

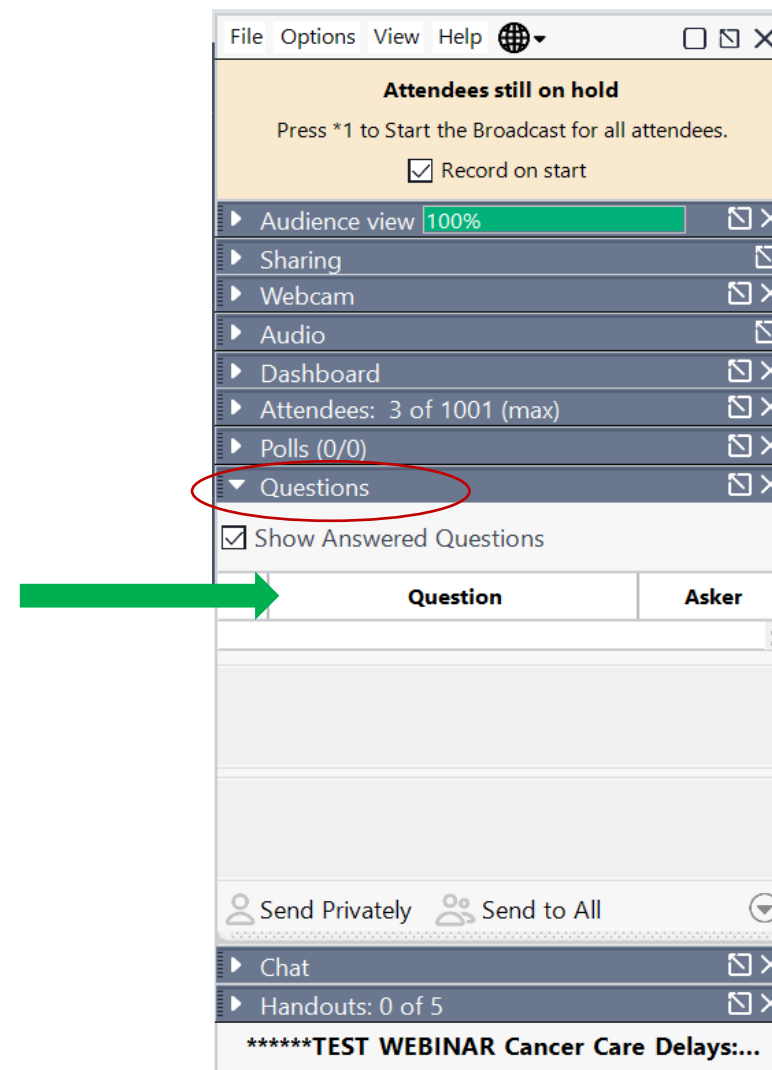
2023 CoC Site Visit Preparation for Operative Standards 5.3-5.8

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



Moderator



Anthony Villano, MD
Surgical Oncologist
Fox Chase Cancer Center

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



James B. Harris, MD, FACS
Western Surgical Group
Chair, CoC Accreditation Committee



Matthew H.G. Katz, MD, FACS
MD Anderson Cancer Center
Chair, Cancer Surgery Standards Program



Erin Reuter, JD, MS
Accreditation Senior Manager
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MD Anderson Cancer Center
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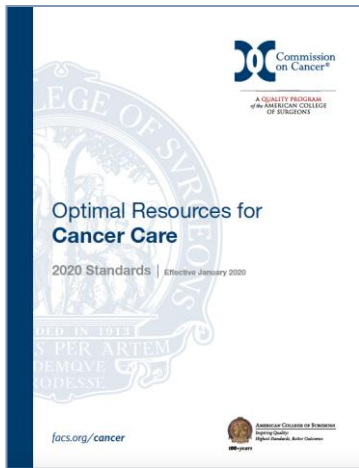
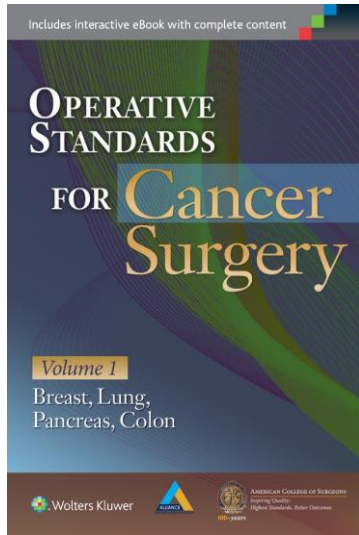


Nadine Walker, MS, CTR
Newark Beth Israel Medical Center

Operative Standards and Compliance Overview

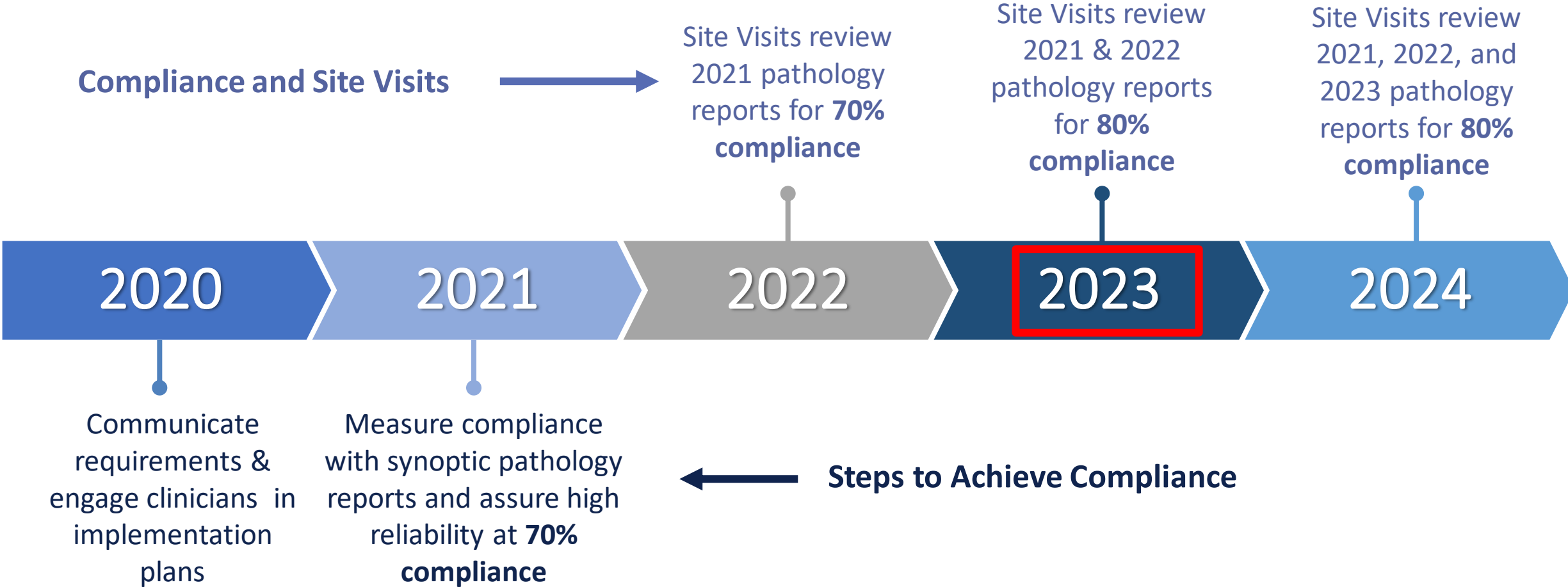


The CoC Operative Standards



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)

Implementation Timeline for Standards 5.7 & 5.8



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**”



COLLEGE of AMERICAN
PATHOLOGISTS

Definition of Synoptic Reporting

Synoptic reporting in surgical pathology is a style of reporting that has advantages for a variety of users of surgical pathology reports.¹⁻³ For pathologists, synoptic reporting can improve the completeness, accuracy, and ease of creating the report.⁴⁻¹² For clinicians, synoptic reports can make data extraction from the report both more rapid and more accurate.¹³⁻¹⁵ For researchers and cancer registrars, synoptic reporting also ensures that these data elements are amenable to scalable data capture, interoperability, and exchange, enabling the creation of structured data sets to facilitate research.

In order to help pathologists achieve these goals, the CAP has developed a list of specific features that define *synoptic* report formatting for accreditation compliance. These include:

1. All required data elements outlined on the currently applicable surgical case summary from the cancer

Synoptic Reporting

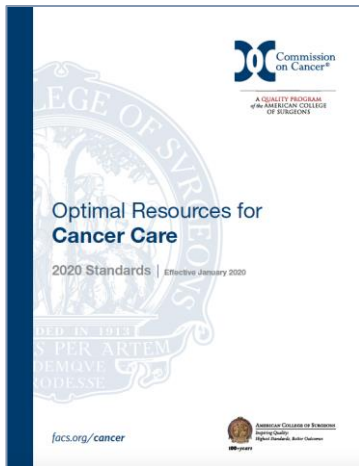
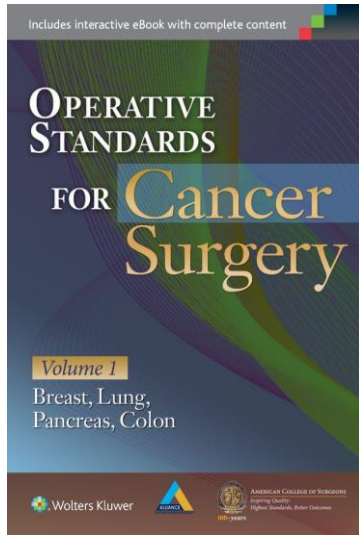
All core and conditionally required data elements outlined on the surgical case summary from this cancer protocol must be displayed in synoptic report format. Synoptic format is defined as:

- Data element: followed by its answer (response), outline format without the paired Data element: Response format is NOT considered synoptic.
- The data element should be represented in the report as it is listed in the case summary. The response for any data element may be modified from those listed in the case summary, including “Cannot be determined” if appropriate.
- Each diagnostic parameter pair (Data element: Response) is listed on a separate line or in a tabular format to achieve visual separation. The following exceptions are allowed to be listed on one line:
 - Anatomic site or specimen, laterality, and procedure
 - Pathologic Stage Classification (pTNM) elements
 - Negative margins, as long as all negative margins are specifically enumerated where applicable
- The synoptic portion of the report can appear in the diagnosis section of the pathology report, at the end of the report or in a separate section, but all Data element: Responses must be listed together in one location

Organizations and pathologists may choose to list the required elements in any order, use additional methods in order to enhance or achieve visual separation, or add optional items within the synoptic report. The report may have required elements in a summary format elsewhere in the report IN ADDITION TO but not as replacement for the synoptic report ie, all required elements must be in the synoptic portion of the report in the format defined above.



The CoC Operative Standards



Standard	Disease Site	Procedure	Documentation
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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)

Timeline for Standards 5.3-5.6



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

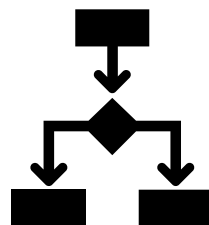
Standard 5.6: Colon Resection

- 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

Visit Year	Standard	Materials Assessed	Requirement
2023	5.3-5.6	Implementation plan for Standards 5.3-5.6	Plan documented in 2022
	5.7	7 rectal pathology reports from 2021-2022	80% compliance
	5.8	7 lung pathology reports from 2021-2022	80% compliance
2024	5.3-5.6	7 operative reports, per standard, from 2023	70% compliance
	5.7	7 rectal pathology reports from 2021-2023	80% compliance
	5.8	7 lung pathology reports from 2021-2023	80% compliance
2025	5.3-5.6	7 operative reports, per standard, from 2023-2024	80% compliance
	5.7	7 rectal pathology reports from 2022-2024	80% compliance
	5.8	7 lung pathology reports from 2022-2024	80% compliance

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 Review Process



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

Noncompliant ✘

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

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.

Noncompliant ✘

Synoptic Format

Nerves identified and preserved during dissection (select all that apply): Long thoracic nerve, Thoracodorsal nerve, Branches of the intercostobrachial nerves

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

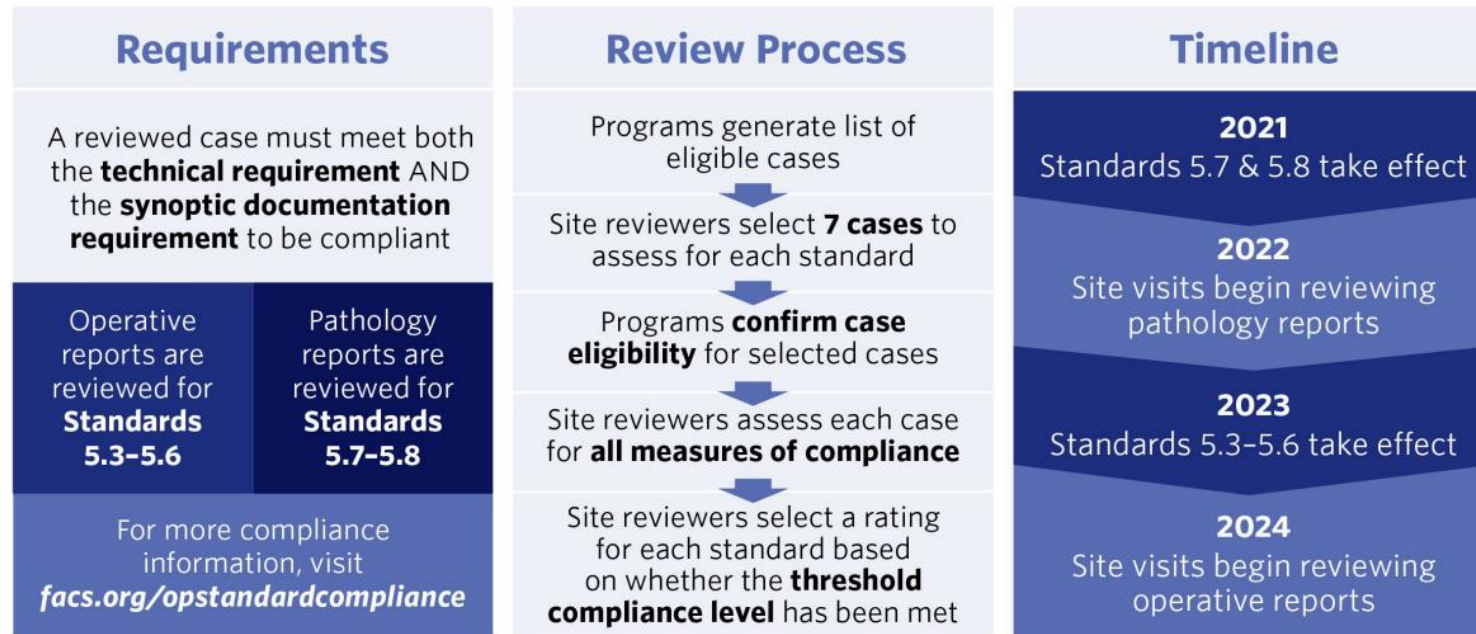


Resources for CoC-Accredited Programs

- [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



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

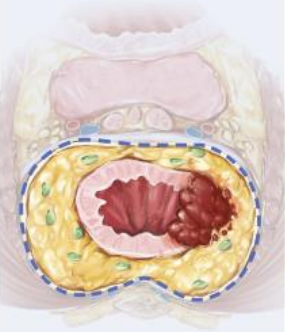
facs.org/cssp



Standard 5.7 & 5.8 Visual Abstracts

Commission on Cancer Operative Standards 2020

Standard 5.7: Total Mesorectal Excision

Operation	Maintain the 'Holy Plane'	Pathology Documentation	When?
<p>Total mesorectal excision (TME) is performed for mid and low rectal tumors, resulting in complete or near-complete TME</p>		<p>Quality of TME documented in synoptic report:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Complete <input type="checkbox"/> Near-Complete <input type="checkbox"/> Incomplete 	<p>2021: Implementation</p> <p>2022 site visits: 70% Compliance</p>
<p>Keep fascia propria of rectum intact, operate in plane between rectum and presacral fascia</p> <ul style="list-style-type: none"> - Ensures negative margins - Protects neurovascular structures 			


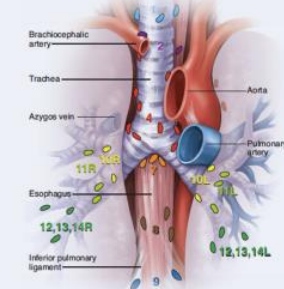
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Commission on Cancer Operative Standards 2020

Standard 5.8: Pulmonary Resection

Operation	Pathology Documentation	When?
<p>For any primary pulmonary resection performed with curative intent (including non-anatomic parenchymal-sparing resections)</p> <p>Resect nodes from:</p> <ul style="list-style-type: none">  Mediastinum (Stations 2-9) ≥ 3 distinct stations Hilum (Stations 10-14) ≥ 1 station 	<p>Synoptic report documents lymph nodes from:</p>  <ul style="list-style-type: none"> ≥ 3 mediastinal stations ≥ 1 hilar station <p>with names and/or numbers of stations</p>	<p>2021: Implementation</p> <p>2022 site visits: 70% Compliance</p>

Adapted from Chest, Vol. 111, Mountain CF, Dresler CM, Regional lymph node classification for lung cancer staging. Pp. 1718-1723, Copyright (1997), with permission from Elsevier.

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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

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