICD-10 PCS codes are triggered to a separate worklist.
- This worklist is managed by CDI for review of Coder compliance with EMR notifications and to assess the effectiveness of Peer to Peer education.

Marshall's 4 Step Process

Smart phrase development

- Synoptic reporting criteria formatted into a smart phrases that can be embedded into operative note templates within the EMR

Education/ Application

- Providers received education regarding the purpose and benefits of synoptic reporting.
- Providers update their operative reports to include the synoptic reporting smart phrases

Quality Control

- EMR Coding validation for procedures coded with specific ICD-10 PCS codes.
- 100% current and retrospective review performed by Clinical Documentation Improvement Specialists to ensure compliance with synoptic reporting.

Provider Follow up

- Cancer Committee's Primary Surgeon will perform peer to peer follow up to provider fall outs.

Opportunities & Challenges

- Onboarding new surgeons
- New Cancer Committee Primary Surgeon
- Collaboration and training with multiple departments
 - Medical Records
 - Coding
 - Clinical Documentation Improvement
 - Information Technology
 - Surgery



Jill A. Mathison, RRT/RCP, CPHQ
USC Arcadia Hospital
Cancer Programs Administrator

USC Arcadia Hospital

- Category of cancer program: CCCP
- Number of surgeons: 43
- Analytic Caseload: 645
- Synoptic operative reporting solution:
 - Took standardized elements from CSSP and built & organized into structured document in MACS (Allscripts EHR)
 - Each procedure has the pre-specified elements collected and stored in MACS
 - Created “smart” phrases and streamlined to make user-friendly operative note
 - Created Job Aid for physician reference and trained 4 surgeons (to include Chief of Staff breast surgeon) to pilot synoptic reporting effective 6/7/22
 - Proposed solution presented at Tumor Board and Cancer Committee beginning May 2022 and Department of Surgery, and Gen/Vasc/Colorectal subsection meetings Sept-November 2022
 - Pilot 6/7/22-9/30/22 by 2 breast and 2 colorectal surgeons with 100% compliance

Communication & Training Job Aid for Surgeons

Operative Report – Synoptic Reporting **IMPLEMENTED: 06/07/2022**

REASON FOR ADDED FUNCTIONALITY: The Optimal Resources for Cancer Care (2020 Standards) for Commission on Cancer (CoC) accreditation were updated in 2020 to include several new operative standards based on evidence from the Operative Standards for Cancer Surgery manuals.

There are four target areas that require documentation by the operative surgeon:

- Sentinel node biopsy for breast cancer (Standard 5.3)
- Axillary lymph node dissection for breast cancer (Standard 5.4)
- Wide local excision for primary cutaneous melanoma (Standard 5.5)
- Colon resection (Standard 5.6)

To open the Operative Report Synoptic Reporting document:

1. With your patient selected, click **Enter Document**
2. Double-click on **Operative Report – Synoptic Reporting**

Document Entry Worksheet - Tp, Charmin

Date of Service: May - 27 - 2022 Time: 14:21

Authored: Date Now May - 27 - 2022 Time: 14:21

Authored by: Me Other Source:

Co-Signer(s):

Mark Note As: Incomplete Results pending Priority

Personal Documents

Type here to enter document

Document Name

- Consultation
- Discharge Summary
- Progress Note
- History & Physical
- Pre-Procedure Note
- Post-Procedure Note
- Operative Report
- Operative Report - Synoptic Reporting

1. Complete the elements for **Synoptic Reporting** (i.e., Colon Resection)
2. Click **Save**
3. Click **Submit as Final**

Structured Notes Entry - Ip, Charmin - Operative Report - Synoptic Reporting

Create Preview Date of Service: May - 27 - 2022 Time: 14:29

Copy Forward Refer to Note Preview Modify Template Acronym Expansion

3 SYNOPSIS REPORTING

Synoptic Reporting Sentinel Node Biopsy for Breast Cancer Axillary Lymph Node Dissection for Breast Cancer

Wide Local Excision for Primary Cutaneous Melanoma Colon Resection N/A

Colon Resection 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

Extent of colon and vascular resection

- Right hemicolectomy - ileocolic, right colic (if present) Extended right hemicolectomy - ileocolic, right colic (if present)
- Transverse colectomy - middle colic Splenic flexure resection - middle and ascending left colic
- Left hemicolectomy - interior mesenteric Sigmoid resection - interior mesenteric
- Total abdominal colectomy - ileocolic, right colic (if present) Total abdominal colectomy with proctectomy - ileocolic, right...
- Other (with explanation)

Save/Cancel **4** Save Cancel

Confirm Document Status

All recommended observations for this document have been charted. Do you wish to save this document as Final?

NOTE A No Edit After Final document will be locked for further editing after all authors have signed the document.

5 Submit as Final Submit as Incomplete Cancel

Operative Report – Synoptic Reporting

If 'Sentinel Node Biopsy for Breast Cancer' is selected:

SYNOPTIC REPORTING						
Synoptic Reporting	<input checked="" type="checkbox"/> Sentinel Node Biopsy for Breast Cancer	<input type="checkbox"/> Axillary Lymph Node Dissection for Breast Cancer	<input type="checkbox"/> Wide Local Excision for Primary Cutaneous Melanoma	<input type="checkbox"/> Colon Resection	<input type="checkbox"/> N/A	
<input checked="" type="checkbox"/> Sentinel Node Biopsy for Breast Cancer operation performed with curative intent	<input type="radio"/> Yes	<input type="radio"/> No				
<input checked="" type="checkbox"/> Tracer(s) used to identify sentinel nodes in the upfront surgery (non-neoadjuvant) setting (select all that apply)	<input type="checkbox"/> Dye	<input type="checkbox"/> Radioactive tracer	<input type="checkbox"/> Superparamagnetic iron oxide	<input type="checkbox"/> Other (with explanation)	<input type="checkbox"/> N/A	<input type="text"/>
<input checked="" type="checkbox"/> Tracer(s) used to identify sentinel nodes in the neoadjuvant setting (select all that apply)	<input type="checkbox"/> Dye	<input type="checkbox"/> Radioactive tracer	<input type="checkbox"/> Superparamagnetic iron oxide	<input type="checkbox"/> Other (with explanation)	<input type="checkbox"/> N/A	<input type="text"/>
<input checked="" type="checkbox"/> All nodes (colored or non-colored) present at the end of a dye-filled lymphatic channel were removed	<input type="radio"/> Yes	<input type="radio"/> No (with explanation)	<input type="radio"/> N/A			<input type="text"/>
<input checked="" type="checkbox"/> All significantly radioactive nodes were removed	<input type="radio"/> Yes	<input type="radio"/> No (with explanation)	<input type="radio"/> N/A			<input type="text"/>
<input checked="" type="checkbox"/> All palpably suspicious nodes were removed	<input type="radio"/> Yes	<input type="radio"/> No (with explanation)	<input type="radio"/> N/A			<input type="text"/>
<input checked="" type="checkbox"/> Biopsy-proven positive nodes marked with clips prior to chemotherapy were identified and removed	<input type="radio"/> Yes	<input type="radio"/> No (with explanation)	<input type="radio"/> N/A			<input type="text"/>



Rogerio I. Neves, MD, PhD FACS, FSSO
Moffit Cancer Center
Senior Member, Cutaneous Oncology Department

Moffitt Cancer Center

- Category of cancer program: NCI-Designated Comprehensive Cancer Center
 - Number of surgeons: Breast (7), Colorectal (3), Melanoma (6)
 - Caseload: 3,913
 - Synoptic operative reporting solution for Cutaneous Oncology:
 - Created an auto-text in Cerner including all Synoptic Operative Report Requirements for melanoma
- **SYNOPTIC DESCRIPTION:**
 - 1. **Operation performed with curative intent: Yes.**
 - 2. **Original Breslow thickness of the lesion: 1.2 mm**
 - 3. **Clinical margin width: 1 cm measured from the edge of the prior scar.**
 - 4. **Depth of excision: Full thickness skin and subcutaneous tissue down to fascia.**

Opportunities

- Identified situations that were not clearly defined in the requirements, such as multiple primary melanomas and preoperative neoadjuvant therapy altering resection margins.

Challenges

- Risk of non-compliance: Solution is surgeon's dependent!
- AutoText works for melanoma and colon standards as they don't require any multi-select items.
- Breast standards have multi-select options and currently Cerner does not support this functionality in Auto-Text.
- Significant concerns regarding consistency and reproducibility.
- Universal solution currently on hold until further notice. There are now three vendors being evaluated for this requirement.
- Off-the-shelf solutions are usually slow in implementing our current fast changing scenarios.



Michael D. Sarap, MD FACS
Southeastern Ohio Physicians Inc
Ohio CoC Co-Chair

Michael D Sarap MD FACS
CLP and CoC Chair in Ohio

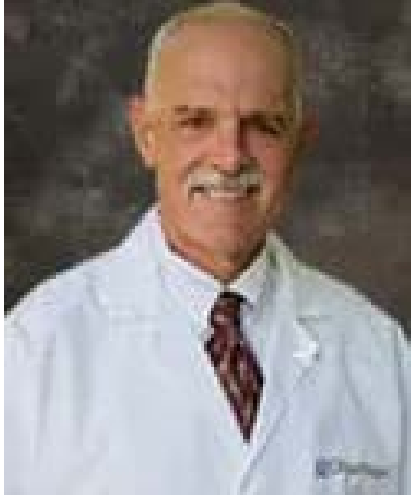
Southeastern Ohio Regional Med Center
Cambridge, Ohio
Community Cancer Program
CoC and NAPBC Accredited

Average Cancer Case Volume/Year
Total New Cases 170
Breast 35
Colon/Rectal 30
Lung 40
Melanoma 10

Surgeons 3 (Private practice group)

Synoptic Operative Reporting: A “Low Rent” Rural Option

- Surgeons still dictating operative reports in PACU over the phone with hospital transcription service
- Surgeon education utilizing CoC materials
- Laminated one-page sheets with each set of standards and specific questions/required responses kept in top drawer of the PACU physician dictation station
- Early education, coordination and cooperation with transcription service
- CLP checks surgery schedule each morning and encourages every surgeon with a cancer case to comply with the new standards
- Small case numbers and few surgeons = high compliance with little resistance and minimal cost



Lawrence Wagman, MD FACS
San Antonio Regional Hospital
Cancer Liaison Physician

San Antonio Regional Hospital--Upland, California

- Category: Comprehensive Community Cancer Program
- Number of surgeons: 13 + 3 Thoracic
- Caseload: 2021: Total: 897 Breast 213, Colon 67, Gastric 16, Melanoma 21, Lung 68
- Synoptic operative reporting solution:
 - Integrated into standard op note with “~” to access list
 - Adjusted language for simplicity
 - One on one in surgical lounge (non-scheduled) to update surgeons
 - Within 30 days (SARH modification time) bring surgeon op note and path report and ask for completion of template

Opportunities & Challenges

- Opportunities

- Use compulsory operative note as a vehicle for synoptic reporting
- Keep local language very simple to collect quality information
- Reduce redundancy

- Challenges

- General surgeons with non-cancer focus and are “too busy”
- CoC agenda based questions without goal explanation(breast)
- Surgeon who do not perform standard of care operations(lung)
- Requiring information not readily available(melanoma)

Question and Answer Discussion

Mediget Teshome, MD FACS

Special Thanks

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Speaker:

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Toni Terry, HIT, CTR

Lawrence Wagman, MD FACS

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CSSP Vice-Chair: Kelly K. Hunt, MD, FACS

CSSP Senior Manager: Amanda Francescatti, MS

CSSP Administrator: Ramsha Kanwal

CSSP Program Coordinator: Clarissa Orr, MS

CSSP Administrator: Linda Zheng

ACS Cancer Programs Staff:

Asa Carter: Senior Manager, Education & Training

Chantel Ellis: Administrator, Education & Training

All who completed the operative standards implementation survey!!