ACS CSSP
Cancer Surgery Standards Program
American College of Surgeons

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American College of Surgeons

2023 Site Visit Preparation Webinar Questions

CoC Accreditation, Compliance, and Site Review Process	
If a site doesn't reach 70% compliance in 2021 or 2022, are we going to be penalized if we are compliant in 2023 and 2024?	It depends on when your site visit is. If your site visit is in 2021 and you do not meet 70% compliance for Standards 5.7 and 5.8, you will need to follow the instructions for sites that are found non-compliant. If your site visit is in 2023 or 2024, you need to meet the 80% threshold of compliance for all applicable years. The overview of compliance requirements and the site visit process for Operative Standards 5.3-5.8 can be found in the Operative Standards Toolkit.
The individual programs' responsibility is to generate a list of eligible cases. Are there guidelines for how to accrue that list of eligible cases? Otherwise, we could generate a list that only includes the times we got it right.	We have provided guidelines documents for registrars to identify eligible cases for each standard (e.g., Standard 5.3). Sites should be familiar with this process as it is similar to what was done for the CAP CoC standard. These standards impact patient care so we remain hopeful that sites will not alter their lists in any way to get an advantage.
The review is on 7 charts for each standard or is it 7 charts per year of review?	As part of your site visit, each standard will have 7 charts reviewed. These 7 charts might be pulled from 1, 2, or 3 years of cases while these standards are getting phased in. After a few years, all site visits will be looking back at the past 3 years of cases. It is not necessarily 7 charts per year. The overview of compliance requirements and the site visit process for Operative Standards 5.3-5.8 can be found in the Operative Standards Toolkit.
What happens if we do not have 7 eligible cases? Our site does not perform lung resections.	If a program does not perform any lung cancer resections, then the standards will be rated 'Not Applicable'. If the procedure is performed at the accredited program but there are fewer than 7 during the review period, then all cases will be reviewed by the reviewer. The overview of compliance requirements and the site visit process for Operative Standards 5.3-5.8 can be found in the Operative Standards Toolkit.
For INCP programs will it be 7 charts reviewed overall or 7 charts per facility?	The number is 7 per facility within the INCP. For example, if there are 5 hospitals within the network, then 35 total reports are reviewed for the standard.

Are op report addendums only allowed for clinical reasons? Or can they be amended to meet the surgical standards?	While not recommended, amended or 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. However, amended or addended reports should only be corrected when the change will affect clinical care.
I was under the impression that amended reports were only going to be accepted for the first few months once gone live. I didn't think it could be a part of the workflow every month.	It is not best practice and should not be relied on. However, it will be counted for accreditation purposes if the amendment will affect clinical care.
If a cancer diagnosis is not known at the time of surgery that case is not valid for the standard then, correct?	If the cancer is unknown before surgery, then the case is not included in the scope of these standards.
What will happen to accreditation if sites are not able to meet standards?	Please reach out to coc@facs.org so your specific scenario can be discussed.
We will have an early 2023 site visit. What if we don't have all of the 2022 case finding/abstracting? How will we identify them for the visit?	It is recommended you reach out to your pathology department as they will likely be able to assist with identifying relevant cases.
How do sites pull the cases in preparation for site review?	The CSSP has developed guidelines for registrars to identify eligible cases in the Operative Standards Toolkit. This resource is available for each Standard 5.3-5.8 (e.g., Standard 5.6). Registrars should also collaborate with surgeons to confirm if resections were performed with curative intent.
Does the denominator for the synoptic operative reports come from the cancer registry? For example, patients with colon cancer in our cancer registry as part of an analytic case and had a curative surgery?	All cases within the scope of each standard are eligible for review during the site visit. For instance, Standard 5.6 applies to all resections performed with curative intent for patients with colon cancer and applies to all operative approaches.
Synoptic Operative Reporting	
Is it OK to incorporate the fillable pdf of the standards into our operative report?	Yes, incorporation of the fillable PDF forms into the operative report of record would certainly fulfill the requirements.
Do the fillable pdf and the narrative report need to be in one document in the electronic record? We have been using the checklists provided but are in a separate entry in the medical record.	Yes, the filled-out PDF can be separate from the narrative report. However, this is the only exception to the requirement for the elements/responses to be in the operative report of record.
Do all potential answers for the synoptic op note need to be present or just the answers?	Just the response that is selected for that data item. For example, "Operation performed with curative intent: Yes"
Our institution built the synoptic operative data elements into the immediate post-operative note which includes the surgeon's narrative of the operation. Is this sufficient?	To meet requirements for compliance, the synoptic elements/responses listed in CoC Standards 5.3-5.6 must be included in the operative report of record. If the brief op note is incorporated into the operative

	report at your institution, then this could be compliant, but this is not usually the case. If the brief op note is a separate entry in the EMR (as is usually the case), then this would not meet the requirement. The only exception to these requirements is for programs utilizing the fillable PDF option, which is intended as a stop-gap measure for institutions that cannot otherwise meet these reporting requirements.
Standard 5.3: Sentinel Lymph Node Biopsy for Breast Cancer	
For Standard 5.3, there is a move to de-escalation of care in women greater than 69 years old with cT1N0 hormone receptor-positive invasive breast cancer to omit sentinel lymph biopsy. How will these cases be viewed? Does the site only provide a list of cases where the sentinel node was performed?	Yes, if a sentinel lymph node biopsy was not performed, then that case would not fall under the scope of Standard 5.3.
Our surgeons want our synoptic operative reports broken out for adjuvant and non-neoadjuvant for the SLNB. Is this acceptable or do we need to combine these into one synoptic operative note?	For any case within the scope of the standard, all data elements/responses required by that standard need to be included in the operative report to meet compliance. Please note that SLNB and ALND have separate requirements.
If we are deferring a part of curative resection like sentinel node biopsy for breast cancer due to patient medical comorbidities, will we be penalized for not meeting standards? If we document the reason for deferring, will we still be in compliance with this case?	This will be compliant if the surgeon documents the reason to omit the sentinel node biopsy. Additionally, if a sentinel node biopsy is not performed the patient would not be included in the audit.
Can we exclude the biopsy-proven nodes marked before chemo be removed for non-neoadjuvant ones since it is always going to be N/A?	For any case within the scope of the standard, all data elements/responses required by that standard need to be included in the operative report to meet compliance.
Standard 5.5: Wide Local Excision for Melanoma	
If a melanoma surgery is not taking place in the accredited facility building but is a shared case for 1st-course treatment, could that case be excluded?	If the surgery does not take place within your accredited program, then the case should not be included in the patient list. Please note that any case done in an outside office owned by the accredited program does need to be included in the patient list.
Melanoma near critical structures (e.g., eye) if margins are less than technical parameters to preserve the critical structure, would that be deficient?	If the cutaneous margin closest to the eye is less than the recommended radial margin width (based on the Breslow depth of the primary melanoma) to preserve the eye, then this is deemed appropriate care. The surgeon can indicate the margin width is "Other – consideration of function".
In our institution, melanoma resections are done by multiple groups: plastics, head and neck, and	We recommend identifying whether the office location in question is included in your accredited hospital's Tax ID. If the office where the WLE was

dermatology. How do we know which cases are included in required synoptic reporting? All of them?	performed is included in your hospital's accreditation, then the WLE would be included in the scope of Standard 5.5. This is regardless of who is performing the procedure.
Standard 5.7: Total Mesorectal Excision	
Rectal cancer underwent neoadjuvant treatment, at surgery there was no residual; therefore, no pathology report was required. Does this case then become excluded from the review?	Standard 5.7 applies to all radical, anatomic operations for rectal adenocarcinoma performed with curative intent and excludes primary resection specimens with no residual cancer (e.g., following neoadjuvant therapy). This is taken directly from the CoC Standards Manual. The Operative Standards Toolkit includes relevant pages from the CoC Standards Manual, here is the Standard 5.7 section.
For Standard 5.7, what if the facility does not conduct total mesorectal resections or does not conduct the 7 total to be reviewed across the timeframes under review?	If a program does not perform any rectal cancer resections, then the standard will be rated 'Not Applicable'. If the procedure is performed at the accredited program but there are fewer than 7 during the review period, then all cases will be reviewed by the reviewer.
If the rectal resection is documented as extremely difficult and the mesorectum is excised as incomplete, can this be reviewed/discussed at Rectal MDT and be clarified? Thereby explaining this at the time of the survey review.	If the requirements of Standard 5.7 are not met (e.g., the quality of the TME resection is not complete or near complete), then that case would not be compliant with the standard. The compliance rate is 80% to account for these exceptions.
For Standard 5.7, what needs to go in the operative report?	Standard 5.7 does not have any requirements for the operative report. However, we do recommend that surgeons record curative intent to assist in the site review process. The CSSP has developed a video on the requirements and best practices for Standard 5.7.
Standard 5.8: Pulmonary Resection	
If nodes were sampled during mediastinoscopy will that count toward Standard 5.8?	Nodes from mediastinoscopy can only count toward the requirements of Standard 5.8 if they are included on the same pathology report as the lung resection.
Standard 5.8: if the LN station resected contained no lymph nodes. Would this be considered not in compliance?	Occasionally, lymph nodes will not be present or safely accessible during the conduct of an operation. The threshold compliance rate is less than 100% to consider this infrequent occurrence. Surgeons should ideally document where they looked to harvest nodes, even if none were found in a particular station, to clarify the thoroughness during the surgery (e.g., "no lymph

	nodes were visible within the level 9L inferior pulmonary ligament station despite thorough dissection").
If the surgeon documents in the op note that they are unable to meet Standard 5.8 due to patient safety that it is compliant?	If at least three distinct mediastinal stations and at least one hilar station are not included in the pathology report, then the case would not be found compliant with CoC Standard 5.8. In these scenarios, we recommend that the surgeon document why nodes/more nodes were not removed. However, this documentation will not change whether the technical requirements of Standard 5.8 have been satisfied.
Why isn't 5.8 an operative synoptic measure? The LN stations could be selected from a drop-down like the nerves are in an ALND. Pathologists have posed this question.	The focus of Standard 5.8 is on the thorough staging of the hilum and mediastinum at the time of lung resection, and compliance requires collaboration between both surgeons and pathologists. The pathology report serves as the documentation on which staging and postoperative treatment are based and represents the sum process of both surgical technique and histopathologic evaluation. We recommend that surgeons include in their operative report whether the operation was performed for curative intent.
What happens when a facility has a low sample size for Standard 5.8 and the surgeons found the node removal to not be warranted due to reasons such as comorbidities etc.? The compliance rate can become easily skewed by 1-2 noncompliant cases for certain facilities and oftentimes a resolution is not possible.	If a program has fewer than 7 charts within the scope of a specific standard, then all charts within the scope of the standard from the applicable time frame will be reviewed by the site reviewer. If a program does not meet the compliance threshold, then the program will be asked to perform a self-audit to resolve the standard.
Are all lung cancer surgeries eligible for review or are certain procedures ineligible due to lymph nodes not normally being removed?	Standard 5.8 applies to all primary pulmonary resections performed with curative intent for non-small cell lung cancer, small cell lung cancer, or carcinoid tumors of the lung and applies to all operative approaches.