CoC Cancer Liaison Physicians Meeting

Quyen Chu, MD, FACS
Chair
Committee on Cancer Liaison

Maria Castaldi, MD, FACS
Vice-Chair
Committee on Cancer Liaison
Welcome New CoC State Chairs

Rakhshanda Rahman, MBBS, FACS
North Texas

Neal Wilkinson, MD, FACS
Montana/Wyoming

Emily E.K. Murphy, MD, FACS
South Dakota
CoC Update

- **Upcoming Meetings**
  - ACS Cancer Accreditation Programs: Continually Advancing Quality Cancer Care Now Virtual!
    - Content available starting July 5
  - ACS Quality and Safety Conference
    - July 15–18, 2022
    - Chicago, IL
  - CoC Fall Meetings
    - October 16, 2022 (Tentative)
    - San Diego, CA
CoC Operative Standards Resources Update

CSSP Education Committee
Vice-Chair, Timothy Vreeland MD FACS

CoC Cancer Liaison Physicians Meeting
4.27.22
CoC Operative Standards Overview

Speaker Name
Event
Date
Overview

- What are operative standards and why are they important?
- What are the CoC Operative Standards?
- What is synoptic reporting?
- When/how should we implement the CoC Operative Standards?
- What resources can help my program implement the CoC Operative Standards?
What are Operative Standards?
What are Standards?

- Standard = Repeatable, harmonized, agreed-upon, and documented way of doing something

- Standards contain precise criteria designed to be used consistently as a rule, guideline, or definition.
  - Why? Simplify and increase reliability & effectiveness

- Result from collective work by experts in a field and provide consensus
Impact of Standards on Oncologic Outcomes

- Improvements in compliance with evidence-based guidelines may result in:
  - Reduced health care costs
  - Reduced hospital length of stay and complications
  - Improved long-term outcomes
  - Increased patient satisfaction

Why are Surgery Standards different?

- First time the **conduct of the surgery** is being scrutinized by CoC standards

- Many surgeons have **limited/no experience** with CoC standards and, therefore, **little knowledge** of the standards

- Imperative that we get buy in from surgeons for these standards
What are the CoC Operative Standards?
## The CoC Operative Standards

<table>
<thead>
<tr>
<th>Standard</th>
<th>Disease Site</th>
<th>Procedure</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.3</td>
<td>Breast</td>
<td>Sentinel node biopsy</td>
<td>Operative report</td>
</tr>
<tr>
<td>5.4</td>
<td>Breast</td>
<td>Axillary dissection</td>
<td>Operative report</td>
</tr>
<tr>
<td>5.5</td>
<td>Melanoma</td>
<td>Wide local excision</td>
<td>Operative report</td>
</tr>
<tr>
<td>5.6</td>
<td>Colon</td>
<td>Colectomy (any)</td>
<td>Operative report</td>
</tr>
<tr>
<td>5.7</td>
<td>Rectum</td>
<td>Mid/low resection (TME)</td>
<td>Pathology report (CAP)</td>
</tr>
<tr>
<td>5.8</td>
<td>Lung</td>
<td>Lung resection (any)</td>
<td>Pathology report (CAP)</td>
</tr>
</tbody>
</table>
Requirements for Compliance

Programs must (1) fulfill specific technical requirements AND (2) report relevant data items in synoptic format.

Standards 5.3–5.6 include requirements for operative reports.
- The required elements and responses (as shown in the 2020 Standards) must be in the operative note in a distinct section.

Standards 5.7 & 5.8 include requirements for pathology reports.
- Pathologists must use cancer protocol templates developed by the College of American Pathologists (CAP) for rectal and lung resection (already required by Standard 5.1)
**Standard 5.3:** Sentinel Lymph Node Biopsy for Breast Cancer

**Measures of Compliance**

1. All sentinel nodes for breast cancer are identified using tracers or palpation, removed, and subjected to pathologic analysis.

2. Operative reports for sentinel node biopsies for breast cancer document the required elements in synoptic format.

**Response Options**

<table>
<thead>
<tr>
<th>Element</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operation performed with curative intent.</td>
<td>Yes; No.</td>
</tr>
<tr>
<td>Tracer(s) used to identify sentinel nodes in the upfront surgery (non-neoadjuvant setting) (select all that apply).</td>
<td>Dye; Radioactive tracer; Superparamagnetic iron oxide; Other (with explanation); N/A.</td>
</tr>
<tr>
<td>Tracer(s) used to identify sentinel nodes in the neoadjuvant setting (select all that apply).</td>
<td>Dye; Radioactive tracer; Superparamagnetic iron oxide; Other (with explanation); N/A.</td>
</tr>
<tr>
<td>All nodes (colored or non-colored) present at the end of a dye-filled lymphatic channel were removed.</td>
<td>Yes; No (with explanation); N/A.</td>
</tr>
<tr>
<td>All significantly radioactive nodes were removed.</td>
<td>Yes; No (with explanation); N/A.</td>
</tr>
<tr>
<td>All palpably suspicious nodes were removed.</td>
<td>Yes; No (with explanation); N/A.</td>
</tr>
<tr>
<td>Biopsy-proven positive nodes marked with clips prior to chemotherapy were identified and removed.</td>
<td>Yes; No (with explanation); N/A.</td>
</tr>
</tbody>
</table>

If both requirements are met, the case is compliant.
Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer

Measures of Compliance

1. 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.

2. Operative reports for axillary lymph node dissections for breast cancer document the required elements in synoptic format.

<table>
<thead>
<tr>
<th>Element</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operation performed with curative intent.</td>
<td>Yes; No.</td>
</tr>
<tr>
<td>Resection was performed within the boundaries of the axillary vein, chest wall (serratus anterior), and latissimus dorsi.</td>
<td>Yes; No (with explanation).</td>
</tr>
<tr>
<td>Nerves identified and preserved during dissection (select all that apply).</td>
<td>Long thoracic nerve; Thoracodorsal nerve; Branches of the intercostobrachial nerves; Other (with explanation).</td>
</tr>
<tr>
<td>Level III nodes were removed.</td>
<td>Yes (with explanation); No.</td>
</tr>
</tbody>
</table>
Standard 5.5: Wide Local Excision for Primary Cutaneous Melanoma

Measures of Compliance

1. 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:
   - 1 cm for invasive melanomas less than 1 mm thick.
   - 1 to 2 cm for invasive melanomas 1 to 2 mm thick.
   - 2 cm for invasive melanomas greater than 2 mm thick.
   - At least 5 mm for melanoma in situ.

2. Operative reports for wide local excisions of primary cutaneous melanomas **document the required elements in synoptic format**.
Standard 5.6: Colon Resection

Measures of 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 resections for colon cancer document the required elements in synoptic format.
Standards 5.7 & 5.8

Standard 5.7: Total Mesorectal Excision

Measures of Compliance
1. 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.
2. Pathology reports for resections of rectal adenocarcinoma document the quality of TME resection in synoptic format.

Standard 5.8: Pulmonary Resection

Measures of Compliance
1. 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.
2. Pathology reports for curative pulmonary resection document the nodal stations examined by the pathologist in synoptic format.
What is Synoptic Reporting?
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
Narrative Reporting vs. Synoptic Reporting

Narrative reporting...
- May be constructed using pre-determined data fields and pre-determined responses
- Constructed by dictation, free text, smarttext, etc.
- May use standardized terminology
- Presented in a **prose** format
- Prone to **omission** of necessary data and **inconsistencies** in language and formatting
- May allow for discrete data capture

Synoptic reporting...
- **Always** constructed using pre-determined data fields and pre-determined responses
- Typically created using a **tool**
- **Always** uses standardized terminology
- Presented in **checklist** format
- **Always** allows for discrete data capture
  - Information is formatted so it can be collected, stored, and is easily retrievable for data repositories
  - Can automatically populate data from the EHR

A note may (ideally?) be a combination of the two!
Accuracy of Pathology Reports – Systematic Review

Shoe on the other foot...

Narrative Path Report

* Diagram courtesy of Cancer Care Ontario
# Synoptic vs. Narrative Reports

<table>
<thead>
<tr>
<th>Outcome or Subgroup</th>
<th># Studies</th>
<th>N</th>
<th>Statistical Method</th>
<th>Effect Estimate – Synoptic v. Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficiency</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time to complete (min)</td>
<td>6</td>
<td>891</td>
<td>Mean Difference (95% CI)</td>
<td>-0.86 m [-1.17, -0.55]</td>
</tr>
<tr>
<td>Time to verified report in EMR (hrs)</td>
<td>1</td>
<td>336</td>
<td>Mean Difference</td>
<td>-373.53 h</td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accuracy</td>
<td>1</td>
<td>208</td>
<td>Mean Difference (95% CI)</td>
<td>40.60% [38.54, 42.66]</td>
</tr>
<tr>
<td>Reduction Critical Error (% of op notes)</td>
<td>1</td>
<td>110</td>
<td>Mean Difference</td>
<td>32.13%</td>
</tr>
<tr>
<td>Reduction Error Rate (% of op notes)</td>
<td>1</td>
<td>110</td>
<td>Mean Difference</td>
<td>75.26%</td>
</tr>
<tr>
<td>Validity</td>
<td>1</td>
<td>208</td>
<td>Mean Difference (95% CI)</td>
<td>3.40% [2.02, 4.78]</td>
</tr>
<tr>
<td>Cost ($/note)</td>
<td>2</td>
<td>72</td>
<td>Mean Difference</td>
<td>-8.27</td>
</tr>
</tbody>
</table>

What is the value of Synoptic Operative Reporting?

- Improve accuracy of documentation
- Improve efficiency of data entry and data abstraction
- Reinforce education (can emphasize the critical elements of oncologic operations)
- Reduce variability in care
- Improve quality of cancer care
When/How Should We Implement the CoC Operative Standards?
Timeline for Standards 5.7-5.8

**Compliance and Site Reviews**

- **2020**: Communicate requirements & engage clinicians in implementation plans
- **2021**: Measure compliance with synoptic pathology reports and assure high reliability for future site visits
- **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**
Site Visit Process

1. Programs generate list of eligible cases
2. Site reviewers select 7 cases to assess for each standard
3. Programs confirm case eligibility for selected cases
4. Site reviewers assess each case for all measures of compliance
5. Site reviewers select a rating for each standard based on whether the threshold compliance level has been met
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 (boxed)
- **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**

**Site Reviews**
Current Options for Synoptic Operative Reporting

01
Create Institutional 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

02
Use Commercial Options
- Tools developed by vendors that include CoC required elements and responses
- Current vendor list available on ACS website: Commercial Options

03
Download Fillable PDF Forms
- Available for download from Standards Resource Library in QPort
- Stop-gap measure to allow programs to ensure compliance with synoptic formatting requirements
Checklist for CoC Programs in 2022

- Conduct self-audits to assess compliance levels *(recommended)*
- **Document formal plans** for how your program will implement synoptic operative reporting starting Jan 1, 2023
- Implement synoptic operative reporting in preparation for Standards 5.3–5.6
- Ensure CAP synoptic pathology reports are in use for rectal cancer and lung cancer cases *(Standards 5.7 & 5.8)*
- Prepare for site visits *(if your program is being reviewed in 2022)*
What Resources are Available to Help My Program?
Educating Programs About the CoC Operative Standards & Requirements

**Brief videos**
- Introduction to the Operative Standards
- CoC Standards 5.7 and 5.8
- Synoptic vs. Narrative Reporting
- Synoptic Operative Reporting Roadmap

**Webinars**
- Requirements for CoC Standards 5.7, 5.8, 5.3, 5.4, and 5.5
- Implementation Strategies for Synoptic Operative Reporting
- Best Practices for Compliance with CoC Standards 5.7 & 5.8
- 2022 Site Visit Preparation for 5.7 & 5.8
- Implementation of the CoC Operative Standards

**Visual abstracts**
- Standard 5.7
- Standard 5.8
- Standard 5.3
- Standard 5.4
- Synoptic reporting for Standards 5.3-5.6
- Site visit process

**Additional resources**
- Comprehensive FAQ document with questions from webinars, CAAnswer Forum, etc.
- Operative Standards Toolkit
Visual abstracts

Commission on Cancer Operative Standards

Compliance Requirements & Site Visit Process Overview

Requirements
- A reviewed case must meet both the technical requirement AND the synoptic documentation requirement to be compliant.

- 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 fas.org/cssp.

Review Process
- 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.

Timeline
- 2021: Standards 5.7 & 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.

Commission on Cancer Operative Standards 2020

Synoptic Operative Reports: CoC Standards 5.3-5.6

Definition
- Standardized sets of data elements organized as a structured checklist or template.

- Each data element's value is filled in using a pre-specified format.

Benefits
- Allow information to be easily collected, stored, and retrieved, resulting in:
  - Accuracy
  - Efficiency of entry
  - Efficiency of data abstraction
  - Variability
  - Costs
- ... thereby increasing the quality of cancer care.

Timeline
- 2022: Programs document final plan for implementation.
- 2023: Operative reports must meet technical & synoptic formatting requirements.
- 2024: Site visits assess 2023 reports for 70% compliance.

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facs.org/cssp
Questions? cssp@facs.org

General Resources

Optimal Resources for Cancer Care (2020 Standards)
facs.org/quality-programs/cancer/coc/standards/2020

CoC Operative Standards
facs.org/quality-programs/cancer/coc/standards/2020/operative-standards

Operative Standards Toolkit
facs.org/opstandardtoolkit

Operative Standards for Cancer Surgery (OSCS) Manuals
facs.org/oscs

ACS Cancer Surgery Standards Program (CSSP)
facs.org/cssp
2022 ACS Leadership and Advocacy Summit Update

- Joseph Blansfield, MD, FACS - PA
- Jeffrey Farma, MD, FACS – Metro Philadelphia
- David Luyimbazi, MD, FACS - AR
- John Lyons, III, MD, FACS - LA
- James McLoughlin, MD, FACS - TN
- Juan Paramo, MD, FACS – South FL
- Jason Wilson, MD, MBA, FACS - FL
Thank you!

Questions?
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