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	Effective Date: 04/02/24
No: CLN.04.04.MOD	**Corporate Approval Date:** 03/04/24
Title: Operative and Invasive Procedures Appropriateness Review (CO-5.006.MOD)	**Previous Versions:** 07/30/18; 08/10/17; 09/15/16; 01/24/13; 03/29/12; 05/31/11; 02/17/09; 01/08/08; 11/24/03
	Medical Staff Approval Date: [Include if policy requires Med Staff approval]
	Governing Board Approval Date: [Include if policy requires Governing Board approval]

I. Scope:

This policy applies to _________ ("Facility") and its Medical Staff.

II. Purpose:

To describe the minimum standards, review Cardiac Operative and Invasive procedures through effective use of evidence-based clinical criteria, to identify performance trends and patterns appropriately and accurately, and to monitor and improve the quality of care delivered to patients for alignment with performance national performance metrics.

III. Policy:

[Facility Name] shall conduct systematic, reliable reviews of Operative and Invasive Cardiac Procedures organized according to the peer review and quality processes set forth in the Facility's Medical Staff Bylaws and state statutes.

IV. Procedure:

A. [Facility Name] shall participate in nationally recognized registries/databanks for purposes of evaluating performance and appropriateness of procedures compared to national benchmarks.

1. NCDR CATHPCI REGISTRY [Include if the Facility performs any Interventional PCI or 100 or more diagnostic catheterization Procedures annually.]
2. NCDR IMPACT REGISTRY. [Include if the Facility performs pediatric interventional or diagnostic cath Procedures.]
3. STS Adult Cardiac Surgery Database Registry [Include if the Facility performs CABG/ Valve Procedures].
4. STS Congenital Heart Surgery Database for all congenital cardiovascular surgery programs performed at pediatric facilities [Include if the Facility performs Congenital Cardiac Procedures].
5. The Facility shall participate in all state and/or federal mandated data registries (including but not limited to LAAO and TVT) and shall provide required data within the prescribed timeframe.

B. Quality Review

1. The Facility shall conduct case reviews in accordance with the peer review and quality processes set forth in the Facility's Medical Staff Bylaws and state statutes.

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2. The Facility shall review, at minimum:

   a. Cases with Complications as identified by national databank entry or quality indicators, including but not limited to:

      (i) Ischemic and hemorrhagic stroke

      (ii) Tamponade

      (iii) New requirement for dialysis

      (iv) Pseudoaneurysm with return to the OR/procedure room or other vascular complications requiring treatment.

      (v) Bleeding events with treatment or drop of > 3gm/dL:

         a) Hematoma at access site

         b) Retroperitoneal bleed

         c) GI bleed

         d) GU bleed

         e) Access site bleed

   b. Dissection or perforation

   c. Valve malfunction/dehiscence

   d. Infections- Wound, pocket, etc.

   e. Return to the OR/procedure room for re-operations.

   f. Cases with Mortality

   g. Other complications as determined by the Facility.

   h. Supplemental case reviews may be performed at the direction of Facility's MEC, Chief Medical Officer and/or the designated quality improvement leaders at the Facility.

3. CV Committee

   a. If not already in existence, the Facility's Medical Staff shall establish a CV Committee, or structure within an existing multispecialty medical staff committee, to provide oversight and review of the cardiac services provided at the Facility to improve the quality of cardiac services.

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b. The CV Committee shall meet regularly, generally on a bimonthly basis but in no less than quarterly, to review quality reports and to develop and implement performance improvement plans for high quality care.

c. The CV Committee shall provide a summary of its findings described in this Policy to the Facility's MEC on a quarterly basis. Reporting should include the most up to date registry data.

4. The MEC shall address any patterns or trends identified, take appropriate action according to the peer review and quality processes set forth in the Facility's Medical Staff Bylaws and state statutes, and report its findings and actions to the Facility Governing Board on a quarterly basis.

V. Enforcement:

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

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