ACS QVP: Hospital and Specialty Case Review Guide

This guide is intended for hospitals that wish to establish or improve surgical case review conferences at both the hospital and specialty (e.g., colorectal, orthopedics, neurosurgery) levels for the purpose of assessing and improving quality.

As outlined in the ACS Red Book and the ACS QVP Standards Manual, Case Review conferences are distinct from Surgeon (Peer) Review (Standard QI.2) and Morbidity and Mortality Conferences (M&M). To clarify, the ACS defines Surgeon (Peer) Review as a conference focused on evaluating individual surgeon performance, while Morbidity and Mortality Conferences are traditionally held to review cases of interest for educational and training purposes.

This guide focuses specifically on **Case Review**, for the purpose of:

- Assessing and anticipating safety and quality issues.
- Identifying opportunities to improve care and reduce unnecessary variation.
- Reviewing compliance with and effectiveness of protocols, appropriateness, and efficiency measures.

Below is a high-level overview of the Hospital-level and Specialty-level Case Review scope and functions. The ACS recognizes that hospitals may have various organizational structures that can effectively achieve this goal.

For additional information on ACS QVP requirements for Case Review, refer to the ACS Quality Verification Program Standards Manual here.

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Hospital Case Review Conference

Scope	• All surgical cases performed at the hospital
Participants	• Surgical Quality Officer and core team • Surgical specialty leadership/SQSC members • Quality dept representation - QI/PI, project management, data analytics • Multi-disciplinary team representatives as appropriate, including but not limited to leadership from: nursing, anesthesia, ICU, OR, floor, IR, et al.
Triggers for Review	• Deaths and serious morbidities • Sentinel events (e.g. retained foreign objects, OR fires, wrong-site surgery) • "Systems issue" complications- not an individual provider error but a problem spanning multiple teams or an opportunity for protocolization across specialties (e.g. issue with pre-op assessment, ERAS, post-discharge pathways, etc.) *Some examples include:* • *Same day surgery cancellation or complication as a result of a pre-op assessment* • *intra-op hyperthermia/hypothermia* • *emergency case (non-trauma) with mortality* • *elective surgery with unplanned LOS > 4 days* • *elective surgery on patients 85+ y/o*
Sources	• Event reporting system • Cases included in NSQIP, Vizient, Regulatory Metrics, EHR slicer/dicer • Referrals from specialty case review conference or peer review committee
Review/Discussion Focus	• Findings of Root Cause Analysis (RCA), if applicable • Adherence to existing surgery-wide protocols/pathways • Opportunities to develop/update new surgery-wide protocols or adopt/align current surgical specialty-level protocols • Identify opportunities for formal quality/process improvement initiatives • Prevention of similar problems in the future by ensuring loop closure (for example, feedback and education)
Referral to	• To peer review- if a surgeon-level issue not previously reviewed • To Specialty Case Review- if determined need for further review within the specialty

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Specialty Case Review Conference

Scope	• Cases grouped by specialty/sub-specialty division, procedure, or disease. (e.g. spine cases done by both ortho and neuro would benefit from one conference)
	• Includes all procedures and surgeons performing cases within the specialty grouping (includes private practice or physician groups)
	• For smaller specialties (1-2 surgeons), may opt to;
	  ◦ combine with a specialty case conference within the hospital system or region (if available)
	  ◦ combine with adjacent specialty case conference within the hospital

Participants	• Specialty Chair and core team (project management, data abstraction, QI/PI) • All surgeons practicing within the specialty area invited (specific attendance requirements and meeting frequency determined by specialty chair) • Multi-disciplinary team representatives as appropriate, including but not limited to: nursing, anesthesia, ICU, OR, floor, IR, allied health, and other related specialties
Triggers for Review	• Deaths and serious morbidities • Specialty-specific post-op complications- these may align with measures tracked in a specialty-specific registry or be determined and tracked independently by the specialty • Issues related to procedure or disease management efficacy • Randomized reviews for specialty protocol adherence and/or appropriateness *Some examples include:* • *Anastomic leak for GI, or vessel nerve injury for vascular* • *Repeat procedures* • *Failure to meet patient post-op goals for pain management or ambulation* • *Cases not adhering to standards or guidelines of care for disease-based management*
Sources	• Clinical registry data, EHR slicer/dicer, or manually tracked data • Referrals from hospital case review conference or peer review committee that are determined "specialty-specific"
Review/Discussion Focus	• Adherence to existing specialty-specific protocols/pathways and disease management standards/guidelines • Opportunities to develop new specialty-specific protocols/pathways or update current specialty-specific protocols • Identify opportunities for formal quality/process improvement initiatives • Prevention of similar problems in the future by ensuring loop closure (for example, feedback and education)
Referral to	• To peer review - if a surgeon-level issue not previously reviewed • To Hospital Case Review - if related to a surgery-wide protocol or determined a "systems issue" (problem spanning multiple teams, such as hand-offs, etc.)