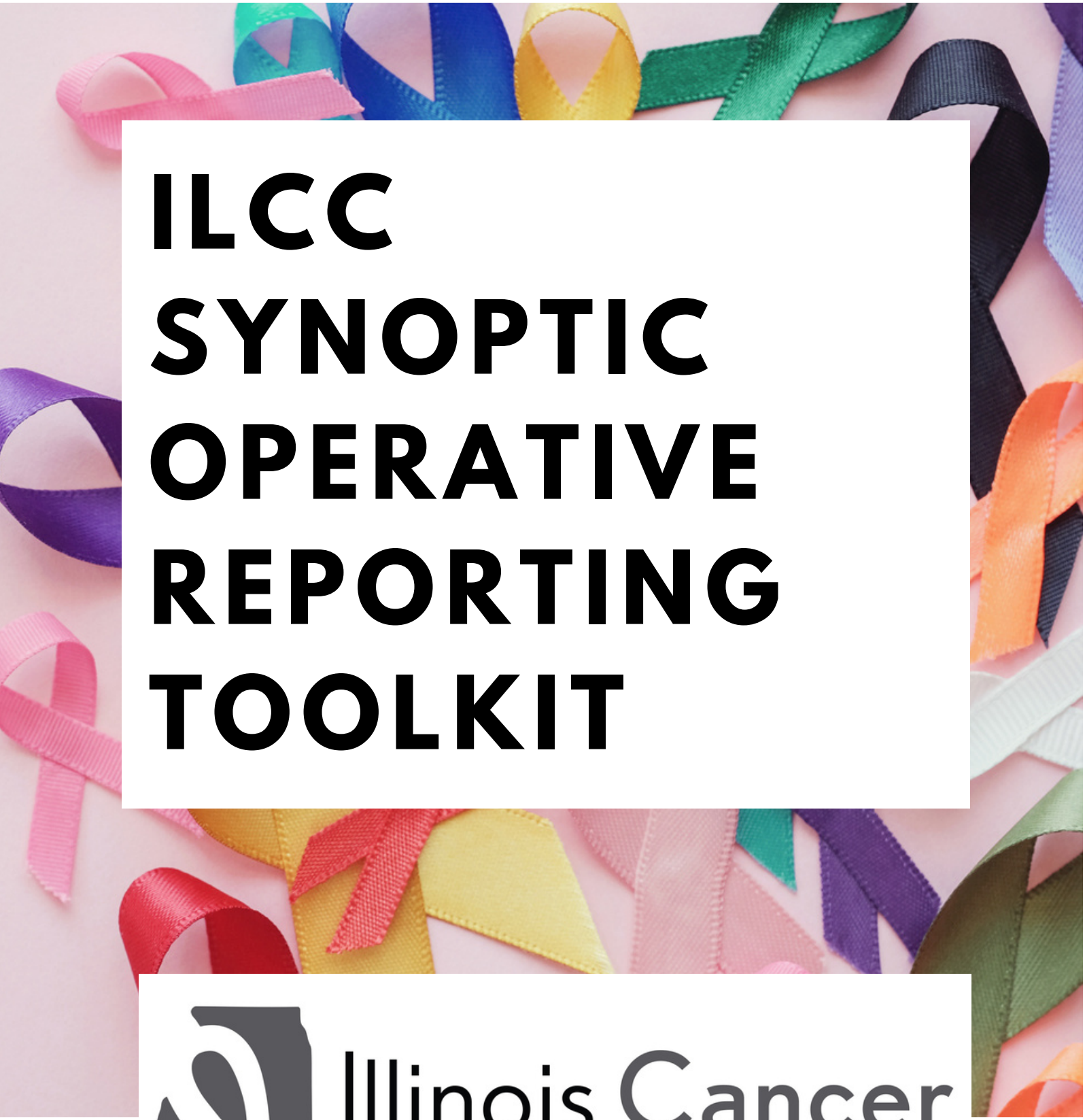

ILCC SYNOPTIC OPERATIVE REPORTING TOOLKIT

Illinois Cancer Collaborative

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Contents

How to Use This Toolkit

Implementing Synoptic Operative Reporting is a major change to the current practices of most surgeons, and requires the buy-in and education of clinicians and staff, as well as coordination across groups at each hospital. The synoptic format is unfamiliar territory for most surgeons, non-surgical clinicians, and staff. This toolkit is meant to offer a roadmap and tools to support your hospital's implementation, with flexibility to do so in a manner that suits your local environment and needs. The resources in this toolkit were primarily organized and/or developed by the Illinois Cancer Collaborative (ILCC) and some of its member hospitals. Excellent reference materials have also been created by the American College of Surgeons Commission on Cancer (ACS CoC), some of which are featured here, as well as a link to their full Operative Standards Toolkit for those who are interested.

We hope you will find the resources in this toolkit useful and that you can easily tailor the implementation options to your institution's needs.

The following functions have been added to this PDF to make it easy to navigate:

1. This PDF is **searchable** so you can type a page number or word into the search box to be taken to places in the toolkit where that search item appears.
2. **Clicking on any section header or sub-header** in the Table of Contents will take you directly to that section.
3. **Clicking on the ILCC logo** in the bottom right corner of each page will take you back to the Table of Contents.
4. You may **click any hyperlink** and the attachment will open in a new PDF window or link in your browser.

Feedback on This Toolkit

We hope this toolkit will assist your hospital in deciding how to implement Synoptic Operative Reporting at your institution. We welcome all feedback so we can iteratively update the toolkit to highlight new resources, clarify existing ones, and generally make the toolkit more user-friendly and helpful. Please send any questions, comments, or overviews of what your institution implemented to the ILCC Coordinating Center (info@ilcancer.org).

Introduction to Synoptic Operative Reporting

The American College of Surgeons Commission on Cancer (ACS CoC) has introduced new operative reporting standards for sentinel node biopsy and axillary lymph node dissection for breast cancer (Standards 5.3 & 5.4), wide local excision for primary cutaneous melanoma (5.5), and colon resection for cancer (5.6). The intent of the new standards is to improve the quality of surgical care provided to people with cancer by improving the completeness and accuracy of clinical documentation.

These standards significantly alter the format in which operative reports are written by surgeons. The synoptic format contains *standardized data elements organized as a structured checklist or template, with a choice of pre-determined values for each data element*. The new standards will require a synoptic reporting format for the specified portions of each selected procedure starting in 2023. The purpose of the synoptic report is to format information in a manner where accurate information can be easily collected, stored, and retrieved.

The ACS CoC has developed a wealth of background materials to introduce synoptic operative reporting, all of which can be found in their Operative Standards Toolkit. Select materials from the CoC's toolkit are highlighted below to provide background and rationale for the new standards and specific criteria for compliance. The materials provided by the CoC are wholly the property of the CoC and should not be accessed inappropriately, or altered in any way, without the express consent of the ACS CoC.

Resources developed by the ILCC Coordinating Center include advice on assembling a team, report content, change management and stakeholder analysis resources, EMR solutions, and monitoring and feedback mechanisms. The next section provides the **ILCC Roadmap for Implementation** and links to specific resources found within.

Background and Rationale

Visit the following resources for detailed information on the background and rationale for the transition to synoptic operative reporting, an overview of the timeline, and questions about compliance:

a. CoC Introduction to the Operative Standards
b. Synoptic vs. Narrative Operative Reports for the CoC Standards (CoC)
c. Implementing Synoptic Operative Reporting (Dr. Ryan Merkow)
d. CoC Timeline for Implementation and Compliance Information
e. CoC Operative Standards FAQs (Standards 5.3-5.8)
f. Brief videos on the CoC Operative Standards

Implementation Overview

Visit the following resources for more information on implementation of Standards 5.3-5.6, and about the ILCC's approach to supporting Illinois hospitals' implementation of synoptic operative reporting:

1. CoC Implementation Options Webpage
2. CoC Webinar held on 3/23/21, "Implementation Strategies for Synoptic Operative Reporting," high-level overview of implementation strategies and answers to specific questions related to accreditation:
    a. Webinar Slides
    b. Webinar Summary and FAQs
3. ILCC Synoptic Reporting Introductory Webinar

Timeline for Implementation of Standards 5.3-5.6

Standards 5.3-5.6 take effect on January 1, 2023 but hospitals need to demonstrate progress towards implementation in 2022. Here are the key dates and milestones:

1/1/22 – 12/31/22	• Programs must document formal implementation plans, which will be reviewed during site visits in 2023, 2024, and 2025
1/1/23 – 12/31/23	• CoC-accredited programs must achieve 70% compliance • CoC Site Visits begin to review implementation plans from 2022
1/1/24 –	• The compliance rate increases to 80% • CoC Site Visits begin to review 2023 operative reports for 70% compliance

See below for the high-level timeline from the CoC, and click ***here*** for detailed information on the requirements for compliance and site visit process.

Standards 5.3, 5.4, 5.5, 5.6

Compliance and Site Reviews

facs.org/cssp

Cancer Surgery Standards PROGRAM

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes
100+years

ILCC's Roadmap to Implementing Standards 5.3-5.6

The ILCC's approach to helping hospitals satisfy Standards 5.3-5.6 is to provide support across the spectrum of implementation of the operative standards, provide resources to smooth the path to successful implementaiton, minimize the impact on surgeons, and provide a forum for hospitals to share experiences and work together to achieve compliance. The following ILCC webinar introduces our approach to helping hospitals satisfy the new standards. Click ***here*** to view the recording and ***here*** for the slides.

The roadmap below provides the ILCC's step-by-step approach to implementing the synoptic operative reporting standards at your hospital with resources to support each step. Click the name of the step to be brought directly to those pages of the toolkit.

1. Assemble your team
   - High-level team role overview
   - Synoptic reporting team roles and responsibilities

2. Determine how you want to satisfy the standards
   - Implementation options and decision aid
   - CoC required elements for standards 5.3-5.6
   - ILCC synoptic operative report templates
   - Stakeholder analysis

3. Make the case for change
   - Talking points for clinical stakeholders
   - Engaging non-clinical stakeholders
   - Presenting to your cancer committee

4. Implement your solutions
   - EMR solutions
   - Sample templates
   - Sample smartphrases
   - Dictation resources

5. Document your work for reaccreditation site visits
   - Timeline and milestones
   - Guidelines for implementation plans
   - Project charter template
   - Description of workplan and EMR builds
   - List of team meetings

6. Track compliance with the new standards
   - Dashboard and analytics
   - Reporting
   - Internal Auditing

1) Assemble your team

A project team with defined roles, ownership, and accountability is critical to the success of any QI project. Teams are multidisciplinary and consist of project sponsors, clinical and administrative champions, process owners, quality leaders, and other members. For a refresher on roles within QI teams, click ***here*.**

Team members are responsible for contributing to the project's direction and implementation; therefore, for this project we recommend delegating, at minimum:

- A team lead who is a breast, melanoma, and/or colorectal surgeon and who is involved with, or familiar with, CoC accreditation.
- An administrator who is involved in CoC reaccreditation.
- One or more supporting clinicians who treat patients with breast, melanoma, and colorectal cancer. Surgeon content experts in each disease site are encouraged.
- A representative from your cancer quality structure and/or a representative who is familiar with CoC accreditation standards.
- A cancer registrar.

You may also decide to include other stakeholders as additional team members, such as representatives from other specialties who use operative reports for patient care, and representatives from billing, compliance, risk, and legal. The roles and responsibilities of each team member for the synoptic reporting implementation project are described in detail ***here***.

2) Determine how you want to satisfy the standards

There are a number of ways to satisfy the synoptic reporting standards 5.3-5.6, all of which depend on your local needs, level of support, and resource availability. Use the chart on the next page to help you determine which approach will best meet your institution's needs. The chart contains links to the relevant toolkit sections depending on which approach you select. All options will require obtaining buy-in from the impacted clinicians and staff, particularly the surgeons who will be implementing the standards in their operative reports. These surgeons will also require education to help them implement the standards. Relevant resources can be found ***here***.

Once you determine which approach to use, click ***here*** for the required elements for Standards 5.3-5.6, and ***here*** for the CoC and ILCC Coordinating Center's Synoptic Operative Reporting Templates for each procedure.

Implementation Option *(most intensive to least intensive)*	Approach	CoC Standards Compliance	Flexibility of Content Captured as Synoptic Fields	Ease of Implementation of Synoptic Elements	Potential Amount of Time Saved by Surgeons Writing Operative Reports	Labor Needed to Implement	Level of Buy-in and Education of Surgeons, Other Clinicians, Staff, and Leadership	Discrete Data Available for Registrars and Research/QI
1. Transition to the CoC's entirely synoptic operative reports for the required procedures	Contract with third-party vendors	Yes, with automated updates as standards evolve over time	Minimal-Moderate; Content is determined by third-party vendor using ACS templates. Some the vendors have options for customizing data fields	Low; All surgeons must transition to one solution	Most; Due to fully synoptic "checklist" format, with ability to individualize pre-selected templates.	Some; Mostly IT for initial installation	Highest; The cost of implementation of the third-party vendor product will need to be covered by your institution on an on-going basis.	All
2. Implement a hybrid synoptic operative report for the required procedures	Develop report locally with input from surgeons, other clinical stakeholders, and staff, in partnership with IT staff	Yes, but may require manual updates for non-Epic hospitals as standards evolve over time	Most; Each hospital determines what information will be captured discretely in addition to the required elements	Medium; Requires some change to workflows but potential for surgeons to maintain existing documentation methods	Moderate-Most; Depends on level of incorporation of synoptic fields and opportunities for individual surgeon customization	Most; Both clinicians' input to develop hybrid report and IT support for EMR build are needed	Middle; Workflow may be the most similar and opportunities to customize to local surgeons	Determined by hospital and customizable to their needs

3. Implement only the elements required by the CoC for the required procedures	Build a template or smartphrase to use within existing operative reports Note: Hospitals using Epic can use ACS CoC templates available within the EPIC App Orchard	Yes, but manual updates for non-Epic hospitals will be required as standards evolve over time	None; Only the required elements and responses are utilized	High; Surgeons can maintain existing documentation methods	Least; Surgeons maintain existing workflow with minor changes; will take slightly more time unless presets are used	Some; Mostly IT for development, implementation, and ongoing maintenance	Lowest; Merely adding on to existing workflow but surgeons may not appreciate more work	Only the required synoptic elements are available

CoC Required Elements for Standards 5.3-5.6

The CoC details required elements and responses for satisfying Standards 5.3-5.6, which can be found in the full document ***here*** and are detailed below for each procedure (*current as of 6/30/22*):

Standard 5.3: Sentinel Node Biopsy for Breast Cancer

Operative reports for patients undergoing sentinel node biopsy for breast cancer must include the following elements in synoptic format. Programs may use the American College of Surgeons or their own synoptic operative reports as long as the data elements required to achieve compliance with the CoC standards are clearly identified and the response options are the same as in the CoC Standard. A uniform synoptic reporting format should be used by all surgeons at the facility.

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.

Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer

Operative reports for patients undergoing axillary lymph node dissection must include the following elements in synoptic format. Programs may use the American College of Surgeons or their own synoptic operative reports as long as the data elements required to achieve compliance with the CoC standards are clearly identified and the response options are the same as in the CoC Standard. A uniform synoptic reporting format should be used by all surgeons at the facility.

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.

Standard 5.5: Wide Local Excision for Primary Cutaneous Melanoma

Operative reports for patients undergoing wide local excision of primary cutaneous melanomas must include the following elements in synoptic format. Programs may use the American College of Surgeons or their own synoptic operative reports as long as the data elements required to achieve compliance with the CoC standards are clearly identified and the response options are the same as in the CoC Standard. A uniform synoptic reporting format should be used by all surgeons at the facility.

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)*.

Standard 5.6: Colon Resection for Cancer

Operative reports for patients undergoing resection for colon cancer must include the following minimum elements in synoptic format. Programs may use the American College of Surgeons or their own synoptic operative reports as long as the data elements required to achieve compliance with the CoC standards are clearly identified and the response options are the same as in the CoC Standard. A uniform synoptic reporting format should be used by all surgeons at the facility.

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)*.

To view the CoC's full Synoptic Operative Reporting Standards for 2020, click here: https://www.facs.org/quality-programs/cancer/coc/standards/2020.

CoC and ILCC Synoptic Operative Report Content

The CoC has fully synoptic operative reports available for use by hospitals. The ILCC Coordinating Center has independently developed operative report templates for breast, melanoma wide local excision, and colectomy for colon cancer, each of which includes the information needed to implement a fully synoptic report for each procedure. Portions can also be adapted by institutions who are implementing a partial or hybrid synoptic operative report; however, the CoC encourages use of their template as the expectation is that the synoptic operative reporting standards will eventually expand over time to include all surgical procedures. Click the links below to access the report content for each procedure.

ACS CoC Synoptic Operative Report Templates

The CoC templates are available to view ***here***. To access, click "Register/Take course" and log in using your credentials. You will then be able to view the templates for Breast Cancer, Melanoma, and Colon Cancer.

ILCC Synoptic Operative Report Templates

- Breast Cancer Surgery Full Synoptic Operative Report, including Mastectomy, Partial Mastectomy, Sentinel Node Biopsy (Standard 5.3), Axillary Lymph Node Dissection (Standard 5.4)
- Wide Local Excision for Primary Cutaneous Melanoma (Standard 5.5)
- Colon Resection for Colorectal Cancer (Standard 5.6) – *Coming soon*

3) Make the case for change

Synoptic operative reporting is new to many surgeons, other clinicians, and staff, and the incorporation of synoptic elements into operative reports will be a major change for most surgeons. A successful transition should include education of surgeons regarding the reasons underlying the adoption of synoptic reporting and the creation of opportunities for each stakeholder group (surgeons, non-surgeon clinicians, and staff) to provide feedback. Identifying and engaging the right stakeholders will be key to successful implementation, and we recommend doing so through individual and/or group conversations with surgeons and other clinicians, clinical and non-clinical staff (billing and coding specialists, clinic scheduling and nursing staff, etc.), in addition to presenting at relevant committee meetings. This section includes resources for engaging stakeholders across your hospital and for managing change across groups.

Clinical Stakeholder Analysis

While the synoptic operative reporting standards primarily impact surgeons, other clinicians at your hospital may use operative reports for patient care, and understanding which components they use will be essential to a successful implementation. As an example, the ILCC Coordinating Center conducted a survey of stakeholders who write and/or use operative reports for care of breast cancer patients. The goal of the survey was to understand how to best implement synoptic operative reporting to facilitate adoption and positively impact patient care. Participants and key takeaways from the survey are listed below, followed by the full summary of results and the survey content itself.

Participating Clinical Specialties:

- Surgical Oncologists
- Radiation Oncologists
- Medical Oncologists
- Pathologists
- Radiologists
- Referring providers

Key takeaways from the survey:

- Existing methods of documentation:
    - 68% of surgeon respondents type their notes using a completely narrative template.
    - 21% dictate using a transcription service or voice recognition software.
    - 11% have already transitioned to a partial or complete synoptic operative report.
- Most common breast cancer-specific components included in operative reports or used for clinical decision making:
    - The top three types of information that **surgeons** reported including in the operative reports for breast cancer were lymph node evaluation, location and/or involvement of other structures, and surgical complications.
    - The top three types of information that **non-surgeons** reported using for clinical care were lymph node evaluation, understanding the completeness of the resection, and location and/or involvement of other structures.

- Familiarity with synoptic operative reports:
    - 83% of respondents had not seen or used synoptic operative reports.
    - 41% of respondents had no familiarity at all with the synoptic operative format.
- Concerns about the synoptic operative format:
    - Many surgeon respondents (63%) had one or more concerns about the transition to the synoptic operative format.
    - Primary concerns included having less autonomy and the synoptic format being more time consuming.
- Impact of the synoptic format on the quality of operative reports:
    - 55% of respondents felt the transition to the synoptic format would make it easier to include or find the information that is important to them.
    - 32% felt the transition would make this harder.
    - 13% were unsure or thought that they wouldn't be impacted at all.

The survey and full summary of the results are linked below, including details on the specific portions of breast cancer procedures that surgeons and other clinicians feel are important to include in operative reports.

1. Survey
2. Results

The survey itself is intended to be used for information gathering; you can implement it at your hospital or use the content to inform your discussions with surgeons and non-surgeon stakeholders. Doing so will help you identify clinicians' needs around education on the synoptic operative reporting standards and areas of focus for discussions on the which elements are important to include and how to best incorporate the changes into their existing workflows. Use the "Participating Specialties" section as a guide for who to include in these discussions. You may find it useful to implement portions of the survey at your own institution or use it to inform discussions with clinicians. It can easily be adapted to other specialties and procedures. The ILCC Coordinating Center can provide assistance in administering a similar survey at your institution; please email info@ilcancer.org for more information.

Talking points and questions for surgeons and other clinical stakeholders

Below is a list of talking points for conversations with surgeons and other clinical stakeholders who will be impacted by the change to the operative report format:

1. The inclusion of synoptic elements in operative reports is part of the Commission on Cancer's 2020 Operative Standards and is required for all surgeons who perform the included procedures for reaccreditation. The Commission on Cancer is requiring that specific elements of the operative reports for four procedures be in a synoptic format starting in 2023: Sentinel Node Biopsy for Breast Cancer (CoC Standard 5.3), Axillary Lymph Node Dissection for Breast Cancer (5.4), Wide Local Excision for Primary Cutaneous Melanoma (5.5), and Colon Resection for Colon Cancer (5.6).
2. A synoptic operative report is a report with standardized elements that are organized into a structured template or checklist format. Synoptic reporting has been shown to improve the accuracy, completeness and efficiency of writing operative reports, thereby reducing the variability in care.

3. As of January 1, 2023, surgeons who perform these operations will begin to be required to include specific defined elements in their operative reports in a synoptic format, in compliance with CoC standards 5.3-5.6. The CoC requires a single solution be implemented for all procedures, and that all the elements be listed in one location, using the exact wording provided by the CoC. [*Information on how your hospital will be implementing the new standards (i.e., partial or fully synoptic operative report, details on the EMR solution).*]
4. [*Questions about their current workflow when writing and using operative reports, including their existing methods of documentation and specific workflows (for surgeons), what portions of the report they need for patient care (for non-surgeons), and how they access the reports once they are in the EMR to sign and/or read them.*]
5. [*Information on how your hospital's solution will impact them, specific to their method of documentation (i.e., writing in narrative format, dictation/transcription)*.]
6. [*Information on whether they will be able to select default responses for the synoptic elements, and whether the presets will be uniform for all or surgeon-specific.*]
7. [*Information on how compliance will be measured and who will be communicating with them regarding the new standards.*]

Engaging non-clinical stakeholders

Obtaining feedback from non-clinical stakeholders prior to implementing the changes to the new report format will streamline the process and save time by avoiding revisions. Make sure to engage the following stakeholders early in your implementation process:

- Leadership (clinical and non-clinical)
- Billers
- Compliance
- Legal
- Risk

We recommend starting with an introductory meeting to present an overview and justification for the new requirements, as they will likely not be aware of them and may express concern about the elimination of narrative fields. Follow this with a preliminary review of the report content to ensure capture of all of the elements needed for their purposes. Finally, have them conduct reviews of test patients so they can familiarize themselves with the new format prior to its launch.

Cancer Committee Slide Deck

We recommend engaging with local cancer center leadership early in this process in order to gain/maintain their support for your local synoptic operative reporting initiative. Your local Cancer Committee, or its equivalent, is an excellent venue in which to engage important leaders. You can consider individual meetings with key leaders as well. Click ***here*** for a slide deck that can be customized to present the project to your local Cancer Committee.

Quality & Process Improvement (QI/PI) Resources

The following are quality and process improvement resources to use during your implementation of the synoptic reporting standards.

1) Change Management Handout
Refer to this one page overview for information on Prosci's ADKAR Model (Awareness, Desire, Knowledge, Ability, Reinforcement), which can be used to support your synoptic reporting implementation initiative.

2) Sample Synoptic Reporting Project Charter

3) Work Plan Template
The ILCC Coordinating Center's work plan template can help you track your progress.

4) Project Plan Template
This comprehensive project plan template includes a wealth of tools to keep your project on track. See the tab "Change Management Playbook" for a step-by-step plan for managing change over the course of the project.

4) Implement your solutions

EMR Solutions

Once you have decided which strategy will best be utilized to implement synoptic operative reporting at your institution (i.e., transition to a fully synoptic operative note, implement only the required elements, or take a hybrid approach), there are several approaches to building EMR solutions. Keep in mind the required elements (CoC Standards 5.3-5.6) must be implemented uniformly across all surgeons who perform the procedures covered under the new standards, and must use the language provided by the ACS CoC.

1. ACS CoC Synoptic Operative Report Templates. The CoC templates are available to view ***here***. To access, click "Register/Take course" and log in using your credentials. You will then be able to view the templates for Breast Cancer, Melanoma, and Colon Cancer.
2. ILCC-developed options. Click ***here*** to access the ILCC-developed report content and EMR templates for hospitals interested in implementing their own synoptic operative reporting solutions.
3. ACS CoC Epic templates. The ACS is working with Epic to provide the required elements to all Epic customers. More information on this offering can be found ***here*** and ***here***.
4. ACS CoC Third-party vendors. The ACS has licensed their content to third-party vendors to develop a fully synoptic operative note for Standards 5.3-5.6. These software options integrate directly into your hospital's EMR. More information can be found ***here***.
5. EPIC EMR Solutions. For hospitals using the Epic EMR platform, you may consider starting with the ACS CoC Epic templates and customizing them to your needs using the resources provided here. For hospitals who use other EMR systems, you can adapt the templates below to develop a similar solution. Information is also provided below for surgeons who dictate using Dragon or transcription services. For the report content for the procedures covered by Standards 5.3-5.6, click ***here***.

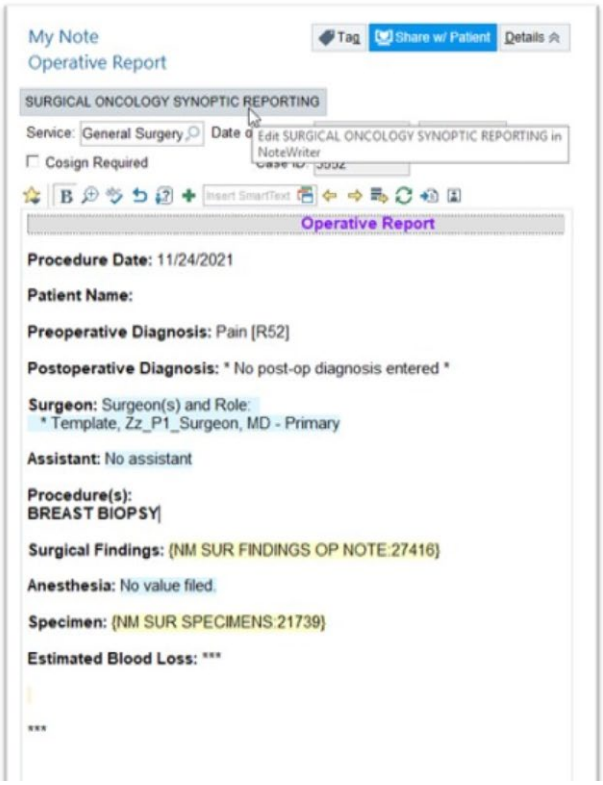
Sample EMR Tools

1. Epic OpTime Sample Solution

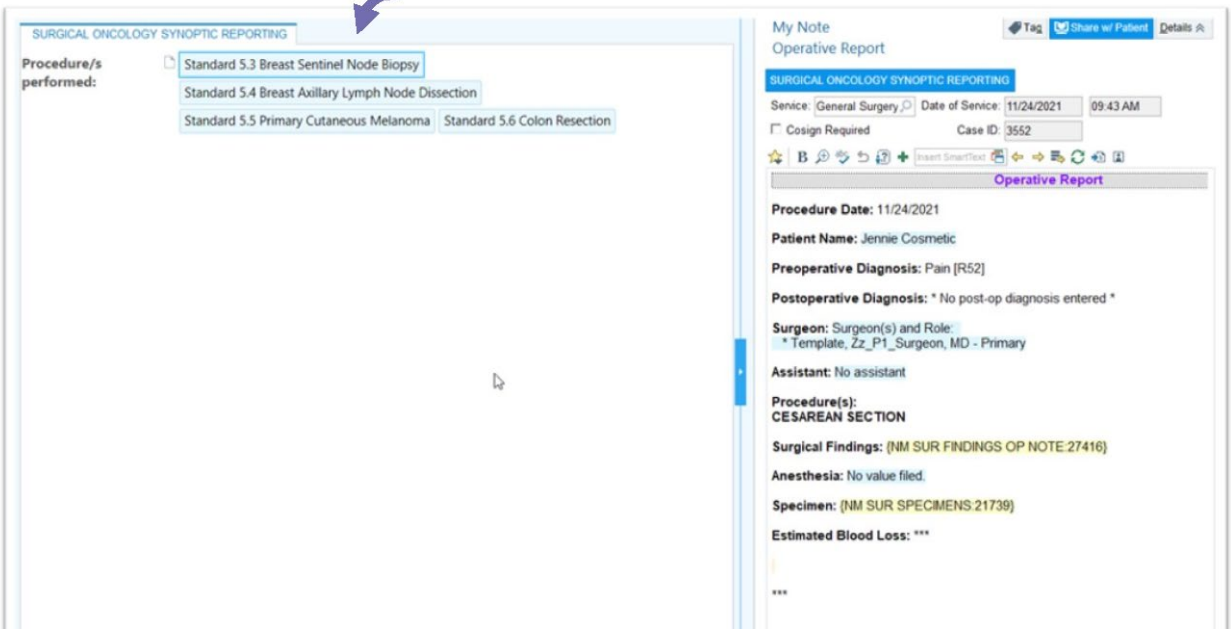
The templates below highlight how the full synoptic operative note would function after being integrated into EPIC OpTime. Each procedure module is its own "note writer macro." Preselected responses for each macro can be set at a center- or surgeon-level to streamline report completion. The operative report data entered via these macros exist as discrete fields in the EMR. Click ***here*** for more information on building reports and dashboards to monitor compliance with the new standards.

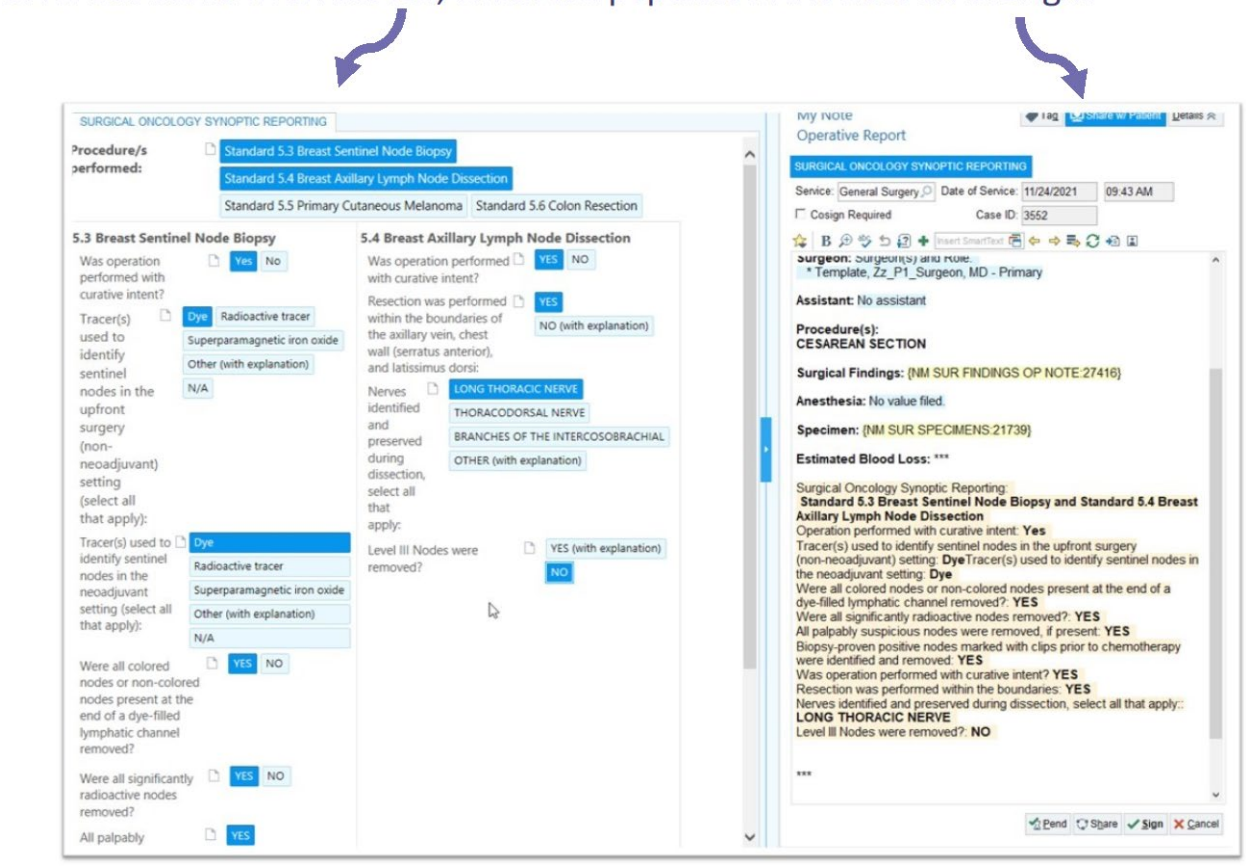
Hospitals using the ***ACS CoC Epic templates*** can use the sample macros below along with the ILCC Coordinating Center's ***Synoptic Operative Report templates*** to add elements to the report that surgeons, other clinicians, and billing and compliance staff identify as being important to capture discretely. This approach will ensure compliance with the new standards while allowing the standardization and capture of the additional elements that are important for patient care.

1. Click to launch



2. Select applicable standards





2. Sample EMR Smartphrases

The following are examples of smartphrases that can be implemented as the simplest method to meet compliance in the event your hospital needs more time to implement its final solutions.

Sentinel Lymph Node Biopsy	
Substrate(s) used for SLNBx	In the {BLANKLIST CH CLN:30424006::"NAC Setting","Non-NAC Setting"}: {BLANKLIST CH CLN:30424006::"Dye","Radiotracer","Clips","Dye and Radiotracer"}
All colored nodes or non-colored nodes at end of blue lymphatics were removed	{BLANKLIST CH CLN:30424006::"Yes","No","N/A"}
All significantly radioactive nodes were removed	{BLANKLIST CH CLN:30424006::"Yes","No","N/A"}
All palpably suspicious nodes were removed	{BLANKLIST CH CLN:30424006::"Yes","No","N/A"}
Clipped nodes were removed:	{BLANKLIST CH CLN:30424006::"Yes","No","N/A"}

Axillary Surgery	
Resection performed within the boundaries of the axillary vein, chest wall (serratus anterior), and latissimus dorsi	{BLANKLIST CH CLN:30424006::"Yes","No"}
The long thoracic and thoracodorsal nerves were spared during dissection	{BLANKLIST CH CLN:30424006::"Yes","No","Not identified"}
Attempts were made to spare the intercostobrachial nerves during dissection if possible	{BLANKLIST CH CLN:30424006::"Yes","No","N/A"}
Were any level III nodes are removed? (If so then document why)	{BLANKLIST CH CLN:30424006::"Yes","No","N/A"}

3. Dictation Resources

If your hospital has surgeons who dictate and use transcription services or software service (e.g. Dragon) to create operative reports, you will have to decide whether and how to incorporate this into your solution. Doing so will require talking to the surgeons who dictate to understand their workflows, as well as discussions with your hospital IT department and transcription vendor to understand the capabilities and limitations of your specific EMR and transcription vendors.

Given that the CoC has mandated one solution for all surgeons at an institution, the best choice is to have all surgeons who use dictation/transcription to switch to a template solution. In our experience, a good template solution can be demonstrated to take less time than dictating/transcribing (both initially and does not require second review to sign).

The following are considerations and questions to ask your hospital IT department and transcription vendors when developing your synoptic operative reporting solutions:

A. Surgeons using transcription services:

Reports that are dictated and transcribed enter the EMR as a block of narrative text. Discrete fields are not a capability of existing transcription systems. When the dictated text enters the EMR the provider is prompted to sign it via the in-basket. Note writer macros built in Epic such as the samples provided in this toolkit cannot be added from the in-basket. To add the macro with synoptic fields to these reports, the surgeon must go into the encounter, type in the associated smartphrase, and complete the required fields. Your hospital's EMR may have different capabilities, so make sure to ask about this in conversations with IT.

An alternative solution is to build a specific synoptic reporting work type template with your transcription vendor that includes the synoptic elements. To use this option, surgeons will have to dictate that reports under that specific work type.

Questions for your hospital IT department:

- *Is it possible to add the synoptic operative reporting template to the transcribed note directly from the in-basket?*

- *Is it possible to auto-populate the synoptic operative reporting template into the transcribed text when the note is opened in Epic?*
- *Is there a way to prompt the provider to complete the required synoptic elements so they don't have to remember to do it every time?*

B. Surgeons using Dragon or similar software:
The operative report text is stored within the EMR. From there the smartphrase for the procedure macro can be added to the note and completed.

Questions for your hospital IT department:

- *Is it possible to auto-populate the synoptic operative reporting template into the transcribed text when the note is opened in Epic?*
- *Is there a way to prompt the provider to complete the required synoptic elements so they don't have to remember to do it every time?*

C. If you are transitioning to a fully synoptic operative report:
Dictation software cannot currently be used to complete operative reports directly in the synoptic format with discrete fields, but often can be used to provide additional details of the procedure in narrative text boxes within a template. If you are transitioning to a fully synoptic operative report for one or more procedures we recommend addressing this in early conversations with surgeons who dictate to begin to set expectations a solely dictated operative report may no longer be an option for them once the synoptic operative reports are implemented. Click ***here*** for more information on engaging surgeons in the implementation process and managing change. You can also ask your hospital IT department or transcription vendor for help troubleshooting this issue.

Questions for your hospital IT department and/or transcription vendor:

- *Is there a way to translate the dictated text into discrete fields?*

Tip for improving compliance:
Consider adding the synoptic elements to your hospital's policies that detail the required fields for operative reports. This may boost compliance among non-employed surgeons and billers who express resistance to the elimination of a completely narrative report. Click ***here*** for sample language.

5) Document your work for reaccreditation site visits

Click ***here*** to view the timeline for Implementation of Standards 5.3-5.6.

Documenting Implementation Plans

CoC-accredited programs must document their plans for implementing Standards 5.3-5.6 in 2022, which will be reviewed at site visits in 2023, 2024, and 2025. The CoC has provided the following guidelines for documenting implementation plans ***here***.

The table below provides materials developed by the ILCC Coordinating Center, in partnership individuals who have extensive experience with CoC site visits, to satisfy the CoC's recommended minimum standards for implementation plans. Click the name of the document listed in the column on the right to download. All templates can be adapted for your local use and tailored to your hospital's implementation plans.

Recommended Content for Implementation Plans for CoC Standards 5.3-5.6	**ILCC's Hospital Documentation to Include in Implementation Plans**
1. Describe how the cancer committee reviewed the CoC Operative Standards, their intent, and the requirements, including the date of the meeting(s) at which this was discussed	• Synoptic Reporting Charter • Cancer Committee Slides
2. Describe all education and training activities conducted or planned for surgeons, pathologists, and registrars for Standards 5.3-5.6	• Synoptic Reporting Handout • Meeting Agenda Template • Log of Meeting Dates and Agendas
3. Describe any internal audit process undertaken or planned to review compliance levels prior to the site review (if applicable)	• Internal audit guidelines and processes
4. Describe any processes put in place or planned at your facility to facilitate synoptic reporting and data collection, including any coordination with IT, the surgery department, the registry, etc.	• Description of Work Plan • Log of Meeting Dates and Agendas *(see above)* • Draft Language for Inclusion in Medical Records Content Policy • Synoptic Operative Report Content • Sample EMR Solution Screenshots
5. Outline the implemented or planned approach for synoptic reporting for Standards 5.3-5.6 and proposed timeline for complete implementation by January 1, 2023	• Description of Work Plan *(see above)* • Synoptic Operative Report Content • ILCC Timeline (if participating in our collaborative-wide project)

6) Track compliance with the new standards

Achieving Compliance

The CoC provide the following guidance on their phased approach to measuring compliance with Standards 5.3-5.6:

2024	Site visits will evaluate charts from 2023 to determine whether 70% of operative reports within the scope of the standards meets the requirements for Standards 5.3, 5.4, 5.5, and 5.6 (*5 out of 7 operative reports reviewed must meet standard requirements*).
2025	The compliance rate will increase to 80% (*6 out of 7 operative reports reviewed must meet standard requirements*) on January 1, 2024. 2025 site visits will review operative reports from 2023 and 2024 for 80 percent compliance.
2026	Site visits will review operative reports from 2023, 2024, and 2025 for 80 percent compliance.

Details on how to achieve compliance can be found ***here***, including the process for chart review at site visits.

FAQs with responses from the CoC can be found ***here***.

Internal Auditing

Though not formally required by the CoC to achieve compliance with Standards 5.3-5.6, we strongly recommend conducting an internal process to identify and audit cases as you begin to track compliance. An ongoing internal auditing process will make compliance issues apparent well in-advance of any site visit.

The following CoC case identification tipsheets can be used to track compliance with Standards 5.3-5.6:

1. Standard 5.3
2. Standard 5.4
3. Standard 5.5
4. Standard 5.6

Mechanisms to feed data back to surgeons and staff

Feeding data on performance back to the surgeons who perform the operations for which synoptic elements are required in their operative reports is an important mechanism to maintain buy-in and compliance with the standards.

1. Email
    a. Even before you have data to feed back to providers, it is important to give updates on implementation progress. We suggest sending an email before the EMR solution goes live,

thanking them for their input and letting them know the go live date, what training materials are available, and information on the testing and feedback period.

b. Following the go live and testing and feedback period, consider sending an email with a brief overview of results to each surgeon *quarterly*. You can consider including blinded (or unblinded, if circumstances allow) comparative reports of individual compliance to applicable standards.

2. Department-level Reports
    a. You may want to create Department-level reports to provide specific groups with more feedback on their compliance and measures of interest. When creating these reports, consider including the following components:
        i. Compliance with the CoC standard that applies to them (e.g., 5.3 and 5.4 for breast surgeons), highlighting specific parts of the operative reports that are not being documented or not documented in the right format
        ii. Reminders of the training materials that are available and specific suggestions to improve documentation
        iii. Process measures of interest that are being captured as discrete elements as part of the synoptic template

3. Presentations at Cancer Committee Meetings
    a. You will want to present the results at least annually at relevant committee meetings (e.g., Cancer Committee or Cancer Quality Committee). Consider including an update on compliance levels, updates to the templates, ongoing training activities, barriers and/or additional resources needed, and, if applicable, any resulting QI work being done using the data.

4. Dashboard
    a. Consider identifying a set of core metrics that will provide details on compliance and build them into a dashboard. We would suggest including the following, individually for each of the standards and reported at the system-, region-, hospital-, and surgeon-level for each:
        i. How often the synoptic reporting template is being used for eligible patients (% template use) (process metric)
        ii. Correct use of the synoptic reporting template (% operative reports with complete data) (process metric)
        iii. Percent compliance with Standards 5.3-5.6 (outcome metrics)