Supplement – Department of Emergency Medicine Peer Review Process for HRURV

As part of the Department of Emergency Medicine's (DEM) quality assurance process, all high risk unscheduled return visits (HRURV) are reviewed by our Peer Review Committee (PRC) which is chaired by the DEM Quality Director and made up of 4-6 additional DEM faculty members as part of their service requirements.

Every month an electronic report is generated by our electronic medical record reporting system on all HRURVs based on the following programmed criteria:

1. Presented to AUBMC ED for a full visit
   AND
2. had a repeat AUBMC ED visit within 72hrs from discharge time of first visit
   AND
3. Had one of the following dispositions on second visit: "admitted to hospital" or "expired"

The Chair of the PRC assigns these cases for review by members of the committee. This is an ***Emergency Medicine*** peer-review committee, thus members focus on reviewing the care of the Emergency Medicine physician/practice standards (not that of the consultants), following the below Peer-Scoring rubric to assign a severity score (Table 1). In addition, members are asked to make an assessment of the root cause based on the following categories: Illness-related, Physician-related, Patient-related, healthcare system-related and "other reasons" where legibility or missing elements of documentation limited capacity for review (Table 2). After the review of the cases, the committee members meet once monthly to collectively review/discuss all cases scored above a 2 for final scoring. System issues that require immediate action as well as cases scored 4 and 5 are referred to the Chair for follow up on recommendation/further action.

Table 1: HRURV Peer-Scoring Rubric

Peer Score	Example
1. Appropriate – no issues.	Pneumonia discharged on appropriate antibiotics, met CURB-65 score criteria for outpatient therapy but returned for worsening symptoms.
2. Appropriate – no physician issues, *but* system factors need improvement.	26 yo presented with hand flank pain, initial CT read as negative and final read reported possible renal infarct. Patient called back for admission and further evaluation.
3. Appropriate – *but* minor physician issues need improvement or differing opinions on management.	40 yo male with presents with flank pain, studies including UA and labs are normal. There is no documentation of assessment of pain level prior to discharge. Returns with pain and gets admitted for pain control for renal colic identified by CT on second visit. Although it is clear CT is gold standard for urolithiasis diagnosis, there are differing opinions on need for definitive diagnosis of kidney stones in ED. In addition, the MD failed to document a reassessment of pain level prior to discharge. So this would be scored as 3.
4. Inappropriate – requiring performance improvement *without* change in scope of practice.	60 yo with pneumonia and CURB-65 score of 4 is discharged with antibiotics and fails outpatient treatment. Performance improvement and development plan for pneumonia care including education regarding inpatient vs outpatient treatment would be recommended for the provider but no change in scope of practice.
5. Inappropriate – requiring performance improvement *with* change in scope of practice until remediation complete.	EKG read by provider, STEMI missed on first visit and patient discharged. This would require change in scope of practice of provider pending remediation/full development plan.

Table 2: Root Cause of HRURV

RCA Category	RCA-subcategory	Example
Illness-related	Progression of disease	Influenza discharged and returns with superimposed
	Failure of outpatient treatment	Pneumonia discharged on antibiotic and returns with worsening symptoms
	Recurrent disease process	Renal Colic returns with renal colic and gets admitted for pain control
	New problem related to 1st visit	1st visit is vertigo and represents with fall/hip fracture
	Complication	Renal Colic with initial normal labs now with AKI
Physician-related	Admission indicated but consultant recommended outpatient management	Pneumonia with CURB-65 score of 4 and ED attending consulted Pulmonary for admission, but consultant opted for outpatient management
	Failure of reassessment	Biliary colic discharged and returned with intractable pain. Missing reassessment note documenting all elements to clear patient for discharge including pain reassessment, repeat exam (these are all parts of our own internal best-practice algorithm for discharge of abdominal pain)
	Misdiagnosis	Missed appendicitis
	Treatment error	Patient with history of ESBL UTI, presenting with recurrent UTI and given antibiotic with inadequate coverage
	Admission indicated on initial visit and ED attending did not attempt to admit	High risk chest pain who was discharged after one troponin.
Patient-related	Discharge against medical advice	Patient refusing admission and understanding risks of leaving home (signed AMA in chart)
	Social issues	Homeless returning frequently to ED with different complaints to seek shelter at night
	Habitual use of ED	Lumbar disc disease returning frequently with pain
	Missed clinic follow-up	Seen in ED and referred for outpatient follow up but returned to ED instead.
	Psychiatric disorder	Anxiety disorder presenting to ED frequently with palpitations
	Noncompliance	Seen in ED and discharged on antibiotics for UTI that were not taken.
Healthcare system-related	Called back because of missed radiograph abnormalities	Flank pain that was discharged because of negative preliminary radiology read, called back to return because of renal infarct noted on final read.
	Instructed to return for re-evaluation	Patient with persistent abdominal pain identified during our routine phone follow up by our mid-levels and instructed to return for reevaluation
	Sent from clinics	Calls to get follow up appointment from clinic and sent back to ED because of unavailable timely clinic appointments.

	Patient unable to get medication	Malaria unable to find specific antibiotic in pharmacy, returns to ED