Best Practices for CoC Operative Standards 5.3-5.6:

A Webinar for ODS-Certified Professionals

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NCRA Members

1.0 Complimentary CE

- Go to cancerregistryeducation.org
- Log in using your NCRA login credentials
- Click on the "My Learning Activities" tab
- Under the **red info box**, click on the header "Live Webinars"
- Click on the webinar title to open
- Follow the instructions for the quiz and to claim the CE
- CE Certificate can be printed and/or saved

2

QUESTIONS

- Send questions to the presenters using the **Question Box** on the dashboard
- Send questions in at any time
- Presenters will take questions at the end of the presentation
- All questions submitted will be answered on a document to be distributed to all attendees within 5 – 7 days following the webinar

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Moderator

Nadine Walker, MS, ODS-C

Senior Director of Professional Practice, NCRA

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Panelists

Mediget Teshome, MD, FACS, MPH
Chief of Breast Surgery & Director of Breast Health, UCLA Health
Chair, CSSP Education Committee

Erin Reuter, JD, MS
Senior Manager, Accreditation
ACS Cancer Programs

Kim Rodriguez, BSPH, CPH, RHIT, ODS-C
Manager, Cancer Data Systems & Cancer Program Accreditation
Eisenhower Health Lucy Curci Cancer Center

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Objectives

- To understand the rationale, technical and documentation requirements for the CoC Operative Standards 5.3-5.6
- To outline best practices for identification of eligible cases for CoC Operative Standards 5.3-5.6
- To define best practices with implementation of the CoC Operative Standards 5.3-5.6 to facilitate compliance

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Agenda

- CoC Operative Standards Overview and Process
- Case Eligibility and Compliance Requirements
- Implementation Best Practices and Resources
- Q&A Panel Session

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CoC Operative Standards Overview and Process

Mediget Teshome, MD, FACS, MPH

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What are Operative Standards 5.3-5.6?

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Rationale for Operative Standards in Cancer Surgery

- **Clinical care guidelines exist to inform medical decision making associated with improved outcomes**
- **Surgery remains a critical treatment for curative therapy for many cancers however until recently, no technical standards existed**
- **The operative standards for cancer surgery define the key critical elements of an operation which are associated with improved cancer outcomes**
  - **Streamlined documentation facilitates multidisciplinary communication**
  - **Expedites review for QA, research**
  - **Focuses operative teaching for trainees**

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CoC Operative Standards: A Challenge and an Opportunity

- 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

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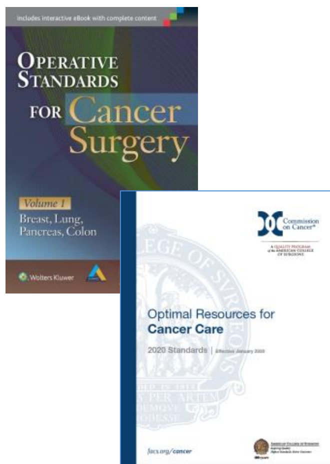
The CoC Operative Standards



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)

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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)

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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**.

If both requirements are met, the case is compliant.

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

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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**.

Element	Response Options
Operation performed with curative intent.	Yes; No.
Resection was performed within the boundaries of the axillary vein, chest wall (serratus anterior), and latissimus dorsi.	Yes; No *(with explanation)*.
Nerves identified and preserved during dissection *(select all that apply)*.	Long thoracic nerve; Thoracodorsal nerve; Branches of the intercostobrachial nerves; Other *(with explanation)*.
Level III nodes were removed.	Yes *(with explanation)*; No.

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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**.

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 (melanoma in situ); Other *(with explanation)*.

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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**.

Element	Response Options
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), 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, inferior mesenteric; Total abdominal colectomy, with proctectomy – ileocolic, right colic (if present), middle colic, inferior mesenteric, superior and middle rectal; Other *(with explanation)*.

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FAQs

- Curative intent must be indicated.
- If bilateral axillary surgery for breast cancer, CoC elements in synoptic format must be listed for both sides.
- If perform first SLN biopsy then ALND in the same operation, CoC elements in synoptic format must be listed for both operations.
- Wide local excisions performed by any provider within the institution is considered a possible case.
- If perform colon resection for colon cancer of 2 lesions within one resection, only one report of CoC elements in synoptic format is needed. However, if resect to colon cancers in 2 separate resections, a report of CoC elements in synoptic format for each is required.

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What is Synoptic Reporting?

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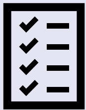
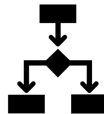
Definition of Synoptic Reporting



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**

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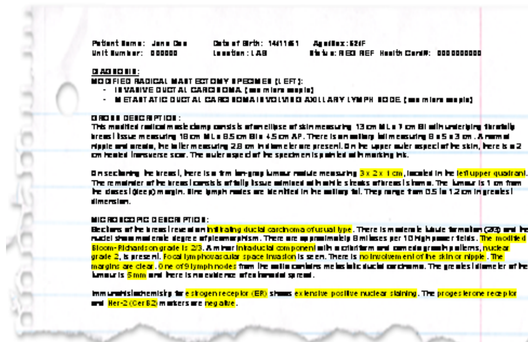
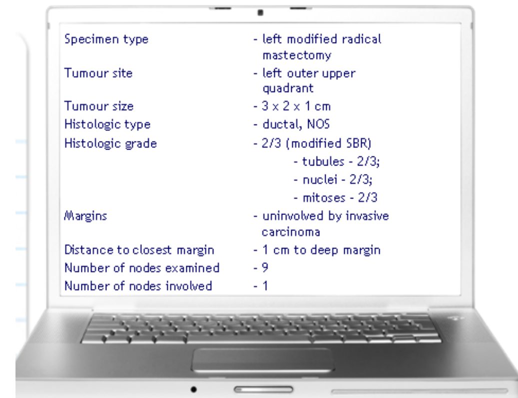
Comparison Synoptic vs. Narrative Pathology Report

Narrative Pathology Report



** Diagram courtesy of Cancer Care Ontario*

CAP Synoptic Report



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Synoptic Reporting for Standards 5.3-5.6

- Full synoptic operative reports are not required
- **Reporting of CoC critical elements in synoptic format <u>within the operative report of record</u> is required**

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Timeline for Implementation the CoC Operative Standards 5.3-5.6

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Timeline & Compliance Requirements for Standards 5.3-5.6

- CoC Standards 5.3-5.6 were required to be fully implemented at CoC-accredited programs beginning January 1, 2023.
- **Starting with site visits this year (2024), site reviewers will assess 7 operative reports for each standard.**
- This documentation will be reviewed at site visits in 2024 and 2025.
  - Compliance levels begin at 70% for the first year of site visits and will increase to 80% for the following years
- Each operation must meet both the technical and documentation requirements for the standard to be found compliant. Documentation must include CoC-required specific elements and responses in synoptic format.

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Timeline for Standards 5.3-5.6

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Case Eligibility and Compliance Requirements

Erin Reuter, JD, MS

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Alternative Compliance Pathway: Standards 5.3-5.6

- Program may conduct an internal audit and develop an action plan
  - Separate audits and action plans are required for each potentially non-compliant standard
  - Must be documented in the cancer committee meeting minutes
  - Audit results and action plan must be documented before Site Reviewer selects cases for review
- Action plan must address all issues affecting compliance and the interventions implemented to meet compliance
  - Be specific!

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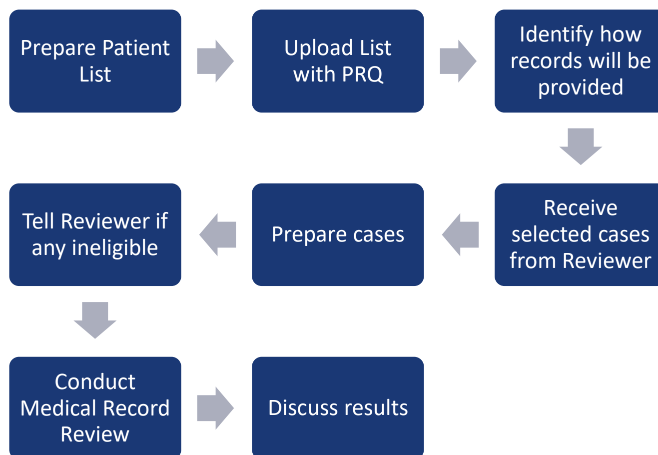
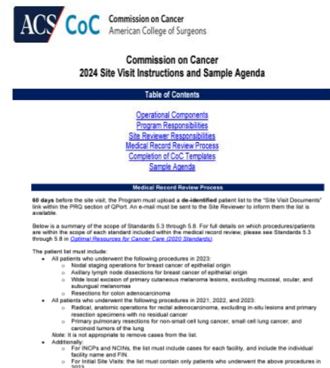
The Site Visit Instructions—The Process





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Commission on Cancer
2024 Site Visit Instructions and Sample Agenda

Table of Contents

Operational Components
Program Responsibilities
Site Reviewer Responsibilities
Medical Record Review Process
Completion of CoC Templates
Sample Agenda

Medical Record Review Process

60 days before the site visit, the Program must upload a **de-identified** patient list to the "Site Visit Documents" link within the PRQ section of QPort. An e-mail must be sent to the Site Reviewer to inform them the list is available.

Below is a summary of the scope of Standards 5.3 through 5.8. For full details on which procedures/patients are within the scope of each standard included within the medical record review, please see Standards 5.3 through 5.8 in *Optimal Resources for Cancer Care (2020 Standards)*.

The patient list must include:

- All patients who underwent the following procedures in 2023:
  - Nodal staging operations for breast cancer of epithelial origin
  - Axillary lymph node dissections for breast cancer of epithelial origin
  - Wide local excision of primary cutaneous melanoma lesions, excluding mucosal, ocular, and subungual melanomas
  - Resections for colon adenocarcinoma
- All patients who underwent the following procedures in 2021, 2022, and 2023:
  - Radical, anatomic operations for rectal adenocarcinoma, excluding in-situ lesions and primary resection specimens with no residual cancer
  - Primary pulmonary resections for non-small cell lung cancer, small cell lung cancer, and carcinoid tumors of the lung

  Note: It is not appropriate to remove cases from the list.
- Additionally:
  - For INCPs and NCINs, the list must include cases for each facility, and include the individual facility name and FIN.
  - For Initial Site Visits: the list must contain only patients who underwent the above procedures in 2023.

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Must off-site surgery centers or physician's offices be included?

If the surgery center or physician's office is part of your accreditation, then it must be included in the patient list

How to tell: If a case seen solely in the surgery center/physician's office is being submitted to the NCDB, then it is considered as part of your accreditation.

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Considerations for Networks

- Must provide lists for each facility within network
- 7 cases are selected per standard, per facility
- Numerator/denominator from each facility's review are combined & compliance percentage is calculated at the network parent level.

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The Patient List

If Case has been Abstracted

- Accession Number
- Sequence Number
- Primary Site Description and Code
- Operative Class of Case (10-22) cases from your facility only (no biopsy cases)
- Histology description and code
- AJCC TNM Pathology Stage Group
- Surgical Procedure of Primary Site at this Facility description and code

If Case has not been Abstracted

- A HIPAA-compliant method to internally identify the record for tracking purposes
- The procedure or treatment performed
- The pathology diagnosis, if available

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HIPAA/Risk Management Reminders

Do not include PHI in Patient List/QPort

This includes, **but is not limited to:**

- Names/initials
- Location
- All dates, **including dates of treatment**
- Phone numbers/Fax Numbers/e-mail addresses
- Social Security Number
- Medical Record Number
- Health plan number
- Account number
- Certificate/license numbers
- Vehicle information
- IP address/URL
- Device identifiers/serial numbers
- Full face photos

MUST identify HIPAA-secure videoconference software (e.g. zoom, teams) AND HIPAA-secure document sharing

MUST confirm what is approved by your facility

Hospitals have differing requirements related to technology to share PHI

Site Reviewer cannot provide document sharing or videoconferencing software

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Alternative ways to identify cases

- Searching ICD-10 or billing codes
- Operating Room Surgery Scheduling System
- Pathology Tracking System

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Communicate with your Reviewer

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Let your Site Reviewer know if any selected cases are ineligible for the standard

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Patient List Potential Issues

- Only including abstracted patients (if not caught up to 2024)
- Only listing 7 cases per operative standards
- Providing a small number of cases on list (despite large analytic caseload)
- Identification of compliant/not complaint cases in the patient list
- Not telling Reviewer when a selected case is not applicable (e.g. not done with curative intent, cancer unknown prior to surgery)

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Corrective Action Process

- Random audit of 10 eligible path reports, after Site Review
  - Must show compliance with the original threshold of compliance from the site review
- If compliance is *NOT MET at Audit*:
  - Submit detailed Action Plan
  - Timeframe for expected compliance
  - How you will report and monitor improvement

One year to resolve standard

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Implementation Best Practices and Resources

Kim Rodriguez, BSPH, CPH, RHIT, ODS-C

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Resources

Ensure you are reviewing the most current version of the CoC Standards, available on the website, including the change log.

2020 Standards & Resources | Implementation Timelines | Operative Standards

The Commission on Cancer has released the latest version of its accreditation standards, *Optimal Resources for Cancer Care (2020 Standards)*. This republication was released in February 2024. Updates reflected in this version are effective as of January 1, 2023.

The Standards Changelog provides an overview of the revisions and updates made to *Optimal Resources for Cancer Care (2020 Standards)*. Please note, this document is not a substitute for reading the CoC standards in their entirety.

Interested in using content from Optimal Resources for Cancer Care (2020 Standards)? Please review the ACS Cancer Programs Accreditation Content Use Permissions Requirements.

Download the Standards | Change Log

Optimal Resources for Cancer Care
2020 Standards | Effective January 2020
Updated February 2024

Implementation Timelines

In most cases, programs have been required to implement the 2020 Standards as of January 1, 2020. The 2020 Standards were last updated in February 2024. More information on implementation timelines for specific standards may be found here.

Operative Standards

The 2020 Standards include six new operative standards. Standards 5.3 through 5.8 were developed from standards described in *Operative Standards for Cancer Surgery Volumes I & II (OSCS)*.

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Resources

Subscribe to Cancer Program News to stay up to date on the latest information regarding changes. Email alerts are sent every 2 weeks.

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Resources

Updated Compliance Information for CoC Operative Standards released on March 21, 2024 here:

- Standards 5.3 through 5.8: Required compliance percentage for sites with less than 7 applicable cases
- Standards 5.3 through 5.6: Alternative temporary compliance pathway for site visits remaining in 2024
- Sites that already underwent a site visit in 2024 but feel the above adjustments would change their rating of Standards 5.3-5.8 should email CoC@facs.org.

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Resources

Log into your program's Qport to see alerts for standard updates.

Home Contact Us

Commission on Cancer
American College of Surgeons

A Cancer Program News archive providing updates regarding the CoC standards will now be available at the bottom of this page.

General Resources

Cancer Program News Articles - Standards Updates

Cancer Program News Article Archive

Standard 3.2 now requires accreditation for anatomic pathology

Standard 5.1 now requires an internal audit of pathology reports

Standards 5.3 – 5.6 an internal audit may be used as an alternative compliance pathway for calendar year 2024

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Resources

Operative Standards Toolkit website is full of resources for everyone.

- Frequently Asked Questions related to standards 5.3 through 5.8
- Quick reference guides
- Visual abstracts for physicians and ODS staff
- Compliance requirements and site visit process
- Physician resources, including short videos for best practices for compliance
- References and suggestions for further reading

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Resources

Overview | About CSSP | Governance | Toolkit | Operative Standards for Cancer Surgery | Protocols for Cancer Surgery Documentation | Events & Education

/ All Resources

- CoC Operative Standards and the Cancer Surgery Standards Program
- CoC Accreditation, Compliance, and Site Review Process
- Synoptic Operative Reporting
- Standard 5.3: Sentinel Lymph Node Biopsy for Breast Cancer
- Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer
- Standard 5.5: Wide Local Excision for Cutaneous Melanoma
- Standard 5.6: Colon Resection
- Standard 5.7: Total Mesorectal Excision
- Standard 5.8: Pulmonary Resection
- References and Suggestions for Further Reading

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Best Practices for Implementation

Identify cancer committee physician(s) who will champion these standards and engage them often.

- Ideally a surgeon impacted by one of the cancer sites (breast, colon, rectum, lung, melanoma)
- Share regular updates on standard news and resources
- Participate when feedback is sought on standards
- Meet regularly to review compliance or opportunities for improvement

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Best Practices for Implementation

Identify physicians that are impacted by cancer sites related to standards 5.3 through 5.8.

- Run a report to identify cases and associated physicians.
- Share regular updates on standard news and resources
- Provide education on standards
- Share compliance rates regularly – to individual physicians and in larger forums, such as cancer committee, disease site teams, general surgery section or disease specific section meetings
- Meet with physicians individually

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Best Practices for Implementation

Review facility performance

- Audit your cases
- Example of audit tool

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Best Practices for Implementation

Audit Spreadsheet

MRN	Surgeon	SurgDate	Date Added	Was cancer known at the time of surgical resection? (Incidental finding or previously negative bx)	Histology epithelial origin?	Operation performed for curative intent?	Standard Applicable?	Tracer(s) used to identify SLN in the upfront surgery (non-neoadj) setting. *Surgeons may select multiples*	Tracer(s) used to identify SLNs in the neoadjuvant setting *Surgeons may select multiples*	All LNs (colored or non-colored) present at the end of a dye-filled lymphatic channel were removed.	All significantly radioactive nodes were removed.	All palpably suspicious nodes were removed.	Bx-proven positive LNs marked with clips prior to chemo were identified and removed.	Overall Case Compliance

Abstractor Tips by Site

COMPLIANCE	Compliant	Non-Compliant	N/A	Total Eligible	Compliance Rate
5.3 - Breast SLN Biopsy	0	2	0	2	0.0%
5.4 - Breast ALN Dissection	0	1	0	1	0.0%
5.5 - Melanoma	1	4	0	5	20.0%
5.6 - Colon Resection	5	15	0	20	25.0%
5.7 - Mesorectal Resection	0	0	9	0	#DIV/0!
5.8 - Pulmonary Resection	1	1	1	2	50.0%
Overall Compliance	7	23	10	30	23.3%

5.3 (breast SLN) | 5.4 (breast ALND) | 5.5 (melanoma) | 5.6 (colon) | 5.7 (rectum) | 5.8 (lung) | COMPLIANCE | Breast | Melanoma | Colon | Rectum | Lung

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Best Practices for Implementation

Your turn to share your best practices

- If you have a best practice to share with the group on how to identify your eligible cases or how you implemented the standards:
  - Type into the chat "BP" then your best practice feedback.
    - ***Example***: BP – at my facility we use the following method to identify eligible cases: xyz.

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Case Discussion

CASE 1

- During a recent faculty meeting, Dr. A states that they do not understand why a synoptic report is necessary for CoC Accreditation.
- Dr. A expresses frustration when, after an audit of their operative notes, they are found not complaint with a Standard

All the Above

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CASE 2

Wide Local Excision for Primary Cutaneous Melanoma

Operation performed with curative intent: Yes
Original Breslow Thickness of the lesion: 0.7mm
Clinical Margin Width (measured for the edge of the lesion or the prior excision scar): 0.5 cm
Depth of excision: Full-thickness skin/subcutaneous tissue down to the fascia (melanoma)

Noncompliant

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ACS CSSP Cancer Surgery Standards Program American College of Surgeons

CASE 3

Axillary Lymph Node Dissection for Breast Cancer

Operation performed with curative intent: Yes
Resection was performed within the boundaries of the axillary vein, chest wall (serratus anterior), and latissimus dorsi: Yes
Nerves identified and preserved during dissection *(select all that apply):* Long thoracic nerve; Thoracodorsal nerve; Branches of the intercostobrachial nerves
Level III nodes were removed: No

- **All core elements** must be **reported** (whether applicable or not)
- All core elements must be reported in a **"diagnostic parameter pair" format**
- Each diagnostic parameter pair must be **listed on a separate line** or in a tabular format to achieve visual separation
- All core elements must be **listed together** in one location in the pathology or operative report

Compliant

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Panel Discussion

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Questions?

cssp@facs.org

Quick Links:

Operative Standards Toolkit
CoC 2020 Operative Standards
CAnswer Forum

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