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Guidelines for Structured Implicit Review of the Quality of Hospital Care for Diverse Medical and Surgical Conditions

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SUMMARY

This Note contains a quality review form and guidelines for its use, originally developed for and used in the RAND PRO Quality Review Validation Study (PQRVS). The form and guidelines were designed for structured implicit peer review of hospital records by physicians, to assess the quality of inpatient care for diverse medical and surgical conditions. The guidelines are designed to be used in a preliminary training session for physician reviewers, as well as for reference thereafter. The form, training procedures, and guidelines are based on and modified from condition-specific structured implicit review methods previously developed at The RAND Corporation for a study sponsored by the Health Care Financing Administration of the effects of Medicare's Prospective Payment System on the quality of care.1

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I. INTRODUCTION

This manual contains a review form and guidelines for using it that were originally designed for RAND's PRO Quality Review Validation Study (PQRVS). The PQRVS form and guidelines provide a framework for "implicit" judgments of the quality of medical care for diverse medical and surgical conditions using the hospital medical record as a database. When performing implicit peer review, a physician reviews a medical record using his or her own standards to rate or judge the care.

Our aim in developing this review form and guidelines was to increase the reliability of implicit judgments of quality of medical care, while preserving their subtlety. The form and guidelines specify the parts of the hospital medical care to be judged (e.g., initial data gathering, use of medications), define these specified parts carefully so that all reviewers understand them in the same way, and attempt to provide a yardstick, or anchor points, for the rating scale used to judge each aspect of care. In this way, we hope to make it more likely that disagreements among reviewers represent true differences of opinion about the quality of care rather than different interpretations of the words used in the form's questions. We call this method "structured implicit review."

The PQRVS Quality Review Form and guidelines included here differ from previous RAND structured implicit review methods in that they are not condition-specific; they are designed instead to allow the reviewer to rate the quality of hospital care for diverse medical and surgical conditions.

We have provided yardsticks for assessing quality of care based on the following definitions.

Excellent quality medical care is the best you can imagine in the average U.S. hospital. Excellent care minimizes the risk of complications, maximizes the likelihood of a good outcome, and maximizes humane care and respect for patients' wishes. The definition of "outcome" is broad, and integrates length of life and health-related
quality of life (e.g., physical function, psychological well-being), as well as short-term and long-term effects.

Medium care is acceptable, but just minimally so.

Very poor care is malpractice. This care has egregious errors and is likely to result in more harm than benefit or is likely to cause more harm or less benefit than alternative approaches available at average U.S. hospitals.

Below is a graphic representation of how the quality of care rating scale used in the form should correspond to the rater's decision about whether the care was "acceptable" or "unacceptable":

<table>
<thead>
<tr>
<th>Very Poor</th>
<th>Poor</th>
<th>Medium or Standard</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unacceptable</td>
<td>Acceptable</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When assigning a rating, raters were asked to consider average conditions at average U.S. hospitals, and to avoid adjusting their ratings according to guesses about the size and type of hospital in which the patient was treated. During analysis, we will use hospital-specific data to adjust for hospital characteristics.

A copy of the PQRVS Quality Review Form is reproduced in Sec. II.
II. IMPORTANT GENERAL CONCEPTS AND ISSUES

RATING THE PROCESS, NOT THE OUTCOME

In performing implicit review of the quality of hospital care, try to divorce yourself from each patient's actual outcome (e.g., death, recovery of function), and try to review the care according to what is recorded about what was done for the patient—the process of care. Do not consider information available on autopsy. Consider if the process under study maximized the likelihood of a good outcome and maximized humaneness and respect for patients' wishes, imagining a population of patients similar to the one described.

INTEGRATING DIFFERENT OR DISPARATE ITEMS OF INFORMATION

Occasionally, it is necessary to integrate several pieces of information to arrive at the specific rating requested. In such cases, weigh each piece of information you are trying to integrate according to how important it was to the patient's care. For example, several physicians may have participated in the aspect of care you are being asked to rate (e.g., initial data gathering about acute problems). Weigh most heavily the physicians' data gathering that most influenced what was done for the patient. Similarly, sometimes nurses and physicians will both be involved in a given aspect of care, but one group will do it well and the other poorly. Again, integrate the information, trying to weigh each group's contribution according to how much it contributed to what was done for the patient.

POOR DOCUMENTATION AND THE QUALITY OF CARE

We recognize that in using the medical record as a database, you as the reviewer cannot be certain whether care that looks spotty was in fact spotty or was adequate with poor documentation. We urge you to use all clues available in the record to assess quality. Take note of and assign credit for the many ways physicians have of documenting process. Nevertheless, if you believe the record does not adequately document the
process, you should downgrade your rating in the relevant sections of
the structured implicit review.

If you are concerned that there is a gross paperwork error in the
medical record you have been sent, e.g., some part of it seems to be
part of a different record, or a section is missing, please call us at
RAND. We will check to see if the problem can be fixed, and inform you
of the resolution.

ASSUMPTIONS ABOUT THE APPROPRIATE GOALS OF CARE

Regardless of what the actual goals of therapy appear to be, we ask
you to assume that the goal should have been maximal prolongation of
life unless (1) there is explicit documentation that the patient wishes
to limit therapy, or (2) the patient has a very poor prognosis that you
believe medical care could not alter, e.g., a terminal illness which is
causing extreme suffering, or poor prior functional status and suffering
with no hope of recovery.

Question 8 gives you the opportunity to indicate whether you
believe the physicians of record attempted to limit care because of a
poor prognosis.

WHEN YOU DO NOT FEEL QUALIFIED TO ASSIGN A RATING

When you think you are not qualified to rate one or more of the
aspects of care the form asks about, we ask you to assign a rating
anyway, but then to indicate in Question 14a that you felt uncomfortable
assigning a rating for that item, and to indicate in 14b which other
kind of physician also needs to review the diagnostic and treatment
issues for this hospitalization.

AVOIDING CONTROVERSIES IN CARE

Try to avoid holding physicians to standards idiosyncratic for you,
your hospital, or your region. Also avoid holding physicians to
standards that colleagues you respect might disagree with, or that are
controversial within the profession. We ask you to concentrate on
problems you believe a group of your knowledgeable peers would agree
with.
QUESTION 1. THE QUALITY OF SPECIFIC COMPONENTS OF THE HOSPITAL ADMISSION DATA COLLECTION AND ASSESSMENT

ITEM 1A. ASSESSMENT BY PHYSICIANS OF THE PATIENT’S PRIOR RISK FACTORS AND PRIOR AND CHRONIC DISEASE

PURPOSE

For this question, we ask you to rate physicians' data gathering about the patient's risk factors and disease before the acute episode of illness or surgical problem. Please judge the physicians' assessment by imagining you are covering for or being consulted by the attending physician. Compare the information collected about prior risk factors and disease to what you would need to prognosticate and to formulate diagnostic and therapeutic plans that will result in the best patient outcome.

Risk factors are social, psychological, behavioral, or biological factors existing before the acute illness that might affect diagnosis or treatment plans for the acute illness. It might be important for the physicians to have noted either the absence or presence of such risk factors. Some examples include alcohol use, smoking, exercise, occupational exposure, medication adherence (compliance), and family history of genetic disease. Prior diseases are significant previous medical problems, even if episodic (e.g., prior surgery, prior myocardial infarction). Chronic diseases are ongoing medical illnesses such as diabetes mellitus, rheumatoid arthritis, hypertension, chronic obstructive pulmonary disease, or chronic lymphocytic leukemia.

DATA SOURCES

The data sources for this item are usually the physicians' notes near the time of admission. These include history documented in the admitting notes by the emergency room physician or other admitting physician, the first note(s) by the primary physician or physician team caring for the patient, or consultation notes near the time of admission.
You may also find information later in the chart (e.g., in the progress notes or discharge summary) that you may want to include in your assessment. Data about prior risk factors and diseases should be gathered at admission, and you would usually assign your rating based on notes that are close to the time of admission. However, in some cases you may need to take into account information documented later in the chart. For example, because of the patient's acute illness or mental impairment on admission, the physicians may not have been able to obtain information about the prior condition until later, e.g., until a key relative was found, until the patient woke up, or until physicians obtained prior records. You might give physicians credit in such a case if it appears they did whatever they could to try to obtain information on admission, and later filled in the gaps when they could.

SPECIAL ISSUES
Discrepant Quality of Data Gathering by Different Providers

When several physicians care for the patient, you may need to integrate information from several notes to assign your rating. You should weigh these different assessments according to how they contributed to the patient's care. We would usually expect the patient's primary physicians' assessments to most affect diagnoses, plans and prognostication. Therefore, the primary physicians' data gathering should usually carry the most weight in your rating. However, you may also take into account others gathering these data if they appear to influence the primary physicians' care.

Individualized Standards for Each Patient

Pertinent positives and negatives in the history will differ for each patient. For example, it may be important to record the absence of history of tuberculosis for a patient with pneumonia and cavitary lesions, but not for a patient with acute myocardial infarction. When some but not all pertinent data have been collected, we ask you to weigh what is there and what is missing according to the importance of each piece of information for formulating diagnoses, prognosticating, making plans, and writing appropriate orders for this patient.
Prior and Chronic Diseases vs. Acute Problems

You may not always be able to separate physicians’ data gathering about prior and chronic disease (rated in this item) from data about acute problems (rated separately in Item 1c). Some items will contribute to both ratings. We include in the definition of data gathering about the prior condition the history of the problem or illness causing the admission (the morbid condition) up to the point of acute deterioration. This definition of prior condition also includes the history of comorbid conditions up to the point of acute deterioration. In the case of elective surgery, the surgical problem would be considered prior disease until the point where it progressed to the stage or kind of problem that caused the admitting physician to believe that surgery was indicated.

The Well-Known Patient

If you have evidence in the record that the patient is well-known to or has had multiple hospitalizations by the attending physician (e.g., references to old records) this may modify your rating of the physicians' data gathering about prior risk factors and prior and chronic disease. However, you should expect critical items about prior condition to be restated in the record to allow appropriate diagnosis, prognostication, and treatment by other physicians.

RATING SCALE ANCHOR POINTS

Excellent: The physician(s) gathered all the data you need about prior risk factors and prior and chronic disease to assess prognosis and to make the best diagnostic and therapeutic decisions. If you were covering for the attending physician, you would not have to gather any further data.

Medium: Although you would definitely want more information about risk factors and prior and chronic disease to prognosticate or to make some of the diagnostic and therapeutic decisions, the evaluation is acceptable, though minimally so, and would allow you to make the most important decisions.
**Very poor:** You would need to start over at the bedside, repeating the initial patient history to obtain your own history of prior risk factors and prior and chronic disease to assess prognosis and make diagnostic and therapeutic decisions.

**ITEM 1B. ASSESSMENT BY PHYSICIANS AND NURSES OF FUNCTIONAL STATUS AND PSYCHOSOCIAL SITUATION**

**PURPOSE**

*Functional status* means the patient's ability to carry out the usual activities of daily life. These include "basic" activities such as walking, eating, bathing, dressing, and toileting (i.e., continence), and "instrumental" activities such as working at a job, doing housework, shopping and attending to finances, and fulfilling social obligations. *Psychosocial situation* refers to information about *psychological and mental factors*, such as the patient's cognition (e.g., dementia), mood (e.g., depression), and personality, and *social factors* such as residence (e.g., nursing home), social support (e.g., nearby family, availability of caretaker), occupation, and financial situation.

**DATA SOURCES**

For this item, use all physicians' and nurses' notes that might provide information about data gathering concerning prior functional status. Include physicians' admitting history and physical, emergency room notes, physician consult notes or reports, physician progress notes, initial nursing assessment, nursing notes, and physician discharge summaries. If there is more than one data source, use all available data in the record to assign your rating. As before, if different data sources give you discrepant impressions, weigh them according to how much you think they contributed to the care of the patient.

As with Item 1a, if the patient's level of consciousness or severity of illness limited the physicians' data gathering about functional status and psychosocial situation at the time of admission, you may wish to incorporate this into your rating and also to take into
account whether there were later attempts to fill in the missing information.

SPECIAL ISSUES
Discrepant Quality of Data Gathering by Different Providers

In some hospital records, nursing assessment forms contain extensive information about functional and psychosocial status. Some physician reviewers feel that physicians use this information, and therefore may not document it separately. While the item asks about physicians and nurses, downgrade your assessment if the physician does not include the most critical items.

Individualized Standards for Each Patient

Just as for prior disease and risk factors, pertinent positives and negatives concerning functional status and psychosocial situation depend on the patient's clinical circumstances. It may be most important for diagnosis and treatment to know about prior residence and social support for an unconscious patient found on the floor and brought into the emergency room, but most important to know about functional status for a hip fracture patient who has had a previous stroke. Thus, you will need to weigh each item of missing or available information differently in arriving at your summary rating depending on the patient's clinical situation.

The Well-Known Patient

If you have evidence in the record that the patient is well-known to or has had multiple hospitalizations by the attending physician (e.g., references to old records), this may modify your rating of the physicians' data gathering about prior functional status and psychosocial situation. However, critical items about prior condition should be restated in the record to allow appropriate diagnosis, prognostication, and treatment by other physicians, and your rating should take this into account.
RATING SCALE ANCHOR POINTS

Assign anchor points as described under Item 1a.

ITEM 1C. INITIAL DATA GATHERING BY PHYSICIANS ABOUT ACUTE PROBLEMS PRESENT AT ADMISSION (INCLUDING INFORMATION FROM HISTORY, PHYSICAL, LABS AND PROCEDURES)

PURPOSE

This question asks you to rate the physicians' initial data gathering about the patient's acute problems at admission, considering what would be necessary to develop diagnostic and therapeutic plans. Do not evaluate data gathering about the patient's health status before the acute episode or current surgical problem; that is evaluated in Item 1a. Consider "initial data gathering" to be data gathering within the first 24 hours.

DATA SOURCES

Use notes within 24 hours of admission, including the physician's history and physical, laboratory data at admission, emergency room work-ups, notes and reports of procedures performed, and physician consult notes.

If different aspects of initial data gathering are discrepant (e.g., emergency room physicians' data gathering was excellent but attending physicians' was very poor), then integrate your rating by weighing how much each aspect affected the quality of medical care the patient received.

RATING SCALE ANCHOR POINTS

Excellent: The physician(s) gathered all the data about the acute problems that you needed in the first 24 hours to make the best diagnostic plans and therapeutic decisions. If you were covering for the physician(s), you would not have to gather any further data.

Medium: Although you need more information about the patient's acute problems around the time of admission to make some of the diagnostic and treatment decisions, this aspect of data collection was acceptable, though minimally so, and allows you to make the most important decisions.
Very poor: You would need to start over at the bedside, repeating initial patient history and data gathering about acute problems at admission to make diagnostic and therapeutic decisions and prognostications.

ITEM 1D. INTEGRATION OF ADMISSION INFORMATION AND DEVELOPMENT OF APPROPRIATE DIAGNOSES

PURPOSE

Item 1d asks you to rate how data acquired during the first 24 hours about acute and chronic disease were integrated to develop diagnostic possibilities and evaluate their likelihood. Use your judgment given the available data to rate how well the physician(s) established the correct diagnoses or named the appropriate set of diagnostic possibilities based on the patient’s initial presentation.

DATA SOURCES

To assign this rating, examine physician notes in the first 24 hours, including admitting history and physical, emergency room notes, progress notes by admitting or attending physicians, and consultation notes for the first 24 hours.

If there are discrepancies (e.g., some physicians evaluated the patient correctly and others did not), integrate different aspects according to how much they affected the patient’s care.

RATING SCALE ANCHOR POINTS

Excellent: You believe the physicians named the appropriate diagnosis or set of possible diagnoses most likely to maximize a good outcome, minimize the risk of complications, and maximize humane treatment and respect for patient wishes.

Medium: Although the physicians’ initial diagnostic assessment contained some important errors or omissions, you consider the assessment acceptable, though minimally so. For example, the physicians generated a list of diagnoses that included the most likely ones, although they omitted some that were possible.
Very poor: You believe the physicians' initial diagnostic assessment had very important errors or omitted very likely diagnoses, and therefore was very likely to cause the patient significant harm or deprive the patient of important benefits achievable for patients with similar conditions at an average U.S. hospital.

ITEM 1E. THE INITIAL TREATMENT PLAN AND INITIAL ORDERS PURPOSE

This item asks you to rate the physicians' initial treatment plan for the patient based on your own assessment of the patient's likely diagnosis(es), or set of diagnostic possibilities, at the time of admission.

DATA SOURCES

Use physicians' admitting treatment plans and orders written during the first 24 hours.

If you would rate different aspects of initial treatment discrepantly, come to a summary rating by considering how much each part contributes to achieving the best outcome, the least risk, and the most humane care respecting the patient's wishes. For example, you may think appropriate medications were prescribed but fluid orders were inappropriate. Integrate these into your overall judgment according to how important each of these areas is for the care of an average patient in this patient's condition at the time the orders were written. If two different physicians treated the patient in the first 24 hours, weigh their treatments according to which affected the quality of the patient's care more.

RATING SCALE ANCHOR POINTS

Excellent: The physicians initiated ideal treatment that maximized the likelihood of a good outcome, minimized the risk of complications, and maximized humane treatment and respect for patient wishes.
Medium: Initial treatment was incorrect or incomplete in some way but was acceptable, though minimally so.

Very poor: Initial treatment when compared with alternative possibilities substantially reduced the likelihood of a good outcome, exposed the patient to substantial risk of complications, or involved gross violations of humaneness and respect for patient wishes.
QUESTION 2. THE PATIENT'S LIFE EXPECTANCY ON ADMISSION
ASSUMING EXCELLENT CARE DURING THE HOSPITALIZATION

PURPOSE
This question asks you to estimate the patient's life expectancy from what you know about the patient's condition at admission, assuming excellent care during the hospitalization.

DATA SOURCES
Use information in the entire record, up through the end of hospitalization, which pertains to the patient's condition at admission. Consider the patient's age, risk factors, prior and chronic diseases, and prior functional and psychosocial status, as well as the acute problem at the time of admission.

SPECIAL ISSUES
You may take into account information that became apparent later in the hospital course but applies to the patient's condition at admission. However, do not use information about changes in the patient's condition during hospitalization that affect the prognosis.

For example, if a patient with fever and cough who was found to have pneumonia on admission is then discovered near the end of the hospital stay to have disseminated non-small-cell lung cancer, then the new information bears on what the patient's condition and prognosis was at the time of admission, and you should take this into account in assessing prognosis. However, if a patient is admitted for elective surgery for varicose veins and later has a stroke in the hospital, this information represents a change during the hospital stay and should not affect your assessment of his likely prognosis at the time of admission.
QUESTION 3. TESTS AND TREATMENTS

PURPOSE

This question asks you to rate the amount of various kinds of tests and treatments used. In rating the amount of use as too much or too little, weigh the benefit and harm that might have resulted from using or not using the test or treatment. Consider if using more or less than the amount used was likely to result in net benefit or net harm for a group of patients like this one.

Benefit and harm are broadly defined to include effects on different kinds of outcome (e.g., survival, function, psychological well-being), as well as more or less humane or respectful care. They may also include short-term and long-term effects.

PLEASE NOTE: Do not consider the cost of tests or treatments when rating the amount of their use; consider only the probable benefit or harm to average patients such as the one described in the chart you are reviewing.¹

DATA SOURCES

Use physician, nursing or ancillary service notes, flow sheets, laboratory test reports, procedure notes and reports, EKG reports, x-ray reports, and pathology reports.

¹We recognize that cost may be an important factor in deciding which tests and treatments are appropriate to use given our current health care systems and resources. However, you are already taking cost into account implicitly when you judge quality against what you think is possible at average U.S. hospitals. Note that even without considering cost explicitly, you may still rate unnecessary tests or treatments "too much," because "harm" is broadly defined to include patient discomfort or worry.
SPECIAL ISSUES

Using the Actual Condition or Course

When judging the amount of use of a test or treatment, consider the patient's *actual course and condition* at the times when the tests or treatments were used or could have been used; do not base your decision on an expected or possible course or condition that might have occurred with different care. For example, you may feel that a patient deteriorated and required intubation because of inadequate antibiotic therapy for pneumonia. When rating the amount of use of intubation, you would rate this "about right" because it was given when needed. You then have the opportunity to rate use of therapeutic antibiotics (Item 4b) "very poor." *Avoid* reasoning that there was "too much" intubation because the patient would not have needed it if he had been initially treated correctly.

What to Do When Question 3 Does Not Cover All Important Tests or Treatments

Frequently you will feel that the list of tests or treatments in this question and the list of specific components of care in Question 4 omit something that was very important for the particular patient whose care you are reviewing (e.g., invasive diagnostic and therapeutic procedures like thoracentesis, paracentesis). In this case, incorporate your assessment of this omission when you assign your global ratings (Questions 12 and 13). The problem may also fit into Items 1e (initial treatment plan and initial orders); 4f (revision of treatment plan due to new symptoms and signs, or due to the results of tests or procedures); or for surgical patients, 5g (postoperative surveillance related to surgical goals); or 5h (postoperative management of medical problems).

We welcome your comments about things that influenced your global ratings, but that did not seem to fit into the form's specific questions. We will incorporate them when redesigning the form and guidelines in the future.
What to Do When Tests or Treatments in Question 3 Do Not Seem Relevant

For many cases, the important diagnostic tests or treatment procedures differ from the ones listed in Question 3, and some of Question 3's items will seem irrelevant. Please rate all items anyway, following the reasoning that if a kind of treatment or test was not indicated during the hospitalization and it was not performed, then the use of this kind of test or treatment was "about right."

Averaging over the Entire Hospitalization

You may think that at times during the hospitalization the amount or kind of a test or treatment was about right, but that at another point it was overused or underused. Please integrate these by weighing them according to the likely total benefit and the likely total harm to the patient as a result of the use of this kind of test or treatment.

For example, you may feel that a patient with pneumonia received appropriate monitoring of arterial blood gases during a critical hypoxemic episode, but that when he improved, arterial blood gases were overused, with some resultant unnecessary discomfort to the patient. On average, you feel that the total benefit of arterial blood gases performed during the hospital stay outweighed the total risk or discomfort to the patient, so you would assign a rating of "about right" to the amount of use of arterial blood gases.

Rating the Process, Not the Outcome

Think prospectively about the likely effect on a group of patients like this one at the time the tests or treatments were used or could have been used. Try to avoid hindsight based on what this patient's outcome turned out to be.
DEFINITIONS OF INDIVIDUAL ITEMS

3a. Intensive care unit asks you to judge the amount of use of a dedicated unit for intensive monitoring and observation. Many of the interventions that would be applied in an intensive care unit are also asked about separately in other items, e.g., intubation and mechanical ventilation, arterial blood gases, invasive hemodynamic monitoring. However, in this item, we would like you to comment on the amount of use of the intensive care unit(s) rather than any specific aspect of intensive care.

3b. Intubation and mechanical ventilation includes just those items; respiratory therapy is in 3c and oxygen therapy in 3d.

3c. Respiratory therapy includes treatment delivered by a respiratory therapist, with the exception of oxygen therapy (see Item 3d). This may include treatments with inhaled medications and chest physiotherapy. When you judge the amount of use, you should take into account both physicians' orders for therapy and what appeared to have been actually delivered by respiratory therapists.

3e. Arterial blood gases includes measurements of arterial blood ph, pO2, pCO2, bicarbonate, and oxygen saturation.

3f. Invasive hemodynamic monitoring includes arterial line blood pressure monitoring, monitoring through pulmonary artery catheters, central venous lines, and other invasive methods of monitoring hemodynamic status. This item does not include arterial blood gas monitoring (see Item 3e).

3g. Follow up visits and clinical examinations by primary physician, continued observation by physicians of symptoms and signs includes both the number of physician visits and the amount of clinical observation during these visits. If the physicians did not visit the patient enough, or if, when they did visit, they did not examine enough, you should judge this probably or definitely "too little."
3h. Transfusions means transfusions of blood components.

3i. X-rays may include contrast radiologic studies like GI series and barium enema. This item includes CT scans and MRI, but not nuclear scans.

3j. EKGs are defined as 12-lead electrocardiogram tracings, with or without rhythm strips. However, use of more continuous electrical monitors, like ICU monitors or telemetry, should be rated in Item 4e.

3k. Serum electrolytes, chemistries, and blood counts include all electrolyte and chemical determinations of naturally occurring substances in blood. The definition does not include drug levels or immunoassays carried out in immunology or serology laboratories. Blood counts are defined as counts of any blood component, including hematocrit, red blood count, blood cell volume measurements, platelets, and differential counts. The definition does not include clotting times.

3l. Urinalyses means routine urinalyses, including measurements of urine specific gravity, glucose, protein, ketones, bilirubin, nitrites, leukocyte esterase, and microscopic examinations of urine for leukocytes, red blood cells, cells, microbes and casts. The definition does not include 24-hour urine protein collections or urine electrolytes, chemistry tests, or toxic screens.

3m. Cultures means microbiologic cultures, including cultures of blood, urine, sputum, cervical discharge, pus, biopsied or excised tissue, etc.

3n. Physical therapy is based on physicians' orders and the delivery of physical therapy by the physical therapist or nurse. When evaluating the use of physical therapy, consider both the physicians' orders and the actual delivery of physical therapy. For example, if physical therapy was ordered but never delivered, and you believe it was necessary, you would rate the amount "probably too little" or "definitely too little."
30. Consultations refers to consultation with other physicians, including medical and surgical specialists and subspecialists, obstetrician-gynecologists, and psychiatrists. When judging the amount of consultation, judge both which consultants were used and how much they were involved in the patient's care. It may be difficult to decide when a physician should have called a consultant. If you think the physician was doing a poor job in an area that should be within the scope of a primary physician caring for a patient like that one, incorporate this into the ratings of the aspects of care you think were poorly done. Avoid judging the use of consultants too little whenever there was poor quality of care, and reserve such ratings for when a physician with a specialty different from the primary physician's specialty or subspecialty should have been called.
QUESTION 4. THE QUALITY OF SPECIFIC COMPONENTS
OF CARE DURING THE ENTIRE HOSPITALIZATION

PURPOSE

This question asks you to rate separately some components of
medical treatment by the physician(s): use of prophylactic medications;
use of therapeutic antibiotics; management of sodium and water balance;
use of other therapeutic medications besides antibiotics and diuretics;
use of electrical cardiac monitoring; and revision of treatment plan due
to symptoms, signs, or results of diagnostic tests or procedures. Rate
the quality of these components of care.

SPECIAL ISSUES

What to Do When Components of Treatment in Question 4
Do Not Seem Relevant

Rate all items in Question 4 even though some items will not be
major treatment issues in a particular case. Follow the reasoning that
if a kind of treatment was not needed during a hospital stay, and was
not administered, the quality of this component of care was "good" or
"excellent," even if you think you are crediting the provider too much
for not using an obviously irrelevant form of treatment.

DEFINITIONS OF INDIVIDUAL ITEMS

Item 4a. Use of Prophylactic Medications

These medications may include antibiotic prophylaxis before
surgery, antibiotic prophylaxis before procedures for patients with
cardiac valvular disease, prophylactic anticoagulation for hip fracture
or immobilized patients, or prophylactic lidocaine for patients with
suspected recent acute myocardial infarction and significant runs of
premature ventricular contractions. Concentrate on prophylactic
medications you feel are standards of care and not controversial.
Item 4b. Use of Therapeutic Antibiotics

Rate how well the physicians used antibiotics as treatments for presumed or documented infections. If antibiotics were not used and you believe they should have been used, assign a rating of "poor" or "very poor."

Item 4c. Management of Water and Sodium Balance (Including Monitoring of Input/Output and Weight, Quality and Type of IV Fluids Used, Use of Diuretics)

This item asks you to rate the management of water and sodium balance during the hospitalization. This includes the quantity and type of IV fluids used, monitoring and documentation of input/output and weight, and anything physicians did to treat water and sodium balance. Although invasive hemodynamic monitoring or serum electrolyte determinations may play a role in the management of sodium and water balance, they should be rated separately in Items 3f and 3k.

Item 4d. Use of Other Therapeutic Medications

This item asks you to rate the use of therapeutic medications besides antibiotics and diuretics. We include in "medications" all intravenous mineral and nutritional supplements except sodium and water supplementation, which you should rate in Item 4c.

Item 4e. Use of Electrical Cardiac Monitoring

This item asks you to rate the use of telemetry and other continuous or intermittently continuous cardiac monitors. The number of single electrocardiograms is rated separately in Item 3j.

Item 4f. Physicians' Revision of the Treatment Plan As a Result of Symptoms, Signs, or Results of Diagnostic Tests or Procedures

This item asks you to rate physicians' response to new symptoms, signs, and test or procedure results, as reflected in ongoing treatment orders.
DATA SOURCES

Items 4a and 4b. Physician progress notes, orders, nursing medication sheets, pharmacy record sheets.

Item 4c. Physician progress notes, orders, nursing input/output flow sheets, pharmacy record sheets.

Item 4d. Physician progress notes, orders, nursing medication sheets, pharmacy record sheets.

Item 4e. Physician orders, nursing notes, telemetry flow sheets, ICU cardiac monitor tracings, ICU order sheets, ICU nursing notes, telemetry notes.

Item 4f. Physician progress notes, orders, laboratory reports, procedure notes and reports.

RATING SCALE ANCHOR POINTS

When rating the components of treatment listed in Question 4, use the basic rating yardstick:

Excellent: You judge this aspect of medical treatment ideal and believe it maximized likelihood of a good outcome, minimized the risk of complications, and maximized humane treatment and respect for the patient's wishes.

Medium: In this aspect of medical treatment, physicians could have done things differently to improve the likelihood of a good outcome, to lessen the risk of complications, or to improve humane treatment and respect for the patient's wishes. However, this aspect of care was still acceptable, though minimally so.

Very poor: Better treatment would have greatly increased the likelihood of a good outcome for an average patient like this, greatly reduced the risk of complications, or greatly improved the humaneness of treatment or respect for the patient's wishes.
QUESTION 5. SURGERY

PURPOSE

Item 5a asks if the patient had surgery, and Item 5b whether the patient should have had surgery. Please answer both Items 5a and 5b for all patients, regardless of whether or not they had surgery.

Items 5c-5h ask you to rate various components of surgical treatment. These should be answered only for patients who had surgery.

DEFINITIONS OF INDIVIDUAL ITEMS

Item 5a. Did the Patient Have Surgery?

For this review, define surgery as procedures ideally performed by a surgeon in an operating room. Please consider some minor surgical procedures to be surgery as well, including incision and drainage and wound debridement, whether at the bedside or in the operating room. However, exclude the following minor procedures from the definition of surgery for purposes of this review: cutdowns, catheter insertions (including Tenkhoff, Broviac, Groshong, and Hickman catheters), superficial biopsies (e.g., skin and lymph node), and endoscopic biopsy. If in doubt about whether a particular procedure should be considered surgery, please call for clarification.

Do not consider thoracentesis, paracentesis, bronchoscopy, endoscopy, or angiography to be surgery. If the quantity or quality of these procedures are important in a particular case, you may be able to fit your thought into Items 1e, 4f, 5g, or 5h. If not, note the issue on the form and incorporate it into your overall rating at the end.

Occasionally a patient has two problems requiring surgery, with surgery being performed for only one of the problems. Answer "yes" to Item 5a if the patient had any surgery and address the question of whether all the necessary surgery was performed in Item 5c, the type of surgery.
Item 5b. Should the Patient Have Had Surgery?

This item asks if surgery was appropriate during this hospitalization. Again, a patient may have multiple problems possibly needing surgery and you may feel that the patient should have had surgery for one problem, but not for another. Answer "yes" if you feel the patient should have had surgery of any kind. You can then incorporate your thought about which kind(s) of surgery should have been done when you rate "the type of surgery."

Item 5c. The Type of Surgery

Integrate your rating of the type of surgery performed for all surgical problems. For example, the patient may have had more than one problem requiring surgery while only one type of surgery was performed.

This item includes decisions about the type of surgery that are made in advance of the surgery on the basis of information available after pre-operative testing, e.g., the type of mastectomy, the type of hysterectomy, the type of valve replacement. More specific technical decisions, e.g., the type of suture used, should be included under 5f below.

Item 5d. Timing of the Surgery

This item asks you to judge whether you think surgery was performed at the appropriate time in the patient's course. If you think the surgery should not have been performed at all, rate the timing by assuming that the surgery needed to be done.

Item 5e. Stabilization Before the Surgery

This item asks you to rate how well medical problems or medical conditions before surgery were optimized to minimize the risk of surgery. Answer this item even if you do not think the surgery should have been performed, or if you think it was the wrong type of surgery.
Item 5f. Technical Quality of the Surgery

Include both the technical quality of the surgery itself as well as the technical quality of all aspects of intraoperative patient management, including anesthesia. Concentrate on what is documented about the process of surgery: the anesthesiologist's vital signs records, the amount of blood loss recorded, the amount of time spent in the operating room, the technical approach and events recounted in the operative note. Avoid judging the technical quality of care by the patient's recovery. A poorly done surgery may still have a lucky outcome, and there may be complications of technically excellent surgery.

Item 5g. Postoperative Surveillance or Management

This item asks you to rate how well physicians monitored the patient for complications that might indicate failure of the surgical intervention or need for further surgical intervention (e.g., wound infection, surgical site infection, failure of repair, anastamotic leak, dislocation of artificial joint), and how well they responded to any signs of such complications. This item and Item 5h overlap somewhat with Item 4f, in which you rated the physicians' response for the entire hospitalization to new symptoms, signs, or test or procedure results. However, for this item, focus only on the postoperative portion of the hospital stay, and limit yourself to management relating to the surgical goals.

Item 5h. Postoperative Management of Medical Problems

This item asks you to rate how well physicians managed pre-existing medical problems postoperatively (e.g., postoperative management of pre-existing diabetes or heart failure), and how well they managed medically treatable problems arising from the surgery (e.g., postoperative fluid overload, pneumonia, urinary tract infection, arrhythmia, or acute myocardial infarction). Again, this item may overlap with your response to Item 4f, but you should focus here on management of medical problems after surgery.
SPECIAL ISSUES

Multiple Surgical Procedures

If the patient had more than one type of surgery, integrate your ratings in Items 5c-5h for all surgery performed. Weight your ratings by the importance of each surgery to the quality of care the patient received in the hospital.

DATA SOURCES

Use operative notes, physician progress notes, operating room, recovery room and intensive care flow sheets, nursing progress notes, laboratory, EKG, x-ray and pathology reports, physician orders, nursing input/output sheets, and medication sheets.

RATING SCALE ANCHOR POINTS

For Items 5c-5h, use the same basic yardstick you used in Question 4, considering whether the aspect of surgery you are rating maximized the likelihood of a good outcome, minimized risk of complications and harm, and maximized humane treatment and respect for the patient's wishes.
QUESTION 7. LENGTH OF STAY

ITEM 7A. HOW WOULD YOU DESCRIBE THE LENGTH OF STAY GIVEN THE PATIENT'S STATUS AT DISCHARGE AND DISPOSITION PLANS

PURPOSE

We ask you to assess, for patients discharged alive, whether the length of stay in the hospital was about right, definitely or probably shorter than needed, or definitely or probably longer than needed. Consider a stay too long if some of the hospital days were unlikely to benefit an average patient such as the one in question, even if they were also unlikely to harm such a patient.

When assigning your rating of length of stay, base it on on the patient's actual condition on each hospital day. Thus, if you believe that the patient had a complication of surgery as a result of poor technical quality of surgery which resulted in prolonged hospitalization, but that the length of stay was appropriate given the complications that occurred, you should indicate that the length of stay was "about right." In this instance, you may downgrade your rating for technical quality of the surgery. In addition, indicate in Item 10c that the patient had prolonged hospitalization as a result of mistake(s).

DATA SOURCES

The front sheet of the medical record may contain the number of hospital days. To assess the patient's status at discharge, consider vital signs in the 48 hours before discharge, last laboratory test results, and physician and nursing progress notes during that period. Disposition plans may be recorded in a final physician or nursing progress note, in the physician orders, in the discharge summary, on a separate discharge sheet, or not at all.
ITEM 7B. IF YOU THOUGHT THE LENGTH OF STAY WAS TOO SHORT OR TOO LONG, WAS THERE ANY INDICATION THAT THIS WAS OUTSIDE THE PHYSICIAN'S CONTROL?

PURPOSE

If you stated the length of stay was too long or too short (Item 7a), Item 7b) gives you the opportunity to state if the overly long or short length of stay was a consequence of poor quality of care by the physician. Occasionally, patients cannot be discharged because there is nowhere to send them or because the patient or family insist that the patient stay. Patients may also be discharged early against medical advice.
QUESTION 8. INDICATIONS THAT THE RESPONSIBLE PHYSICIANS HAD LIMITED GOALS OF CARE

PURPOSE

This question attempts to discover whether you think the responsible physician had limited goals of care, that is, that the physician was not attempting to prolong the patient's life maximally.

The question does not ask you whether you think the goals of care should have been limited but rather whether you think the physician caring for the patient was operating with a limited set of goals.

RESPONSE SCALE

Please indicate only one choice.

DNR order: There is an explicit DNR (Do Not Resuscitate) order. Other equivalent abbreviations include "NCR" and "No code"; you may be aware of others.

No DNR order but other evidence that there were limited goals of care: There is no DNR order but other notes indicate that the physician did not wish to maximally prolong survival. For example, there may be documentation of a discussion with patient or family that demonstrates agreement by all parties to limit care, a note indicating limitation of intervention under certain circumstances (e.g., "no antibiotics," "no blood tests," "supportive care only," "no resuscitation"), or documented withdrawal of life support or nutrition with the expectation of death.

No clear evidence but I believe the physician(s) had limited goals of care: You believe that the physician had limited goals of care despite any clear notation. You might think so because of the patient's advanced age, poor prior functional status, or poor prognosis, combined with an apparent lack of aggressive intervention by the physician. While you may decide that this combination of circumstances resulted from poor quality of care, you might believe in some cases that this limited treatment resulted from intentionally limited goals of care. Note that the item does not ask for your impression of what the goals of
care should have been, but rather for your assessment of the primary physician's goals of care.

No evidence or reason to believe goal of care was limited: You believe that the physician's goal in treatment was maximum prolongation of survival.
QUESTION 9. EVIDENCE OR DOCUMENTATION IN THE CHART THAT THE PATIENT WISHED TO LIMIT AGGRESSIVE THERAPY

PURPOSE

This question asks whether you found evidence in the chart that the patient wished to limit the therapy, regardless of your answer in Question 8.

Evidence of documentation of this kind may include a living will or other advance medical directive in the chart, documentation of a conversation with the patient in a physician's note, or documentation of a conversation with the family that indicated the patient's desire to limit some kinds of therapy.

Note that the question does not distinguish a medical record with clear documentation that the patient would like aggressive therapy from a medical record in which there is no documentation about the patient's wishes. You should answer "no" for both of these situations.

DATA SOURCES

Attached materials at the back or front of the record may include advance directives or patient correspondence. Other relevant notations may be in physicians' admitting notes, progress notes, orders, or discharge summary.
QUESTION 10. ADVERSE CONSEQUENCES RESULTING FROM PHYSICIAN MISTAKES

PURPOSE

This question asks you to review each of the outcomes listed, and decide if the patient experienced the outcome as a result of a mistake or mistakes by the physician(s).

When thinking about the adverse outcomes listed (e.g., death, disability, prolonged hospitalization, nursing home discharge) consider that the adverse outcome may be contributed to by:

a. Poor condition(s) at admission.
b. Low degree of treatability of the condition(s) by medical science under the best circumstances.
c. Poor quality of care the patient received during hospital stay, i.e., acts or omissions by hospital staff that you would classify as mistakes.

In the event gross errors were made that led to death, disability or another listed outcome, it may be easy to judge if the outcome was at least partially the result of a mistake or mistakes. However, also consider the situation where a series of smaller acts, omissions, or non-optimal treatment methods might have caused eventual death, disability, need for discharge to a nursing home, or extra pain and suffering. These adverse consequences might then also be at least partially the result of a mistake or mistakes, although there is no one act you can point to.

Note that you should answer each item for all patients regardless of whether the patient experienced these outcomes or not, or even could have experienced them. If the patient did not or could not experience the outcome, please check "did not occur or not applicable."
DATA SOURCES

Use all relevant information in the hospital record to address this question. By this point, after answering the specific questions earlier, you will probably have reviewed all materials and aspects of care that would affect this judgment.

RATING SCALE ANCHOR POINTS

Did not occur or not applicable means that the patient either did not experience this adverse consequence, or could not have experienced it.

Occurred, not result of mistake(s) means that the patient experienced this consequence, but you do not believe that a mistake or mistakes by physicians caused it (wholly or partly).

Probably result of mistake(s) means that the patient experienced this adverse consequence, and that you suspect the outcome may have resulted at least in part from an act or acts or an omission or omissions by the physicians that you would classify as mistakes.

Definitely result of mistake(s) means that the patient experienced this adverse consequence, and that you are fairly certain that this outcome resulted at least in part from an act or acts or an omission or omissions by the physicians that you would classify as mistakes.
QUESTION 11. OUTCOME AT DISCHARGE, GIVEN THE ACUTE AND CHRONIC CONDITIONS ON ADMISSION

PURPOSE

This question focuses on outcomes at discharge given the level and kind of illness at the time of admission, and the treatability of the condition. Do not consider the quality of care the patient actually received during the hospitalization when deciding on the likely outcome. Decide upon the likely outcome for the patient based on the level and kind of illness at admission and the treatability of the condition, assuming adequate care. Then base your rating on whether the actual outcome was worse, better, or the same as the most likely outcome.

If the patient's outcome was worse than expected you should so indicate, whether you believe this occurred because of "random," unlucky complications, or because of quality of care problems. Similarly, if the patient did better than expected, you should so indicate, whether this occurred because of luck, or because of outstanding care.

DATA SOURCES

To address this question, use all relevant information in the hospital record describing the patient's status at admission and outcomes.
QUESTION 12. THE OVERALL QUALITY OF CARE

PURPOSE

The purpose of Question 12 is for you to specify your overall rating of the care delivered to this patient during this hospitalization, integrating everything you know about the patient.

DATA SOURCES

Use all relevant information in the hospital record to address this question.

RATING SCALE ANCHOR POINTS

The rating scale terms for this question are different from those used in earlier questions.

Standard means that care was acceptable, though minimally so. It does not mean your idea of what most physicians do, but rather what most physicians would agree should be done. For example, if a physician did not perform surgery in a situation in which you feel most physicians agree it should be done, you would rate that aspect of care "below standard."

The rating scale should correspond to your decision about whether the care was "acceptable" or "unacceptable" as follows:

<table>
<thead>
<tr>
<th>Extremely Below Standard</th>
<th>Below Standard</th>
<th>Standard</th>
<th>Above Standard</th>
<th>Extremely Above Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unacceptable</td>
<td></td>
<td></td>
<td>Acceptable</td>
<td></td>
</tr>
</tbody>
</table>
QUESTION 13. WOULD YOU SEND YOUR MOTHER TO THESE PHYSICIANS IN THIS HOSPITAL?

PURPOSE

This question is designed to integrate your thought and judgment with your feelings and intuition.
QUESTION 14. COMMENTS ON YOUR REVIEW

QUESTION 14A.

Indicate each item you do not feel completely qualified to rate. (We would like you to answer each earlier question even if you indicated in this question that you felt uncomfortable answering it.)

QUESTION 14B.

This question asks: If you did not feel completely qualified to assign a rating for some aspects of care, what other kind(s) of physician(s) also need to review the diagnostic and treatment issues in this hospitalization?

Additional reviews by other specialists or subspecialists are often informative even if not necessary. However, confine your answer to additional kinds of physicians whom you feel should be reviewing this chart in addition to someone in your own specialty or subspecialty because of aspects of care that you do not feel qualified to judge.

Again, even if you responded to Item 14b, you should answer all earlier questions.
QUALITY REVIEW FORM FOR DIVERSE MEDICAL AND SURGICAL CONDITIONS

*This PQRVS Quality Review Form for Structured Implicit Review of hospital care for diverse medical and surgical conditions was developed by Haya Rubin, Lisa Rubenstein, Katherine Kahn, Marjorie Sherwood and Robert Brook for The RAND Corporation, and modified from the RAND DRG/QC Study Condition-Specific Implicit Review Forms developed by Lisa Rubenstein, Katherine Kahn and Marjorie Sherwood.
PQRVS STUDY
QUALITY REVIEW FORM

CASE ID ___ ___ ___ ___ ___  Review Date ___ ___ / ___ ___ / ___ ___  6-16/

1. How would you rate the quality of each of the following components of the hospital admission data collection and assessment:

   a) Assessment by physicians of patient's prior risk factors and prior and chronic disease ............
      Very Poor  Poor  Medium  Good  Excellent
      ___  ___  ___  ___  ___  17/

   b) Assessment by physicians and nurses of functional status and psychosocial situation ............
      ___  ___  ___  ___  ___  18/

   c) Initial data gathering by physicians about acute problems present at admission (including information from history, physical, labs, and procedures) .............................
      ___  ___  ___  ___  ___  19/

   d) Physicians' integration of admission information and development of appropriate diagnoses .............................
      ___  ___  ___  ___  ___  20/

   e) Physicians' initial treatment plan and initial orders .............................
      ___  ___  ___  ___  ___  21/

PROGNOSIS

2. From what you know about the patient's acute and chronic condition at admission, after reviewing the entire record, what do you believe would have been this patient's life expectancy assuming excellent care during this hospitalization?

   < 1 month ________  22/
   1-6 months ________
   > 6 months - 1 year ________
   > 1 year ________
TESTS AND TREATMENTS

3. Considering the entire hospitalization, on average, do you believe the amount used of each of these kinds of tests or treatments was:

<table>
<thead>
<tr>
<th></th>
<th>Definitely Too Little</th>
<th>Probably Too Little</th>
<th>About Right</th>
<th>Probably Too Much</th>
<th>Definitely Too Much</th>
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</thead>
<tbody>
<tr>
<td>a) Intensive care unit</td>
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<td>b) Intubation and mechanical ventilation</td>
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<tr>
<td>c) Respiratory therapy</td>
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<td>d) Oxygen therapy</td>
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<td>e) Arterial blood gases</td>
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<td>f) Invasive hemodynamic monitoring (e.g., with pulmonary artery or central venous catheterization)</td>
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<tr>
<td>g) Follow-up visits and clinical exams by primary physician(s), continued observation by physicians of symptoms and signs</td>
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<tr>
<td>h) Transfusions</td>
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</tr>
<tr>
<td>i) X-rays</td>
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<tr>
<td>j) EKGs</td>
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<tr>
<td>k) Serum electrolytes, chemistries and blood counts</td>
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<tr>
<td>l) Urinalyses</td>
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<tr>
<td>m) Cultures</td>
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<tr>
<td>n) Physical therapy and other rehabilitative services</td>
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<tr>
<td>o) Consultations</td>
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</tbody>
</table>
4. Considering the entire hospitalization, on average, how would you rate the quality of the following components of hospital care by physicians:

<table>
<thead>
<tr>
<th>Component</th>
<th>Very Poor</th>
<th>Poor</th>
<th>Medium</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of prophylactic medications (e.g., antibiotics, lidocaine, anticoagulants)</td>
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<tr>
<td>Use of therapeutic antibiotics</td>
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<tr>
<td>Management of water and sodium balance (monitoring of I/O and weight, quantity and type of IV fluids used, use of diuretics)</td>
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<tr>
<td>Use of other therapeutic medications (besides diuretics and antibiotics) including IV supplements like K, Ca, Mg</td>
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<tr>
<td>Use of electrical cardiac monitoring (e.g., telemetry)</td>
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<tr>
<td>Revision of treatment plan due to symptoms, signs or results of diagnostic tests or procedures</td>
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</tr>
</tbody>
</table>

37/ 38/ 39/ 40/ 41/ 42/

SURGERY

PLEASE ANSWER Q.5a-5b FOR ALL PATIENTS:

5. a) Did the patient have surgery during the hospital stay?

   Yes _____ No _____

43/

b) Do you believe the patient should have had surgery?

   Definitely not _____
   Probably not _____
   Not sure _____
   Probably yes _____
   Definitely yes _____

44/
PLEASE ANSWER Q.5c - 5h ONLY IF PATIENT HAD SURGERY.

If the patient had surgery, how would you rate:

<table>
<thead>
<tr>
<th></th>
<th>Very Poor</th>
<th>Poor</th>
<th>Medium</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>c) The type of surgery chosen</td>
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<tr>
<td>d) The timing of surgery</td>
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<td>e) Stabilization prior to surgery</td>
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<tr>
<td>f) Technical quality of the surgery</td>
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<tr>
<td>g) Postoperative surveillance and management relating to surgical goals</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>h) Postoperative management of medical problems</td>
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</tbody>
</table>

OUTCOME

6. Did the patient die during this hospitalization?

Yes _____ No _____ 51/

LENGTH OF STAY

ANSWER Q.7a - 7B ONLY IF THE PATIENT WAS DISCHARGED ALIVE.

7. a) How would you describe the length of stay given the patient's status at discharge and disposition plans?

- Definitely shorter than needed _____ 52/
- Probably shorter than needed _____
- About right _____
- Probably longer than needed _____
- Definitely longer than needed _____

PLEASE ANSWER Q.7b ONLY IF YOU THOUGHT THE STAY WAS TOO SHORT OR TOO LONG.

b) If you thought the length of stay was too short or too long, was there any indication that this was outside the physician's control?

Yes _____ No _____ 53/
GOALS OF CARE

8. Were there any indications that the responsible physician(s) had limited goals of care? (CHOOSE ONLY ONE RESPONSE)

   DNR order

   No DNR order but some evidence that the responsible physician had limited goals of care (e.g., note in chart indicating "supportive care only")

   No clear evidence but I believe physician(s) had limited goals of care

   No evidence or reason to believe goal of care was limited

9. Did you find evidence or documentation in the chart that the patient wished to limit aggressive therapy?

   Yes ________  No ________

EFFECTS ON OUTCOME

10. Did the patient have any of the following adverse consequences resulting from acts or omissions by the physicians that you would classify as mistakes? (PLEASE ANSWER FOR EACH ITEM)

    | Occurred, definitely result of mistake(s) | Occurred, probably result of mistake(s) | Occurred, not result of mistake(s) | Did Not occur or not applicable |
    |--------------------------------------------|------------------------------------------|-----------------------------------|---------------------------------|
    a. Extra pain, suffering, or worry .............. | ______ | ______ | ______ | ______ |
    b. Extra therapy, procedure or surgery ........... | ______ | ______ | ______ | ______ |
    c. Prolonged hospitalization ...... | ______ | ______ | ______ | ______ |
    d. Death ........................................ | ______ | ______ | ______ | ______ |
    e. Long-term disability .............. | ______ | ______ | ______ | ______ |
    f. Discharge to nursing home .................. | ______ | ______ | ______ | ______ |
11. How would you characterize the patient's outcome at discharge, given the patient's acute and chronic condition on admission?

   Much better than expected  ____  62/
   Better than expected       ____
   As expected                ____
   Worse than expected       ____
   Much worse than expected  ____

OVERALL QUALITY OF CARE

12. Considering everything you know about this patient, how would you rate the overall quality of care?

   Extreme, above standard  ____  63/
   Above standard           ____
   Standard                 ____
   Below standard           ____
   Extreme, below standard  ____

13. Would you send your mother to these physicians in this hospital?

   Definitely yes  ____  64/
   Probably yes    ____
   Not sure        ____
   Probably not    ____
   Definitely not  ____
COMMENTS ON YOUR REVIEW

14.  a) If there were any question(s) on this form you did not feel comfortable answering for this patient (given your own background and knowledge) please indicate which ones:

1a  3k  5g  10-58/
1b  3l  5h
1c  3m  6
1d  3n  7a
1e  3o  7b
2   4a  8
3a  4b  9
3b  4c  10a
3c  4d  10b
3d  4e  10c
3e  4f  10d
3f  5a  10e
3g  5b  10f
3h  5c  11
3i  5d  12
3j  5e  13
5f

b) If you did not feel comfortable rating all aspects of this patient's hospital care, which other kind(s) of physician(s) should also review the diagnostic and treatment issues in this hospitalization?

General internist  
Internal medicine subspecialist  WHICH KIND:  59-60/
General surgeon  61-62/
Surgical subspecialist  WHICH KIND:  63-64/
Obstetrician/gynecologist  65-66/
Other kind of physician  WHICH KIND:  67-68/

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