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General Appendices

Chapter

1 - none
2 - none
3 - none
4 - none

5A - Letter, MPS to sample hospitals with SPARCS release form attached

5B - Screening criteria for California Medical Association Study; Pilot Study of Medical Practice Study, and main Study

5C - Hospital Record Screening Manual

5D - Physician Record Review Manual

6 - none

7 - none

8A - Patient Interview Survey Instrument

8B - Hospitalization Study QC Manual

9A - Physicians' Mailed Survey Instrument

9B - Letters, Charles Sherman, M.D. and Howard Hiatt, M.D. to New York State physicians regarding mailed survey

9C - Physicians' Structured Interview Instrument

9D - Letters, Charles Sherman, M.D. and Howard Hiatt, M.D. to New York State physicians regarding interview

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HARVARD UNIVERSITY

HARVARD SCHOOL OF PUBLIC HEALTH
BRIGHAM AND WOMEN'S HOSPITAL
HARVARD LAW SCHOOL

MEDICAL PRACTICE STUDY
221 LONGWOOD AVENUE
BOSTON, MA 02115
(617) 732-5991

January 5, 1988

Dear Dr.

We have learned from the office of Commissioner David Axelrod of the State Department of Health that your hospital will participate in the study to be conducted by the Medical Practice Study Group. We are delighted that you will do so. We look forward to a partnership with you so that you may understand the purpose and goals of the study and the need for certain information. Further, we hope that you will help us arrange for the retrospective medical record survey in a manner that is least troublesome and disruptive for you. We are especially concerned about maintaining complete patient, physician, and institutional confidentiality within the study.

The importance of this study being conducted by the Medical Practice Study Group may have been emphasized to you by Commissioner Axelrod and his staff. We agree, I am sure, about the widely recognized disadvantages of the current "malpractice" system related to compensation for patients and quality control of the professional activities of highly trained physicians. It is our expectation that our study will provide current information about the incidence of compensable events in hospitals and the standards of medical care. This could lead to major modifications in patient compensation and monitoring the quality of care. There has been no comparable study since one conducted in California over 15 years ago. (Medical Insurance Feasibility Study. Sponsored by California Medical and Hospital Association. Published by Sutter Publications, Inc., San Francisco, Cal., 1977.)

In the coming months there will be an opportunity to meet with you and members of your hospital staff to provide answers to questions and cover details that may best be discussed in a personal conference. We wish to assure you at this time that plans will be developed together and in a manner consistent with your partnership in our project. It is expected that the record survey will start for most hospitals in March 1988 although a few hospitals may begin sooner. Ample time will be allowed for our joint planning and discussion of the details of the conduct of the medical record review.

There is one matter that requires immediate attention. The Medical Practice Study will need access to your hospital's 1984 Discharge Data Abstract (DDA) and Uniform Billing Form (UBF) data on the Health Department's SPARCS system. We need these data at once in order to implement the sampling plan for selection of discharges and to provide you with a list of medical records to be reviewed by our physicians. We have enclosed a release form supplied by the Health Department. We ask that you execute this release and return it to the Medical Practice Study.

We would also like your opinion on another matter of importance to our planning. A number of hospitals across the State of New York have been willing in the past to send patient records to the office of the Hospital Association of the State of New York in Albany for various types of processing which the Association has completed with dispatch, with appropriate precautions for security of the records, and with apparent satisfaction to the hospitals involved. Would your hospital give permission for records to be reviewed at a central location either in New York City or in Albany? The plan would require records of selected patients treated in 1984 being sent for a two-week period to a central location for record review by trained medical record administrators and physicians. We would propose that only a quarter or less of the records to be reviewed be sent from your hospital at any one time so that the majority of records that we are interested in would remain in your hospital at all times. The total number of records for your hospital will be approximately 1,000 depending on case mix.

There are distinct advantages to this approach for the study in that it eliminates the necessity of finding appropriate space for reviewers to study records in a hospital, allows standardized supervision of the record review process to be accomplished more easily, and handles the valuable records in a way that has been carefully worked out and validated by the experience of the Hospital Association of the State of New York.

We are aware of the importance of records remaining within your control, and I emphasize that we are confident that the records can be handled safely and confidentially in a central location. However, the decision is, of course, entirely yours. Whether in a central location or in your institution we look forward to working with you in this important activity.

Sincerely yours,

B.A. Barnes

B.A. Barnes, M.D.

Encl: Release form

cc: David Axelrod, M.D.

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PFI (s): 00017

Request #_____

SPARCS REQUEST FORM FOR HOSPITALS REQUESTING THEIR OWN DATA

1. _____
Name of Requestor Professional Title

2. _____
Institution/Firm Name (Area Code) Telephone No.

3. _____
Street Address City/Town Zip Code

4. We are requesting, as provided for by the SPARCS Privacy Regulation,

Match Merged

[x] DDA Data [x] UBF Data [ ] Case Mix Data

resident in SPARCS for patient discharges from our hospital for the period

of: 1 / 1 / 84 through 12 / 31 /84 .
month/day/year month/day/year

We request the data in the following medium:

[x] Computer Tape
IBM STD. Label
6250 BPI

[ ] Printout

5. In consideration of any data received, I agree and promise that no "deniable" data will be released or disclosed to any person or entity or published in any manner whatsoever without prior written approval pursuant to the SPARCS Privacy Regulation.

_____ _____
Date Signature of Requestor

HOSPITALS
08-03-83

SEND TAPE TO: A. Russell Localio
Project Director
Medical Practice Study
221 Longwood Avenue, Room 129
Boston, MA 02115

CALIFORNIA MEDICAL ASSOCIATION STUDY CRITERIA

CRITERION 1 - Hospitalization at this or any other acute care hospital prior to this admission: For patients under 65; the time limit is one year: for patients 65 and over, the time limit is six months.

CRITERION 2 - Hospitalization at this hospital subsequent to this discharge.

CRITERION 3 - Admitted (from any source, including transfer from another health care facility) for conditions suggesting potential prior failure or adverse results of medical management.

CRITERION 4 - Hospital-incurred trauma.

CRITERION 5 - Adverse drug reaction while patient in hospital.

CRITERION 6 - Patient transferred from general care to special care or isolation unit, e.g., ICU, CCU, isolation (including transfer of newborn from delivery room to special care or isolation unit).

CRITERION 7 - Patient transferred to another acute care facility.

CRITERION 8 - Patient returned to operating room on this admission.

CRITERION 9 - Patient operated for repair of a laceration, perforation, tear or puncture or and organ subsequent to the performance of an invasive procedure.

CRITERION 10- Unplanned removal of an organ or part of an organ during an operative procedure.

CRITERION 11- Acute myocardial infarction and a surgical procedure on same admission.

CRITERION 12- Wound infection present on last full day prior to or day of discharge.

CRITERION 13- Neurological deficit (not present at admission or prior to surgery) on last full day prior to and/or day of discharge.

CRITERION 14- Death

CRITERION 15- Length of stay exceeds the number of days listed at the 90th percentile (PAS western region).

CRITERION 16- Cardiac or respiratory arrest, including newborns with Apgar equal to or less than four at birth requiring resuscitation in delivery room.

CRITERION 17- Discharge with indwelling urinary catheter.

CRITERION 18- Febrile: Temperature equal to or more than 101° F on last full day prior to and/or day of discharge.

CRITERION 19- Parental analgesics last full day prior to and/or day of discharge.

CRITERION 20- Other complications.

MEDICAL PRACTICE PILOT STUDY CRITERIA

CRITERION 1 - Hospitalization at this or any other acute care hospital prior to this admission: For patients under 65, the time limit is one year: for patients 65 and over, the time limit is six months.

CRITERION 2 - Hospitalization at this hospital any time subsequent to this discharge.

CRITERION 3 - Admitted (from any source, including transfer from another health care facility) for conditions suggesting potential prior failure or adverse results of medical management.

CRITERION 4 - Hospital-incurred trauma.

CRITERION 5 - Untoward drug reaction while patient in hospital.

CRITERION 6 - Patient transferred from general care to special care or isolation unit, e.g., ICU, CCU, isolation (including transfer of newborn from delivery room to special care or isolation unit).

CRITERION 7 - Patient transferred to another acute care facility.

CRITERION 8 - Patient returned to operating room on this admission.

CRITERION 9 - Patient treated medically or subjected to operation for repair of a laceration, perforation, tear or puncture of an organ subsequent to the performance of an invasive procedure.

CRITERION 10- Acute myocardial infarction, cerebrovascular accident, or pulmonary embolism during or following a surgical procedure on same admission.

CRITERION 11- Neurological deficit (not present at admission or prior to surgery) on last full day prior to and/or on day of discharge.

CRITERION 12- Death

CRITERION 13- Length of stay exceed two standard deviations of the "normal" length of stay (or other appropriate contemporaneous standard) for the primary diagnosis in a patient over 50 years of age; for patient less than 50, length of stay exceeding 1.5 standard deviations.

CRITERION 14- Febrile: Oral temperature equal to or more than 101° F (38.3° C) or unexplained abnormal vital signs on last full day prior to and/or on day of discharge.

CRITERION 15- Cardiac or respiratory arrest, including newborns with Apgar score less than 6 at five minutes after birth requiring resuscitation in delivery room.

CRITERION 16- Obstetrical mishap or complication of abortion, labor, or delivery.

CRITERION 17- Other complications.

MEDICAL PRACTICE STUDY CRITERIA

CRITERION 1 - Hospitalization at this or any other acute care hospital prior to this admission: For patients under 65, the time limit is one year: for patients 65 and over, the time limit is six months.

CRITERION 2 - Hospitalization for a possible related adverse event at any hospital any time subsequent to this discharge.

CRITERION 3 - Admitted (from any source, including transfer from another health care facility or private physician's office) for conditions suggesting potential prior failure or untoward results of management.

CRITERION 4 - Hospital-incurred trauma

CRITERION 5 - Untoward drug reaction

CRITERION 6 - Patient transferred from general care to special care or isolation, e.g. ICU, CCU, isolation (including transfer of newborn from delivery room to special care or isolation unit).

CRITERION 7 - Patient transferred to another acute care facility.

CRITERION 8 - Patient returned to operating room on this admission.

CRITERION 9 - Patient treated medically or subjected to operation for repair of a laceration, perforation, tear or puncture of an organ subsequent to the performance of an invasive procedure.

CRITERION 10- Acute myocardial infarction, cerebrovascular accident, or pulmonary embolism during or following any surgical or invasive procedure on same admission.

CRITERION 11- Neurological deficit (not present at admission or prior to surgery) at time of discharge.

CRITERION 12- Death.

CRITERION 13- Febrile: Oral temperature equal to or more than 101° F (38.3° C) or other unexplained abnormal vital signs on last full day prior to and/or on day of discharge.

CRITERION 14- Cardiac or respiratory arrest, including newborns with Apgar score less than 6 at five minutes after birth requiring resuscitation in delivery room.

CRITERION 15- Obstetrical mishap or complication of abortion, labor, or delivery.

CRITERION 16- Other undesirable outcomes.

CRITERION 17- Correspondence from a hospital administrator, an attorney, patient, or relative that suggests litigation is pending or contemplated.

CRITERION 18- Length of stay above 90th percentile for diagnosis - related group in patients under 70, and 95th percentile in those 70 or older.

Appendix 5 C

HOSPITAL RECORD SCREENING MANUAL

FOR

MEDICAL PRACTICE STUDY

Prepared by the Medical Practice Study Group

Harvard Schools of Public Health,

Medicine and Law

April 1988

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SECTION 1: FOREWORD AND ACKNOWLEDGEMENTS

The purpose of this manual is to instruct professional record review personnel for the survey of hospital records for the Medical Practice Study.

As part of this study, record review personnel will screen hospital records for adverse events. The screen will be the first step in a review process designed to compile data for the investigation of issues of (a) patient injury, (b) patient compensation, (c) complications due to diagnostic studies or treatment, (d) complications necessitating prolonged patient care, (e) patient management problems necessitating education or discipline of medical personnel, and (f) patient injury resulting from system errors such as inadequate communications. The results of this study will eventually contribute to a policy analysis of the medical liability and compensation issues plaguing the United States today.

We are indebted to the California Medical and Hospital Associations for their 1977 "Report on the Medical Insurance Feasibility Study." Much of the methodology in their report has been broadly adopted by us after consultation with the principal author, Professor Don Harper Mills. Some departures from the methodology of the California study are based on improvements suggested by Professor Mills and on modifications we introduced because of changes in medical practice over the past ten years. Our intention is to assemble data that will in certain respects be compared to the earlier California study.

In the preparation of this manual, we are particularly indebted to the Ad Hoc Work Group to Study Medical Liability Alternatives of the Medical Society of the State of New York. We suggest that this manual be used as a permanent notebook in which unusual cases or interpretations may be briefly recorded for subsequent discussion and for establishing consistent policies in

interpretation for all medical record administrators. The blank pages are planned to permit such notations next to the relevant criteria.

April 1988

SECTION 2: PROCEDURES FOR RECORD PROFESSIONALS

I. OVERVIEW

The hospital record review portion of the Medical Practice Study consists of several stages. The Department of Health of New York State will provide raw data from which will be drawn a representative sample of hospitals discharges at 50 hospitals across the state. Medical records professionals will first screen approximately 30,000 medical records to determine whether the hospitalization in question meets any of 17 criteria. Any case for which at least one criterion is met will be referred to two physicians, who will perform independent reviews. If the physicians come to different conclusions about the chart, a third physician will review the record. Results will be forwarded to Boston, and a survey firm will then contact patients to determine the economic impact of illness and hospitalization on their lives. None of the interviewers or patients will have information on the results of the medical record review, and the interviewers are instructed not to discuss issues of medical care.

II. INITIAL CHART VERIFICATION

A. The Hospital Medical Record List

Each hospital will have a list of all medical records to be pulled for the Medical Practice Study. These lists will contain medical record numbers sorted whenever possible to comply with standard record room storage conventions. In addition, the Medical Practice Study will have a list of records with both medical record numbers and the unique 7-digit identifier. Tracking of all information for the study will be by means of the 7-digit case number. You should refer to this number if any problems arise in the course of your work.

B. The Hospital Record Screen Form

The hospital record screen form is a 3-page, computer generated document bearing a unique 7-digit identifier. Preprinted on the form are Health Department data on each hospital stay. Hospital name, medical record number, admission number, admission date, and discharge date will enable the medical record administrator to locate the hospitalization to be subjected to the screening process outlined in Sections 3 and 4 of this manual.

Page 1 lists patient identification data and provides the reviewer with blanks for information and comments required in part IV of this section. Page 2 lists physician and diagnostic data. Page 3 lists briefly the 17 screening criteria and leaves room for the medical record professional to note reasons for checking a criterion.

C. Verification of patient identification

First, you should verify that the person identified in the 3-page form is the same patient as in the medical record. If there are flagrant age, sex, or diagnosis discrepancies, set aside the medical record for resolution of the error. Next, you should print the name of the patient, and if available the social security number, in the spaces provided on page 1 of the Hospital Record Screen form. <u>You should write in the patient name (and social security number) for every record you review, whether or not you find any of the 17 criteria outlined in section 3 of this manual.</u>

D. Index hospitalization

The index hospitalization is the unique inpatient stay that is the subject of this review. The medical record number, admission number and admission and discharge dates define the index hospitalization. In applying the screening criteria

outlined in section 4, you should base your determinations on the fact that the index hospitalization included either (1) an adverse event, or (2) medical management that produced an adverse event documented subsequently in the hospital record.

III. THE 17-CRITERIA SCREEN

The overall purpose of the medical record professional is to flag medical records for review by a physician. For hospitalizations which exceed a threshold length of stay, the records can be sent directly to the physician after you have completed and verified all patient identification information (see part IV below). On page 2 of the hospital record screen form, look for the message "LOS OUTLIER, SKIP SCREEN STEP". If you do not find this message, you must look for one of the 17 other screening criteria outlined in section 4.

When you find one criterion is met, you must complete page 3 of the hospital record screen form. Once you have found 1 criterion, you should not look for others. If in the course of your review you find more than one, feel free to check additional criteria, if doing so will not increase the time of your review.

IV. PATIENT IDENTIFICATION INFORMATION

For any record which either meets one of the 17 criteria, or length-of-stay exceeds the threshold length-of-stay, or is a Reliability case (marked for the Leader on the Worksheet), you must obtain complete patient descriptive information. For information on patient name, social security number, employment status, and occupation, you should consult first the face sheet and additional documents from the index hospitalization in 1984. For all other patient information, you should first consult the most recent admission in the patient's record to obtain the most up-to-date facts. After examining the last admission, you should then check any additional hospitalizations since the index

admission.

Medical records will vary considerably in format and content. You should examine face sheets, patient profiles (which might also be described as the social history or family assessment), nursing history, and consent forms, for in-patient admissions or outpatient visits, including emergency room records. All handwriting must be legible, and all abbreviations should be commonly understood, so that interviewers will contact the correct person at the correct address. Below are some general guidelines for this process. When in doubt, you should use section "other patient information" on the bottom of page 1 of the Hospital Record Screen form to alert subsequent reviewers to an inconsistency or discrepancy.

1. INFORMATION TO BE INCLUDED ON THE HOSPITAL RECORD SCREEN

A. PATIENT

1) Name (maiden and married names, if divorced)
2) Address (including changes or discrepancies between documents)
3) Telephone number (including multiple numbers, changes or discrepancies)
4) Demographics (sex, age, race, marital status, employment status)
5) Most recent employer and employee telephone number (note if self-employed)
6) Social security number

B. NEXT OF KIN (include even if living with patient because patient and next of kin may have split up and next of kin may be easier to locate)

1) Relationship to patient
2) Name
3) Address
4) Telephone number
5) Most recent employer and employer's telephone

number (note if self-employed)

C. GUARANTOR (if different from patient and next of kin)
   1) Same information as listed above for next of kin

D. OTHER DESCRIPTIVE INFORMATION
   1) If patient is a child and the parents are divorced or separated, name, address and telephone number of non-custodial parent, if known
   2) Note if non-English speaking (if so, record native language)
   3) Briefly describe any cognitive or emotional problems that might make interview difficult to administer (e.g., illiteracy)

E. Disposition and Third Party Payer Information
   1) For each case sent for second-stage review, the reviewer must verify information of page 2 of the Hospital Record Screen.
   2) Note any necessary changes by crossing out the error, and checking the appropriate response or writing in the correct information.

2. REVIEW PROCESS

A. Review the following documents for the sampled admission and complete the Hospital Record Screen.
   1) Medical history face sheet
   2) Patient profile (which may also be described as the "nursing history," "social history," or "family assessment"). Other terms that are commonly used to describe forms that provide a personal history should be added.
   3) Consent form

B. First, obtain patient name, social security number, employment status and occupation from the 1984 index hospitalization.

C. Next, examine documents from the most recent admission or out-patient visit for the most up-to-date information.

D. Third, look at any intervening hospitalizations for any additional information or for changes or inconsistencies.

E. Summary of changes or discrepancies to look for:

1) Changes in the patient's next of kin or guarantor
2) Changes in the home address or telephone number or any of the above
3) Changes in employer or employer's telephone number for any of the above
4) Discrepancies in telephone numbers at the same address (which may indicate transposition errors)
5) Differences in the spelling of names, addresses or employers (which should be noted)

3. SPECIAL CHECKS

A. <u>IN-PATIENT ADMISSIONS - MEDICAL HISTORY FACE SHEET</u>

1) The face sheet typically contains information on patient's address, telephone number, next of kin (including relationship), demographic characteristics, and employment status (including whether homemaker or child). Note if the next of kin has a different address and/or telephone number from the patient.
2) The face sheet will often list the guarantor (or payer), who may be different from the patient and next of kin. If so, record his or her name, address and telephone number.
3) Sometimes the patient will have a different telephone number from his or her next of kin, even though they show the same address. Record both telephone numbers.
4) The employer will typically be recorded for payer

or guarantor; however, employer may also be recorded for the patient, next of kin, and guarantor, if they are different. Record the employer's telephone number if listed. Sometimes the guarantor's employer (name and telephone number) will be listed under a commercial health insurance policy (which may be a secondary policy). An example would be "...secondary insurance with husband's employer, Ashland Oil."

5) Note if the patient, next or kin or guarantor is self-employed (e.g., company has same name as person).

6) Define any acronyms or abbreviations

B. PATIENT PROFILE OR SOCIAL HISTORY

1) Most hospital admissions include the patient's personal and family history, which is contained in a document variously described as a "patient profile," "nursing history," "social history," "family assessment," etc. (include other descriptions).

2) The patient profile typically will include information on the patient's address and phone number, and demographic characteristics. These items should be compared to the face sheet for consistency and any differences noted.

3) The patient profile may also include information on the patient's next of kin or guarantor (such as employer, home and office telephone number) that may not appear on the face sheet or that may be different from the face sheet. Record any additional information or differences.

4) If the patient is under age 18, the patient profile may provide information on the names and addresses on the non- custodial, next of kin (if the parents are separated or divorced).

5) For the elderly patient, the Next of Kin will

often be a child who may also live at a different address from the patient or have a different last name.

6) Review any marginal notes or comments for information that may indicate an interviewing problem, such as illiteracy, non-English speaking, marital separation, cognitive or emotional problems.

C. CONSENT FORM

Briefly review the consent form and note if the signature is awkward (a possible literacy problem) or if any marginal notes were recorded concerning the patient's next of kin (e.g., the person signing the consent form may be a non-custodial parent).

D. EMERGENCY ROOM MEDICAL RECORD FACE SHEET

The face sheet typically contains many of the same descriptive items included on the in-patient medical record face sheet. Review any out-patient records that occurred subsequent to the sampled in-patient admission to determine if there are any changes in next of kin or guarantor, or in the address, telephone number, or employer recorded for the patient, next of kin, or guarantor.

SECTION 3: PRINCIPLES OF ADVERSE EVENT SELECTION AND CLASSIFICATION FOR THIS STUDY

1. Fundamental Definitions:

AN ADVERSE EVENT (AE) is a disability occurring as a consequence of to health care management.

A. A DISABILITY is a temporary or permanent impairment of physical (including disfigurement) or mental function or economic loss even in the absence of such impairment.

B. HEALTH CARE MANAGEMENT includes both affirmative actions (commission) and inactions (omission) of any health care provider or attendant, whether or not such actions or inactions constitute legal fault.

C. Disabilities caused by a disease process (and not by medical management) do NOT constitute and AE.

2. Five Minimum Disability Thresholds Definitions for an Adverse Event:

A. It OCCURRED DURING the sample hospitalization and PROLONGED the patient's length of stay (LOS) or CONTINUED after discharge from the hospital (Example: postoperative wound infection which was not substantially resolved within the assigned LOS for this study); or

B. It was RESPONSIBLE for admission to the sample hospital, whether for observation or treatment (Example: admission for observation following a drug reaction in the office); or

C. It was TREATED during the sample hospitalization even

though it had occurred prior to admission and was not the reason for admission (Example: patient admitted for treatment of a fractured humerus. During hospitalization, an abdominal incisional hernia was repaired); or

D. It was PRESENT during the sample hospitalization even though it had occurred any time prior to admission, it was not the reason for admission, and it was not treated during this admission, provided:

(1) It was characterized as at least a "major permanent partial disability;"
(2) It was the type of disability that does not usually require hospitalization for its management; and
(3) It occurred subsequent to January 1, 1981. Example: disfiguring keloid scar in a surgical incision in a patient admitted for hypertension.

E. The causative event OCCURRED DURING the index hospitalization, producing an adverse event of delayed onset severe enough to require subsequent rehospitalization for its treatment. (Example: delayed small bowel obstruction due to adhesions following hysterectomy performed during this admission)

As a corollary, an adverse event is inconsequential and not relevant to this study if it (1) occurred during the index hospitalization, (2) was completely, or nearly completely, resolved within the usual course of hospitalization for the disease and patient type, and (3) would probably not cause continuing disability following discharge from the hospital. (Example: hematoma at site of venipuncture)

ADDITION No. 1 - 5/5/88

GENERAL PRINCIPLES OF SCREENING

The process of screening can be simplified by bearing in mind the following principles:

1. If an event, such as readmission, is part of a planned program of treatment, it does not fulfill the screening criteria 1, 2, 3, 7, sometimes 8, or 12 if, for example, the patient was classified DNR on admission. If there is evidence in the chart that the action is part of a previously determined plan, the chart should not be referred for physician review.

2. If an event, such as a readmission, can reasonably be attributed to progression of a disease process whose course cannot be controlled in the present state of medical knowledge, the chart should not be referred for physician review. An example might be readmission for small bowel obstruction due to metastatic carcinoma of the pancreas.

3. The consequence of an event that occurred during the index hospitalization may become apparent only later, leading to readmission or other disability. If the reviewer is suspicious that the patient's course after the index hospitalization might have been influenced by events during the index hospitalization, the chart should be referred for physician review.

SECTION 4: SCREENING CRITERIA

If a reviewed record meets any one of the following criteria, it is referred for review by a physician. It is not necessary to determine if more than one criterion is met.

The following first fifteen criteria are not a set of mutually exclusive or exhaustive criteria to allow reviewers to spot records of all patients that have had an adverse event. They alert the reviewer to a large majority of such records but some records representing an adverse event will be referred for physician review only on the basis of Criterion 16, "Other Undesirable Outcomes", a criterion that depends critically on the ingenuity, imagination and judgement of the initial reviewer to consider other unclassified circumstances. The first fifteen criteria are not mutually exclusive as any record could qualify for more than one criterion such as a patient with an index hospitalization for treatment of hospital-incurred trauma (Criterion 4) which occurred at a previous hospitalization within a year of the index hospitalization (Criterion 1).

CRITERION 1 - **Prior hospitalization within 1 year (Patient less than 65); within 6 months (Patient 65 or older)**

Element:

Hospitalization at this or any other acute care hospital prior to the index admission: For patients under 65, the time limit is one year; for patients 65 and over, the time limit is six months.

Exceptions:

A. This admission is for normal delivery.
B. Dates of year of prior hospitalizations not ascertainable, but probably greater than one year or six months, respectively, prior to the index admission.
C. Prior hospitalization obviously not related to index hospitalization.

Instruction for Data Retrieval:

A. If the prior admissions were in <u>this</u> hospital, report dates, record numbers, final diagnosis, procedures performed, and plans for future procedures from prior record unless Exception C applies.

DISCUSSION:

This criterion identifies the record of any patient previously hospitalized within a specified time period unless the index hospitalization was for normal delivery or an obviously unrelated condition. We wish to review both present and prior records, if available, to help determine whether the patient's present condition was related to prior medical management unless Exception C applies.

EXAMPLES:

1. Index admission was for metastatic rectal carcinoma. Ten months previously the patient was hospitalized for hemorrhoidectomy. The reviewer examines both records and determines a possible relation between the cancer and the hemorrhoids as the diagnosis could be confused and delay

prompt cancer therapy.

2. Index admission was for metastatic rectal carcinoma. Ten months previously the patient was hospitalized for treatment of a fractured humerus caused by an automobile accident. There is no obvious connection between the fracture and the cancer.

In the first example the record is referred for physician review, but not in the second example.

CRITERION 2 - **Subsequent admission this hospital**

Element:

Hospitalization for a possible related adverse event at any hospital any time subsequent to this discharge.

Exceptions:

A. Subsequent hospitalization obviously not related to index hospitalization.

Instructions for Data Retrieval:

A. Report dates, record numbers, diagnoses, procedures and to where discharged (or died) unless Exception A applies.

DISCUSSION:

This review of subsequent hospitalization records might provide clues to untoward events whose causal events occurred during the index hospitalization but were not identifiable in the present record because of a delayed outcome, a missed diagnosis, or other reason.

EXAMPLES:

1. Index admission was for surgery during the course of which a blood transfusion was given. Subsequent hospitalization was for serum hepatitis.

2. Index admission was total hip replacement for surgery during the course of which, blood transfusion was given. Subsequent hospitalization was for total hip replacement on the opposite side.

In the first example the record is referred for physician review, but not in the second example.

CRITERION 3 - **Prior medical management failure**

Element:

Admitted (from any source, including transfer from another health care facility or private physician's office) for conditions suggesting potential prior failure or untoward results of management.

Exceptions:

None.

DISCUSSION:

By this criterion all records containing information that raised any questions concerning the relationship between the patient's condition on admission and prior management are identified for review by physicians. Read the admitting history for statements of attribution by the admitting physician. A list of diagnoses frequently associated with iatrogenic injury is provided. (List A, below)

EXAMPLES:

Use "hunches" and those clues for conditions potentially related to prior failure or untoward results of management:

(a) Condition occurred while patient taking drug (e.g. Parkinsonism/tranquilizers; lupus erythematosus/pronestyl; phlebitis/birth control pills; GI Bleeding and any statement of possible attribution to drugs, especially aspirin compounds, steroids, butazolidin, indocin, reserpine, and all anticoagulants; congenital birth defect and any statement of possible attribution to drugs during pregnancy; any transfusion reaction, hemolytic reaction, anaphylactic reaction, serious sickness or hepatitis, aplastic anemia, thrombocytopenia, or exfoliative dermatitis; diabetic patients out of control due to high or low insulin therapy);

(b) Missed diagnosis (e.g. advanced tuberculosis, metastatic cancer, appendicitis as suggested by

intraperitoneal abscess);

(c) Malunion or non-union of fractures;

(d) Untoward results of outpatient therapy/procedures (e.g., burns from irradiation, physical defects from plastic procedures, neurological deficits following treatments);

(e) Condition may occur as a complication of operative or hazardous procedure previously performed (e.g., incisional hernia, prolonged hoarseness following bronchoscopy, pneumothorax following a chest tap);

(f) Failure to screen, including lack of stool guaiac checks in patient with colon cancer; lack of mammograms in patient with breast cancer; lack of Pap smear in patient with cervical cancer; and lack of appropriate follow-up of hypertensive patients.

(g) Possibility of indicated therapy having been omitted (e.g. appropriate sedation for conditions prone to develop convulsions, appropriate antibiotics prior to oral surgery in patients with a cardiac valve prosthesis, appropriate hospitalization for observation following head trauma, etc.)

List A for Criterion 3

Radiation therapy injury
Leukemia or lymphoma following therapy for a primary tumor
Hypothyroidism following radiation therapy
Aplastic anemia in patient on antibiotics or other medications
Thrombocytopenia in patient taking medications
Acquired hydrocephalus
Decubitus ulcer
Stevens-Johnson syndrome
Aspiration pneumonia
Acute tubular necrosis
Nonunion, malunion of fracture

Retrolental fibroplasia
Hepatitis following admission to hospital
Pulmonary embolus following operation
Mumps, measles in patients under 17 years of age
Complications in the healing of surgical incisions
Complications in the general anatomical location of an operation (intestinal obstructive following laparotomy, incontinence following TUR, palsies or paresthesis explained by trauma to nerves at an operation, etc.)

CRITERION 4 - **Hospital-incurred trauma**

Element:

Hospital-incurred trauma

Exceptions:

A. Resulting problems resolved prior to discharge and did not require treatments extending length of stay

DISCUSSION:

This criterion identifies for review those records documenting a serious hospital-incurred trauma not resolved by the time of discharge or requiring treatment that extended the period of hospitalization. Exception A excludes such trauma as IV infiltrates, phlebitis of arm, falls resulting in bruises only, lacerations not requiring sutures, minor chemical burns from skin preps, etc.

EXAMPLES:

Fractures, significant burns, lacerations requiring sutures, loss of or damage to teeth, disabilities with loss of motion of extremities not present on admission.

Instrument breakage such as malfunction in a bronchoscope that results in hemorrhage in the lung.

Injury that occurs during intubation such as damage to the larynx or perforation of a viscus.

Medication or transfusion error causing an adverse event.
Pneumothorax following central intravenous line placement.

Allergic reaction resulting in systemic reaction such as hypotension requiring medical treatment or renal damage following contrast injection.

Aspiration pneumonia following oversedation of patient.

Embolic event following any invasive diagnostic procedure such as those following manipulation.

Osteomyelitis developing postoperatively.

Postoperative genito-urinary or recto-vaginal fistula or intestinal perforation.

Endocarditis following cardiac catheterization or surgery.

CRITERION 5 - **Untoward drug reaction**

Element:

Untoward drug reaction

Exceptions:

None

DISCUSSION:

Records documenting a drug reaction that occurred in the hospital or caused a hospital admission are identified for review by this criterion. However, for those reactions occurring in the index hospitalization they must lead to problems that remained unresolved by the time of discharge or required an increased length of stay to qualify for further review by physicians.

EXAMPLES:

See Example (a) for Criterion 3.

Toxic drug levels leading to morbidity such as a seizure and fracture following theophylline overdose.

Acute tubular necrosis following aminoglycoside therapy.

Gastrointestinal bleeding after aspirin administration

Severe hypoglycemic reaction in patient on insulin or oral hypoglycemic.

CRITERION 6 - **Transfer to special care unit**

Element:

Patient transferred from general care to special care or isolation, e.g. ICU, CCU, isolation (including transfer of newborn from delivery room to special care or isolation unit).

Exceptions:

A. Scheduled prior to surgery because need for special care recognized in advance.
B. ICU used as recovery room.
C. Admission through or transfer from emergency service area.
D. Isolated for administration of radiation therapy immunosuppressive therapy, or burn therapy.
E. ICU used as admitting holding area until general bed available.

Instructions for Data Retrieval:

A. Obtain list of special care units in this hospital
B. For Exception A: Pre-op notes or orders specify post-op care in special unit
C. For Exception B: Stay in ICU less than one day and orders and nurses' notes document observation primarily, not therapy other than usual postoperative support such as O2, IV's, etc.
D. For exception E: Temporary stay on admission with no intensive nursing care initiated.

DISCUSSION:

An unscheduled patient transfer from a general care unit to a special care unit might be a signal for the presence of an adverse event. Criterion 6 flags any record documenting such a transfer. Where a transfer is documented, the reviewer then checks for the documentation of any of the listed exceptions that reflected the non-adverse event related reasons for transfer to special care unit. If none

of the exceptions are found in the record, the chart is referred to a physician to determine whether or not an untoward event is responsible for the transfer.

EXAMPLES:

1. A patient was admitted to the general floor with a diagnosis of "epigastric pain, unknown etiology." Twenty-four hours later the patient was transferred to CCU in shock. Since none of the situations specified by the exceptions was present, the record was referred for physician review for the possibility of an adverse event (e.g. delay in diagnosis leading to worsening of patient's condition).

2. A patient recovering from general anesthesia was discharged from the recovery room to the general floor only to be reintubated as an emergency measure and returned to recovery room because of hypoventilation due to morphine sedation, the medical management causing the adverse event which was anoxia secondary to hypoventilation.

3. A patient undergoing cardiac catheterization had continual severe chest pain and hypotension which required observation and support in CCU.

4. A patient with myasthenia gravis following excision of a thymoma was admitted to an ICU for titration of the anticholinesterase medication. The pre-operative notes planned for this sensitive therapy to be closely monitored in an ICU during the postoperative period.

Only the first three examples would be referred for physician review.

CRITERION 7 - **Transfer to acute care hospital**

Element:

Patient transferred to another acute care facility

Exceptions:

A. Mandatory transfer to government, HMO facility, or other unit for administrative reasons.

B. Transfer for test, procedure, or specialized care not available at this hospital always provided that transfer was obviously <u>not</u> precipitated by an unexpected deterioration in the patient's condition.

Instructions for Data Retrieval:

Report name and location of second facility, state reasons for transfer and transfer diagnosis, if ascertainable.

DISCUSSION:

A transfer to another acute care facility for other than administrative reasons or for a special test, procedure, or specialized care not available in this hospital is reviewed in order to determine whether or not an adverse event is responsible for the transfer.

EXAMPLES:

1. Reviewer noted that a newborn, 12 hours after the delivery, went into shock and was transferred to a specialty pediatric hospital. A critical review by a physician disclosed that an esophageal tube was passed with difficulty and that three hours later a nurse noted and reported to the physician that bright red blood was present in the infant's mouth. An x-ray was taken just before transfer disclosed hemopneumothorax.

2. A patient from a day surgical clinic was transferred to an acute care facility.

3. In a small rural hospital a patient was admitted with a serious head injury, an alcoholic breath, and in coma. The vital signs and respirations of the patient over several hours did not stabilize during the neurological diagnostic workup, and the gradual deterioration prompted the hospital to refer the patient to a neurosurgical center for a craniotomy as a subdural hematoma was the probable diagnosis.

The first two examples would be referred for physician review but not the third case as the hospital review apparently forwarded the patient as soon as it became clear that a neurosurgical procedure probably was needed in view of the continuing deterioration. If delays and misjudgments were remotely suspected in the diagnostic workup, the record would be referred for physician review.

CRITERION 8 - **Return to O.R. this admission**

Element:

Patient returned to operating room on this admission.

Exceptions:

A. Planned second procedure or second stage procedure.

Instructions for Data Retrieval:

A. Consult reason for return generally given in a progress note, consult note, or operative report. Consider delivery as a first operation.

B. For Exception A admission, progress, or consult note must demonstrate a "plan" made prior to first operation indicating staged or second procedure.

DISCUSSION:

Criterion 8 calls for the review of all unplanned returns to the operating room in order to determine whether or not an adverse event had occurred requiring this return for additional surgery.

EXAMPLES:

1. On the day after admission, a patient was subjected to a hysterectomy followed by reoperation four days later to investigate the cause of urine draining through the vagina.

2. A patient admitted with third degree burns covering 40 per cent of the body had 15 skin grafting procedures as different parts of the burn were prepared for autografts.

Only the first case would be referred for physician review as multiple skin grafting procedures are an acceptable way to manage extensive third degree burns. Referral for physician review would be considered if a skin grafting procedure did not result in a successful graft.

CRITERION 9 - **Damaged organ subsequent to an invasive procedure**
Element:

Patient treated medically or subjected to operation for repair of a laceration, perforation, tear or puncture of an organ subsequent to the performance of an invasive procedure.

Exceptions:

None.

Instructions for Data Retrieval:

Injuries to organs or tissues during a procedure that are recognized and repaired during the procedure are not included unless such repair is followed by an adverse event such as a prolonged hospitalization or disability following hospitalization.

Invasive procedures include: intubations (tracheal, esophageal, gastric, etc.); percutaneous aspirations (thoracentesis, pericardiocentesis, paracentesis, bladder aspiration, lumbar puncture, etc.); percutaneous biopsy (breast, thyroid, heart, liver, kidney, lungs, prostate, etc.) catheterization (heart, bladder, vascular system, etc.); endoscopies (bronchoscopy, cystoscopy, colonoscopy, esophagoscopy, mediastinoscopy, peritoneoscopy, culdoscopy, urethroscopy, ureteroscopy, arthroscopy, etc.); x-ray procedures (arteriograms, ventriculograms, bronchograms, pneumoencephalograms); miscellaneous (pacemaker insertion, Scribner shunt for dialysis, etc.).

DISCUSSION:

Criterion 9 screens for all surgical repairs or organs damaged following invasive procedures. This criterion is actually a subset of Criterion 4; however, Criterion 9 isnecessary to focus the reviewer's attention to the sequence of an invasive procedure followed by unusual medical therapy or by a surgical repair procedure.

EXAMPLES:

1. A patient was admitted to the hospital for the purpose of an esophagoscopy which was performed on the second hospitalization day. Within hours after the esophagoscopy the patient was taken to the operating room for the repair of an esophagal tear. Had the following operative procedure been for the performance of the treatment of a disease found at esophagoscopy, the case would not have been flagged by Criterion 9.

2. Cholecystitis, pancreatitis, or perforation following endoscopy.

3. Damage to vocal cords or hemorrhage following bronchoscopy.

4. Surgical intervention following cardiac catheterization.

5. A patient during a radical dissection for retroperitoneal malignant disease has a ureter accidentally transected, recognized, and immediately repaired. The postoperative course was not complicated in any way by the ureteral repair.

The last example would not be referred for physician review as an adverse event did not occur. Had a ureteral obstruction developed at site of the ureteral repair and required further treatment or had resulted in impaired function or infection of the ipsilateral kidney the record would be referred to a physician because of the adverse event.

CRITERION 10 - **Acute MI and surgical procedure**

Element:

Acute myocardial infarction, cerebrovascular accident, or pulmonary embolism during or following any surgical or invasive procedure on same admission.

Exceptions:

None.

DISCUSSION:

This criterion is designed to flag records of patients who sustained myocardial infarction, cerebrovascular accident, or pulmonary embolism during surgery or in the postoperative period. Of necessity some patients who entered with a myocardial infarction and were subsequently operated upon for myocardial revascularization are flagged by this criterion. These cases are referred so the relationship between the complication and the treatment can be critically reviewed by a physician.

This criterion tends to duplicate part of Criterion 6 because patients who developed major postoperative complications generally would be transferred to special care units.

EXAMPLES:

1. A patient entered for the performance of a gastrectomy, followed two days later by the diagnosis of an acute myocardial infarction with transferral to the CCU.

2. A patient with a history of pulmonary emboli from leg veins unresponsive to anticoagulation is operated upon to interrupt the superficial femoral veins. Following this operation another embolus is lodged in the lungs on the first post-operative day. Despite the likelihood that the last embolus had formed prior to the operation on the femoral veins and probably was not caused by any treatment,

complicated clinical decisions of this sort are always referred for physician review.

CRITERION 11 - **Neurological deficit at discharge**

Element:

Neurological deficit (not present at admission or prior to surgery) at time of discharge.

Exceptions:

None.

Instructions for Data Retrieval:

A. We are concerned here with convulsions ("seizures, fits, spells"); loss of consciousness (coma, fainting); impairment of memory or cognition; impairment of senses (taste, sight, hearing, numbness); impairment of motor functions (paralysis, weakness of extremities, hemiparesis, paraplegia, quadriplegia or tetraplegia, stroke, CVA, weakness of face, speech defect); urinary or fecal incontinence; see especially progress, nurses' and consult notes.

DISCUSSION:

Criterion 11 requires that the chart of any patient still demonstrating a hospital acquired neurological deficit (not present on admission) be reviewed. The instructions provide clues to the reviewers for identifying situations that might demonstrate such a deficit.

EXAMPLES:

1. On the day of discharge following a tonsillectomy, a five-year-old patient was noted by the nurses to be limping and seemed to have weakness of the right leg. A critical review of the record revealed that preoperative and postoperative injections had been given into the right buttock.

2. New onset seizure disorder.

3. Following general anesthesia for a 90 year old patient,

nurses' notes related family reports of subtle changes in memory and recall for recent events not present prior to anesthesia.

CRITERION 12 - **Death**

Element:

Death.

Exceptions:

Patient admitted for planned terminal care, had a DNR order, or was gravely ill from a major disease process such as massive trauma, thermal burns >50%, etc.

Instructions for Data Retrieval:

For the Exception, history must reveal a very sick patient, but admitting notes and orders must reflect palliation and not diagnostic or therapeutic maneuvers, or history and progress notes reveal an almost insurmountable medical problem caused by the patient's condition <u>at the time of admission</u> to the hospital. This extremely poor prognosis would be a consequence of the disease process, not a consequence of therapy.

EXAMPLES:

1. A patient with metastatic cancer spread throughout the abdomen and lungs was admitted because of intestinal obstruction for the fourth time. A severe pneumonia developed and because of the terminal status of the patient and no prospect of leaving the hospital, limited therapy was provided and DNR order written. The patient died of anoxia and cardiac arrest.

2. A patient following an automobile accident and thermal burns was admitted with multiple rib fractures, pelvic fractures, cranial fracture and a 60% surface area 2nd and 3rd degree burn. The extremely poor prognosis was recognized at the time of admission, and major therapeutic efforts never stopped the deterioration of the CNS function or pulmonary function. A severe pneumonia developed and the patient died of anoxia and cardiac arrest.

3. A patient was admitted with the complaint of nausea and apprehension immediately following a nuclear reactor accident exposing her to a lethal dose of radiation. Her good physical condition rapidly deteriorated resulting in death on the 18th hospital day despite therapy.

4. A patient following general anesthesia for an elective and uneventful cholecystectomy vomited in the recovery room and developed extensive aspirative pneumonia. An endotracheal tube was incorrectly placed in the esophagus, and before this was corrected the patient had a cardiac arrest and could not be resuscitated.

The first three examples would not be referred for physician review, but the last one would be referred as the death was unexpected and precipitated by the medical management.

CRITERION 13 - **Temperature > 101 F prior to discharge**

Element:

Febrile: Oral temperature equal to or more than 101 F (38.3 C) or other unexplained abnormal vital signs on last full day prior to and\or on day of discharge.

Exceptions:

Diseases in which fever is a symptom of the disease, i.e., Hodgkins disease, non-Hodgkins lymphoma, acute leukemia, renal cancer; carcinoma of the pancreas, lung, bone or liver; thyrotoxicosis, congestive heart failure (in absence of other causes such as myocardial infarction, pulmonary embolism, urinary tract infection, etc.)

DISCUSSION:

The presence of fever or other abnormal vital signs persisting to the day of discharge prompts a review of the record for a possible adverse event, considering the possibility that an undisclosed complication or an unresolved admitting problem persisted. The purpose of this criterion is to force a critical review of each such chart by a physician to determine if an unrecorded complication might have existed. Common sense will help in recognizing "abnormal vital signs" as abnormal means "unexpected", given the circumstances.

EXAMPLES:

1. A postoperative patient was discharged with a temperature of 101 degrees F. The nurse's note stated that the wound was erythematosus. The patient was readmitted with a severe wound infection.

2. A patient admitted for study of peptic ulcer symptoms was found unexpectedly to be mildly hypertensive, and a few days before discharge was started on thiazide diuretics. Blood pressure on the day of discharge (the third day on thiazide medication) was 160/105.

The first example would be referred for physician review, but the second example with the elevated blood pressure at time of discharge would be interpreted as a possible consequence of the duration of the thiazide therapy being only three days. Since blood pressure response is often delayed, hypertension of 160/105 could easily be an expected finding. This record need not be referred for physician review.

CRITERION 14 - **Cardiac or respiratory arrest**

Element:

Cardiac or respiratory arrest, including newborns with Apgar score less than 6 at five minutes after birth requiring resuscitation in delivery room.

Exceptions:

Patient admitted for planned terminal care, had a DNR order, or was gravely ill from a major disease process such as massive trauma, thermal burns > 50%, etc.

Instructions for Data Retrieval:

A. Assume arrest if any cardiac or pulmonary resuscitation is performed. Delivery room resuscitation includes intubation and suction, positive pressure oxygen, bag breathing, prolonged aspiration or tracheal suction, artificial respiration, etc., Check physician's and nurse's notes, delivery room record, and discharge summary.

B. Depending on the usage of individual obstetrical and pediatric neonatal services the maternal and neonatal records may be needed together to permit a judgement to be made as to a referral to a physician. Some information such as Apgar scores may be on maternal or neonatal records. When indicated or in doubt the complementary record of a mother-baby pair should be requested. Usually where a complication occurs in the mother, only the maternal record is needed. For the evaluation of a complication in the neonate, however, the maternal record is sometimes needed. Note that the index hospitalization refers only to the mother or neonate complications.

CRITERION 15 - **Obstetrical mishap**

Element:

Obstetrical mishap or complication of abortion, labor, or delivery.

Exceptions:

None.

Instructions for Data Retrieval:

A. We are concerned here with Apgar score less than 6 at five minutes, fetal distress noted, maternal blood loss requiring transfusion, high forceps delivery, maternal transfer to ICU, fetal transfer to PICU or NICU, etc. Caesarian sections, unless causing some unintended disability, are not considered to be an adverse event.

B. Depending on the usage of individual obstetrical and pediatric neonatal services the maternal and neonatal records may be needed together to permit a judgement to be made as to a referral to a physician. Some information such as Apgar scores may be on maternal or neonatal records. When indicated or in doubt the complementary record of a mother-baby pair should be requested. Note, as in Criterion 14, usually where a complication occurs in the mother, only the maternal record is needed. For the evaluation of a complication in the neonate the maternal record is sometimes needed. Note the index hospitalization refers only to the mother or neonate complications.

CRITERION 16 - **Other undesirable outcomes**

Element:

Other undesirable outcomes

Exceptions:

None.

Instructions for Data Retrieval:

A. Review documented complications and all otherwise unexplained major significant diagnostic, therapeutic maneuvers, or organ failures not present at admission and refer all records with any slight suspicion of an adverse event for physician review.

DISCUSSION:

This criterion allows the reviewers to exercise judgement in reporting any complications or questionable outcomes not addressed by other criteria. Concerns or skepticism on the part of the reviewers as to the possible relation of medical management to an undesirable outcome warrant additional review of the record by physicians. Imagination, past experience, common sense, "tricks" and signal events, hunches, flashes of intuition, and the like all play a role here. Often errors of omission are recognized under this criterion.

EXAMPLES:

1. A patient receiving immunosuppressive therapy for cancer including corticosteroids was admitted to a hospital for treatment of dyspnea, fever, and cough. Sputum examination was not helpful in identifying a pathogen and erythromycin was started as an effective agent for M. pneumoniae or H. influenzae, which represent two common pathogens. After no improvement in six days and an alarming deterioration in chest x-rays, it was realized that the immunosuppressive therapy could be the basis for P. carinii

pneumonia, and a week after admission specific therapy with pentamidine resulted in a delayed but ultimately successful cure of the pneumonia.

2. A patient underwent a difficult resection of a carcinoma of the lower sigmoid colon, and at the conclusion of the primary anastomosis the surgeon noted the cyanotic appearance of the proximal side of the anastomosis suggesting a marginal blood supply. He elected not to do a protective transverse colostomy "upstream." On the fourth postoperative day the patient developed peritonitis from a leak at the anastomosis. A transverse colostomy was performed, and the patient left the hospital four weeks later having recovered from his peritonitis and healed the anastomotic leak.

These two examples both represent errors of omission that might have been flagged by other criteria or perhaps by the impression that the clinical course was not optimal for some undefined (that is undefined in the hospital record) reason. Prompt testing for P. Carinii by bronchoscopic examination in the first example and performing a complementary colostomy at the time of the colon resection in the second example are errors of omission.

CRITERION 17 - **Correspondence indicating litigation**

Element:

Correspondence from a hospital administrator, an attorney, patient, or relative that suggests litigation is pending or contemplated.

Exceptions:

None.

Instructions for Data Retrieval:

Occasionally, the medical record will contain correspondence from a patient, an attorney, or a liability insurer, suggesting that the patient is dissatisfied with the quality of medical management. At some institutions, the medical record will be stamped "LEGAL" on the jacket. In other hospitals, correspondence is always segregated in a separate file outside the medical record department. When in doubt, the medical record administrator should circle number 17 and indicate in the note the location and nature of the correspondence.

PHYSICIAN RECORD REVIEW MANUAL

FOR

MEDICAL PRACTICE STUDY

Prepared by the Medical Practice Study Group

Harvard Schools of Public Health,

Medicine and Law

Contents

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SECTION I. MEDICAL RECORDS REVIEW

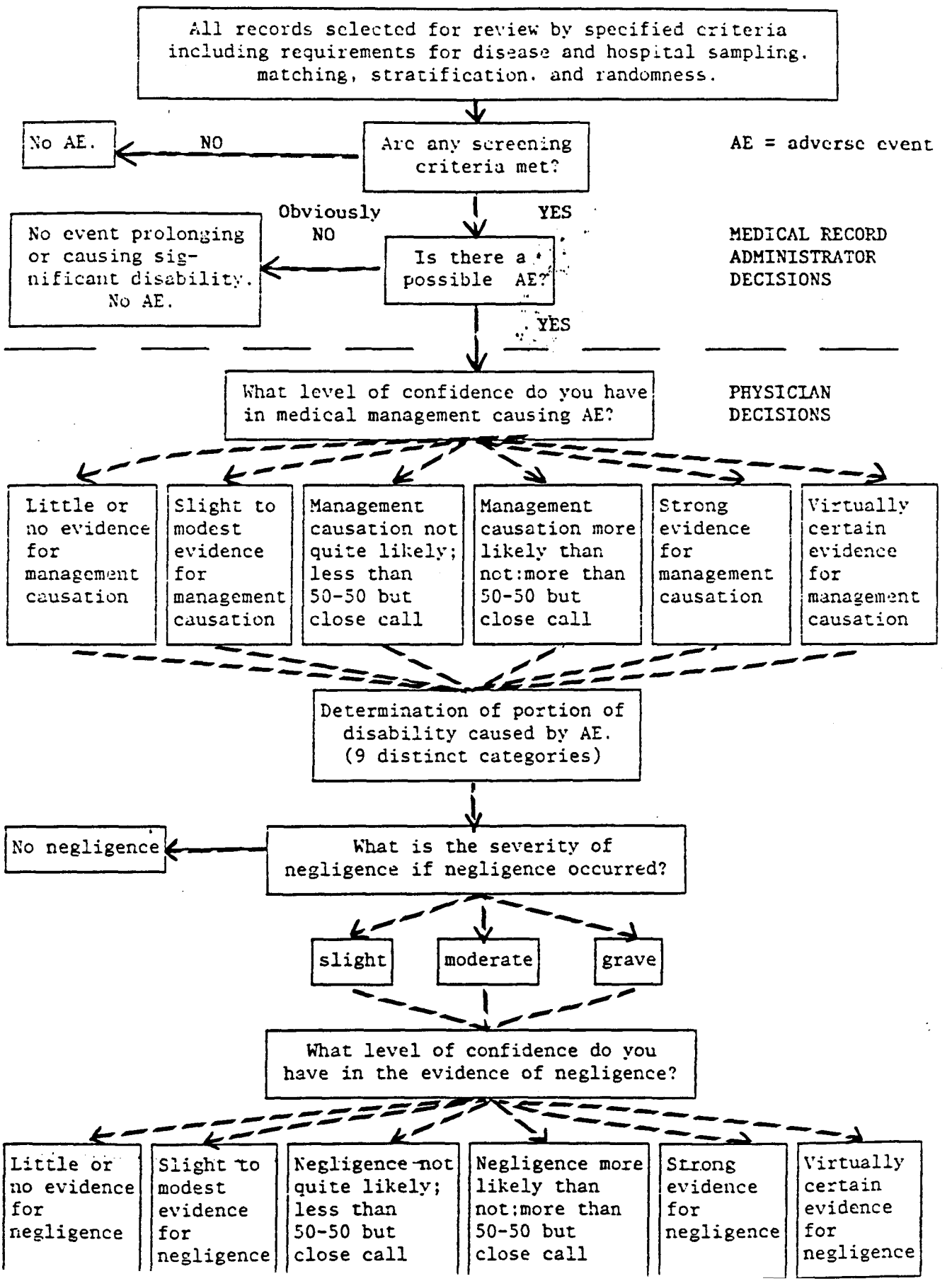
The medical records review is the key entry point into the Medical Practice Study. This review determines whether patients have been injured by medical care -- the adverse events (AEs) -- and also identifies the subset of cases in which injury was due to negligence on the part of the medical care system. This identification must be consistent and reliable. We want all physician-reviewers to produce essentially the same assessment of any given chart. We realize, of course, that there will be some variation: judgments about quality of care are difficult. But to achieve our goal of reproducible judgments, we have designed the following systematic approach for analyzing adverse events. It will be the subject of this section.

A. THE STRUCTURE OF THE CHART REVIEW

Figure 1 presents the design of the retrospective record survey. Hospital events reviewed in this study are classified by health care professionals who perform the primary screening, board-certified physicians who judge adverse events and negligence, and physician-specialists who evaluate unusual cases.

FIGURE 1

DECISION TREE FOR HOSPITAL
RETROSPECTIVE RECORD SURVEY IN MEDICAL PRACTICE STUDY PROJECT



1. The Medical Record Administrator Review

All records are initially reviewed by medical record administrators and other health care professionals (MRAs). They use 17 criteria (defined and discussed in the Hospital Record Manual), based in part on the California 1977 Medical Insurance Feasibility Study, to identify signal events in patient care that might be associated with undesirable outcomes and that might result from medical management. A computer program will also determine whether the patient's length of hospitalization exceeds a threshold for the patient's age and diagnostic groups. If an MRA finds none of the 17 criteria, and if the length of hospitalization does not exceed the threshold, the record will be returned to the facility without a secondary review by a physician-reviewer. MRAs are likely to eliminate approximately 75% of the records. Those remaining will be reviewed further.

2. Assessment by Physician-Reviewer

Physician-reviewers analyze the record identified by the MRAs and eliminate those in which: (a) the screening criteria were inappropriate or (b) the criteria were met but there was no AE. When they identify more than one AE in the index hospitalization, they evaluate only the most serious one as determined by the disability produced (see section I, C(4)(c) below). They then estimate their confidence in medical management causation for the AE, and --if there has been negligence-- the severity of negligence and their confidence in

the evidence for negligence. The reviewer also answers a series of questions on the type and location of the medical management causing the AE, the extent and nature of the patient's disability, and the amount of injury attributable to the adverse event. S/he will also describe the AE and indicate any areas of uncertainty.

For each record, a second physician-reviewer will conduct an identical and independent analysis and will complete a second Adverse Event Analysis Form. In those cases in which the two physicians disagree significantly on factual issues, a third independent review will be performed by the physician-supervisor who will then review all three determinations and resolve the conflict.

To improve the degree of reliability of physician-reviewers, the Study has developed a set of questions and descriptive items to assist the reviewer in arriving at the determination of both causation and negligence. These questions and items have been incorporated in the Adverse Event Analysis Form. Only a small minority of entries are checked for any one record. A discussion of some of the issues involved in the completion of these entries follows. More detailed instructions are found in Section II.

3. The consultation/ consensus process

All of this material is finally collated and analyzed by the staff physicians of the Study. Where appropriate, specialists will resolve issues beyond the expertise of the physician-reviewer and their physician-supervisors. This multi-level review process is designed to minimize the rating variations which occur as a result of the uncertain nature of information in the medical record.

B. A LEGAL APPROACH TO MEDICAL INJURY

In our approach to analysis of adverse events, we have consciously used legal concepts. There are several reasons for this approach, the primary one being our need to translate our results into data that will inform those involved in the legal policy debate on malpractice. The following are some relevant elements of malpractice law.

In a malpractice case the plaintiff must prove four points. First, the plaintiff must show that he was injured. Second, he must show that the provider of health care took certain actions, or failed to take certain actions. Third, he must show that the provider's actions failed to meet a standard set by the medical profession; in other words he must show that the doctor, some other provider, or the system was negligent. Finally, he must demonstrate that there was a causal connection between the

provider's negligent action and the injury. If the patient can convince the judge or jury of these points, he wins the case.

In essence, we are asking you, the physician-reviewer, to follow a similar reasoning process in your analysis of charts. We ask you first to determine whether there was an injury attributable to medical management and, if so, to rate your confidence in the evidence for medical management causation. Then you will determine whether there was negligence. If you deem there was, you will rate your level of confidence in the evidence for that as well. This is a complicated process, and we need to discuss at some length the meaning of these terms. Clinical examples will illustrate important points.

C. CAUSATION

1. Injury

The term injury is used throughout this study to apply to all forms of additional morbidity that result from medical management, as well as from trauma in general. The context will make it clear as to whether the term injury refers to a complication of medical management or refers to a difficulty not caused by management, such as a traumatic injury leading to hospitalization.

2. Adverse event (AE)

Instead of referring separately to the actions (or failure to act) of a particular health-care provider or the medical system, we will use the term medical management for both. Disentangling the consequences of the medical intervention itself from those of the original condition requiring treatment is often difficult. Suppose, for example, that someone injured his leg seriously in an auto accident, was hospitalized for treatment, and eventually left the hospital with a permanent limp. Suppose, as well, that the medical care was excellent, and the limp unavoidably resulted from the original trauma. The person has an injury, but it was caused by the original accident, and not by medical management.

On the other hand, suppose that the original injury was reparable, but that a wound infection developed at the site of an open reduction of a leg fracture and prolonged the hospitalization, impaired neighboring joint function, and caused a limp. The injury or disability was caused by medical management. We call this an ADVERSE EVENT. Since the central purpose of this study is to determine the frequency and consequences of adverse events, a precise definition is crucial. Our definition follows:

ADVERSE EVENT (AE):

> An untoward event that occurs during or following the course of treatment and that has all three of the following characteristics:

(a) INJURY (see definition, page 5) can be described and resulted in disability. Even when there is a clear cut error in management, if there is no injury, there is no adverse event. However, prolongation of hospital stay because of a complication is evidence of injury, even if the patient has no symptoms.

(b) Medical MANAGEMENT was a significant cause of the injury, i.e. that without the particular management, injury would not have occurred.

(c) The injury was an UNINTENTIONAL (and generally unexpected) result of management. We emphasize that the management need not be negligent; indeed, generally it is not.

Determination of an AE requires showing a causal relationship between medical management and the increased morbidity. Such morbidity must, therefore, be distinguished from the morbidity caused by the disease process itself.

It is not sufficient to find that a particular disability was the consequence of medical management: it must be the unintentional consequence of such treatment. For example, injury to the recurrent laryngeal nerve during partial thyroidectomy, while a recognized complication, is unplanned and unintended. Therefore, it is an AE. On the other hand, intentional sacrificing of the same nerve in a radical thyroid resection for cancer will cause the same disability, but is not considered an AE.

The causal judgment must be made in a variety of situations where the injury results from <u>either</u> the condition <u>or</u> medical

management. Injuries can arise from the whole range of medical interventions, including surgery, drug treatment, advice, and even no treatment. In every case, the physician reviewer must consider his confidence in a judgment that a component of the injury was the result of medical management rather than the consequence of the underlying disease process.

As noted, the medical management which causes an AE is generally not negligent. For instance, a person might suffer a severe allergic reaction to an appropriately prescribed antibiotic such as penicillin. If there was no history of allergic reactions, then the doctor who prescribed the drug cannot, of course, be said to have acted negligently: he fulfilled the standard of care by asking whether the patient had allergies in general and ever had an allergic reaction to penicillin. Nonetheless, the patient was injured by medical management, and thus suffered an AE. We find causation but not negligence.

Our notion of cause includes not only what one might call errors of commission, but also errors of omission, i.e., the AE which occurred because appropriate medical management did not occur. In all these cases one must consider the criteria for determining what should have happened to the patient with proper medical management, in terms of both diagnosis and treatment. If someone failed to make a diagnosis or executed improper

treatment and an injury resulted, then medical management was responsible. In order to determine whether negligence was involved, one must consider the standard of care for making the diagnosis or treatment at that point in the disease history when the patient's care was the responsibility of a provider.

You probably are now asking, what is the standard we should apply in such cases? Suppose that the disease could have been cured if it had been treated by the top practitioner in a major metropolitan area. Should one apply this standard of optimal diagnosis and care to the practitioner in a small town who failed to diagnose and successfully treat a particular disease, or should one apply, instead, a standard of the reasonable care to be expected of the average doctors in the same specialty? The latter is appropriate and consistent with current law. We want to apply the standard of the reasonable and competent practitioner, not the world's expert or the most isolated rural physician. Physicians have different views about the details of the reasonable care standard, but we expect that most views are broadly similar.

Consider some other examples illustrating these points. A 50-year-old woman noticed a lump in her breast. Her physician recommended a needle biopsy of the lump. The biopsy was interpreted as a malignancy, and a mastectomy was performed. Complete pathological examination revealed the lump to be benign

breast tissue. We would call the diagnosis of malignancy an error of commission. The fact that a woman had an unnecessary mastectomy defines this as an AE. There may be further discussion as to whether negligence occurred, perhaps on the part of the pathologist, and that discussion would center on the reasonable care standard. The AE was, however, caused by the error of commission. We summarize this case by stating that an incorrect diagnosis resulted in an unnecessary mastectomy.

Now consider a similar case. The needle biopsy was performed following a positive mammogram, and atypical breast tissue was found. The doctor took no further action. Six months later the patient presented with widely metastatic cancer, with the primary lesion in the same area of the same breast. This was clearly a case of failure to diagnose, but is it considered an error of omission?

Determining whether medical management caused or contributed to the untreated advanced state of the disease turns on the nature of the breast biopsy and what the pathologist should have known. If the biopsy was judged to be properly performed by the standard of reasonable care and if the samples were definitely determined to be neither malignant nor premalignant by a competent pathologist-- again using the reasonable care standard-- there is then little evidence of a causal connection between medical management and the ultimate disability. Here we regret

the inability of medical science to make an early diagnosis, but the disseminated malignant disease is not considered an AE. We summarize this case by stating that standard and acceptable measures did not permit the diagnosis of malignancy. The unfortunate outcome was a consequence of the natural history of the disease.

The Adverse Event Analysis Form asks the physician-reviewer first to determine causation and then negligence (see below). If one finds causation and an injury, then there was an AE. Only then does one decide whether there was negligence or not. The foregoing discussion illustrates that sometimes this straightforward approach is not so simple and that issues of negligence might affect issues of causation. For example, in the last case had the surgeon not taken precautions to secure the biopsy from the precise area of pathology noted in the mammogram, he would be considered negligent. Then the disseminated malignant disease would clearly be caused by medical management and therefore would be an AE.

3. Confidence in judgments concerning causation and negligence

Up to now we have implied that judgments about causation involve absolute, all-or-nothing verdicts. In the real world, however, we are accustomed to making such judgments in proportionate, more-or-less terms. Everything we have said so

far about the context of medical injuries suggests that the latter approach is more appropriate. Given the occurrence of an injury, a primary function of the physician-reviewer is to determine to what degree he can be confident that medical management was a cause.

For example, a person with serious heart disease suffered a myocardial infarction during emergency surgery for intestinal obstruction. Here we may be able to delineate with a high degree of confidence the actual links in the causal chain. Underlying heart disease predisposed the patient to such an injury, but it was found that the anesthesiologist mistakenly gave an overdose of a medication which resulted in a period of hypotension during the operation. In this case the drug overdose was a partial cause of the heart attack because it interacted with the patient's heart condition. If the drug had not been given in excess, the myocardial infarction would probably not have occurred at that time. Therefore we judge this injury to be an AE. Given the extenuating circumstances of the underlying heart disease, however, our confidence in the judgment is less than 100%. We need a scale with which to express our degree of confidence in the medical management as a cause of the AE.

Let us take another example: assume that bypass surgery for peripheral vascular insufficiency in the foot is followed in some patients with advanced vascular disease by thrombosis in the

graft. Suppose further that about half of these thromboses are the result of poor operative technique in a very demanding situation, and that the other half come from the disease process itself, due to "poor runoff" and sluggish arterial flow even when surgical technique and selection of the patient for the procedure are optimal. In most situations it will be extremely difficult to identify which thromboses are attributable to the underlying disease and which to the technique. If the record review reveals only a postoperative graft thrombosis, in the absence of more detailed and precise information one's confidence level may be only slightly more or slightly less than 50-50 that this particular complication was caused by the medical treatment rather than the generalized vascular disease.

Given the complexity introduced by determinations of partial or probable causation, we have avoided asking the physician reviewer to make an "either/or" decision on the issue of causation. Instead, we have opted for a judgment of your confidence. We ask you to use the following ordered categories to classify the degree of your confidence that medical management caused the injury.

CATEGORY	DESCRIPTION
1	There is <u>minimal</u> or no possibility that the injury was caused by medical management.

2 It is slightly to moderately likely that the injury was caused by medical management.

3 Close call - nearly 50:50, but on balance it is slightly less than probable that the injury was caused by medical management.

4 Close call - nearly 50:50, but on balance it is more likely, though barely so, that the injury was caused by medical management.

5 It is moderately to highly likely that the injury was caused by medical management.

6 It is virtually certain that the injury was caused by medical management.

The physician-reviewer must commit to a judgment about each record in the same way that a jury must arrive at a verdict after hearing evidence about a particular case. (Please note that the need for such a decision forces us to exclude exactly 50:50 judgments.)

4. Special review problems

a. Issues outside of the physician-reviewer's areas of competence. Some cases will involve issues that require specialty knowledge outside your area of expertise. We ask you to make the best judgment you can. We also ask, however, that you indicate the need for the opinion of a specialist and name the specialty review you recommend. The physician-reviewer then contacts a specialist from the list provided by the Medical Practice Study, poses the question(s) for the specialist, and

obtains a resolution to the problem at hand. S/he then completes the Adverse Event Analysis Form incorporating the specialist's opinion. If the specialty needed is one other than provided by the Medical Practice Study specialty panel, the case is referred to the physician-supervisor for resolution.

b. Patient morbidity and disability. In addition to making judgments about causation and negligence (see below), you will have to judge the nature of the additional morbidity produced by the AE. In some cases the morbidity will amount solely to prolongation of hospitalization. In all cases, estimate the number of days, if any, by which hospitalization was prolonged. If the AE led to a continuing disability after the hospitalization, this disability should be graded on the 8-level scale in the Adverse Event Analysis Form.

c. Multiple AEs in one hospitalization. When you encounter a chart with more than one AE, you must select one for analysis and description. Your initial question is whether the AEs are independent, or whether they are linked together in a single causal chain from the initial AE to the eventual disability. Independent AEs arise from unrelated instances of medical management. For example, a patient suffered a wound infection (AE #1) and shortly afterwards fell out of the hospital bed (AE #2). Linked AEs relate to one course of medical management. For example, a patient suffered an hydrocollator

burn (AE #1) and after the skin grafting to repair the burn the patient developed a wound infection (AE #2). If the burn had not occurred, the patient would not have been exposed to the risk that medical management might cause an infection. Therefore, the second AE follows from the first.

If the AEs are independent, use the following rules: (1) If only one AE has a confidence in causation score (Item 4.8 on the Adverse Event Analysis Form) of 4 or higher, choose it and disregard all others. (2) If you give more than one AE a confidence score of 4 or higher, then choose the AE which produced the greatest morbidity. (3) If all AEs have a confidence score of 3 or less, choose the one which produced the greatest morbidity.

If the AEs are linked, and not independent, then you should evaluate the initial AE and the associated negligence, if any, and the ultimate disability caused by all linked AEs. If the management resulting in a subsequent, linked AE involves negligence, describe this instance of negligence in section 11 of the Adverse Event Analysis Form, not in sections 7-10.

D. NEGLIGENCE

As in our current legal system of determining fault and establishing responsibility for compensation, the final step of

our assessment, the determination of negligence, is the most critical. At times, it can be very difficult to determine whether an AE is the result of negligence. And, as noted previously, even the judgment as to whether an injury is an AE may depend on a decision concerning negligence. To the extent that it is possible, however, the decisions about the presence of an AE and about negligence should be kept separate.

In making judgments about negligence, you must answer three questions. Was an error committed? If so, how severe was it? How confident are you of the evidence?

1. Error in management

First, was there an error in management? If there was no error, there was no negligence. If an error was committed, a judgment of negligence is possible, but not assured. An example of error without negligence is the prescription of an antibiotic prior to knowledge of culture reports which in turn prove the choice of the first antibiotic to be an error (unavoidable, of course). Unfortunately, analysis of whether there was negligence often depends on details of management that are not recorded in the record. In such cases, the reviewer must use his experience and judgment and "read between the lines". For example, if a patient falls out of bed and there is no record in the nurse's notes that the side rails were up or that the patient was restrained, we assume that those precautions were not taken. The

judgment about negligence in this case will then depend on the reviewer's opinion as to whether failure to take those precautions was an avoidable error in management for this patient.

The definition of an error implies that a standard of treatment was not met. The appropriate standard to apply is a national one: the current expected level of performance of the average practitioner who treats this type of problem. The fact that complications occasionally occur even in the best of hands is irrelevant to this determination. If there was an avoidable error, you will be asked to classify it as an error in diagnosis, prevention, performance, drug treatment, the system, or other.

2. Severity of negligence

The judgment of the <u>severity</u> of negligence also requires application of a standard: did the practitioner take reasonable care to avoid harm? The severity will be greater if there is significant deviation from the accepted norms of practice, if the error has potential for great harm, or if it occurs with such frequency that the physician should reasonably be expected to take special precautions to prevent it. Conversely, there may be mitigating circumstances which in your judgment decrease the severity of the negligence.

a. Deviation from accepted norms. Did the management vary from accepted practices? Excessive delay, omission of standard precautions, hasty treatment, all suggest lack of due care. Treatment that is unorthodox or flies in the face of accepted consensus constitutes a deviation from standard therapy. Were accepted standards met? Severity of negligence is in part proportional to the extent of deviation from the norm.

b. Potential consequences of the error. A mistake which has the potential to be fatal (even if it was not fatal in the individual under consideration) is clearly more serious than one which has only trivial consequences. For example, failure to treat respiratory failure represents more serious negligence than failure to remove an IV which causes a superficial phlebitis. Application of this standard assumes that the average practitioner would be aware of the consequences of the act or omission.

c. Frequency of occurrence. Also relevant to a determination of severity is the number of patients at risk for injury from the negligence if it were allowed to continue. Generally, a hazard which potentially affects many persons is more serious than one which exposes only a few. Therefore, the common operative procedure, negligently performed, should carry a higher severity score than the rare intervention, if all other circumstances are the same.

d. Mitigating circumstances. Several factors should temper a judgment of severity of an error which in another situation might be considered egregious. Among these are treatment under emergency conditions, co-morbidity, AE occurring in a complicated case, and lack of consensus about appropriate treatment. Again the standard is reasonable care.

We ask you to take all of these factors into consideration in judging the severity of the negligence as follows.

CATEGORY	DESCRIPTION
1	SLIGHT. Examples: untreated mild hypokalemia; no chest x-ray prior to removal of chest tube inserted for treatment of pneumothorax.
2	MODERATE. Examples: no follow-up investigation of a positive stool guaiac; no order for restraints in a disoriented patient; failure to explore common duct at time of cholecystectomy when indications were present.
3	GRAVE. Examples: permitting a large air embolus while inserting a subclavian venous line; not prohibiting smoking by patient receiving oxygen inhalation therapy; inadvertent severance of recurrent laryngeal nerve at thyroidectomy.

3. Confidence in Evidence of Negligence

Finally, you are asked to rate the level of your confidence in the evidence for negligence. Your judgment may be hampered by lack of detailed information about either the nature of the error or the presence of mitigating circumstances. Put another way,

you are not sure if such-and-such happened, but if it did, it was an error, the severity of which you have already judged as above. How sure are you from reading the record that negligence was present? We ask that you give us a separate rating of your confidence in the evidence for a negligent act which could be slight, moderate, or grave in severity.

Note that this is a rating of your confidence about the presence of negligence, not its severity. The two may vary in opposite fashion. For example, a patient with serious multisystem injuries required several episodes of resuscitation in the emergency room. He developed a pneumothorax as a result of repeated attempts to insert a subclavian catheter, and required placement of a chest tube. Because of the mitigating circumstances and the fact that the complication is relatively minor, the severity rating is slight, but your confidence that negligence took place is high.

Conversely, suppose the same patient suddenly died and at autopsy was found to have exsanguinated from a ruptured spleen. He was obese, had no evidence of abdominal wall trauma, and a peritoneal tap in the emergency room was described as negative. You wonder whether it was properly done, whether it contributed to the splenic laceration, whether a complaint of shoulder pain was properly evaluated, or if his vital signs were appropriately followed. The record is incomplete. Failure to diagnose an

intraperitoneal hemorrhage is negligence of grave severity, but you wonder if he didn't die of other causes. You aren't sure, so your confidence rating would be low.

Gradations of confidence in negligence are identical to those for causation. You will be asked to rate your confidence according to six categories.

E. POLICY ISSUES

Certain recurring issues merit special notice. To achieve consistency in grading, specific policies have been developed for dealing with them. The issues are: infections in incisions, falls, drug reactions, "do not resuscitate" orders (DNR), system errors, and patient compliance. We ask that you rate your confidence in the evidence for negligence using the following scores.

1. Infections in incisions

In most of these there will be no evidence that the surgeons committed any error. In others, there will be evidence that a standard was not met. All surgical wound infections are considered to be a consequence of medical management; that is, they are AEs with high causation scores. The confidence score for evidence of <u>negligence</u> will vary greatly. Among the extenuating critical factors in this judgment are:

(a) infection or contamination caused by the patient's underlying disease, as in operations for pelvic inflammatory disease or perforated bowel followed by incisional sepsis,

(b) alterations in patient's resistance caused by the disease or treatment (diabetes, uremia, immunosuppression, radiation therapy).

Error in technique or management would be clear evidence for negligence.

Examples of postoperative wound infection:	Confidence Score for the Evidence of Negligence
Following drainage of an abscess	1
Following a non-elective operation in an immunosuppressed patient	1
After an uncomplicated "clean" operation in a patient with no mitigating factors	2-3
After an operation which is inappropriate because of the patient's condition (e.g., elective foot surgery on a patient with compromised circulation)	4-5
After surgery in which the colon was inadvertently entered	6

2. Falls

Falls which occur in the hospital and produce injuries are almost invariably AEs. The hospital is presumed to have responsibility to protect the patient from harm (even

self-induced) and thus a high causation score is expected. An exception would be a seizure leading to a fall in a hospitalized patient who had no history of such episodes. Whether the AE is a consequence of negligence will depend on several critical factors:

Factors increasing the likelihood of negligence-

(a) patient risk factor such as dementia, stroke, or ataxia

(b) past patient history such as prior fall or attempt to climb over bed rails

(c) patient on medication known to alter judgment or coordination

Factors decreasing the likelihood of negligence-

(a) evidence of appropriate preventive measures such as bed rails, restraints, special attendants

(b) patient being prepared for imminent discharge or self care

Examples of falls:	Confidence Score for the Evidence of Negligence
Fall from bed by active, coordinated, and well-oriented unsedated patient	1
Fall by a patient who is a known risk for whom reasonable precautions have been taken	1-3
Fall from bed by a high-risk patient for whom the hospital staff had taken inadequate precautions	4-5
Fall by a high-risk patient for whom no precautions were taken	6

3. Drug reaction and side effects

Unintended or undesired consequences of drug administration might pose difficulties in evaluating causation. For example, the leukopenia associated with administration of cytotoxic agents for malignant disease is a common, predictable, and serious event; but, because of the potential benefits of the agents, practitioners are not deterred from using such agents by the frequent occurrence of undesired effects. Contrast this with an episode of anaphylaxis following the appropriate administration of an antibiotic to a patient with no known prior exposure and no elicitable allergies. The latter outcome is exceedingly rare, unpredictable by our present knowledge, and may be much more serious in its consequences than the potential benefit of administration of the antibiotic. Should both be called AEs in the sense in which we use the term?

We believe that drug side effects can be arrayed along a continuum with respect to their regularity of appearance, probability of occurrence, threat to the patient, and probably other attributes as well. There seems to us no easily definable line which might separate, for drug reactions, AEs from non-AEs, however intuitively appealing such a distinction might seem. To simplify and to preserve more of the details surrounding drug reactions in the charts you will review, we have adopted the following policy.

All drug reactions that prolong hospitalization or cause disability will be recorded as AEs, subject only to the rule that if there is more than one AE in the index hospitalization, the one chosen will be selected as stated on page 15. In order to capture further information about drug reactions, we ask for some additional details in Sections 5.21 through 5.24 of the Adverse Event Analysis Form. Although the designation of an AE follows from the finding that there is a significant drug reaction, this interpretation does not change the reviewer's opportunity to express on the form a series of different levels of confidence in the evidence that a drug reaction, and hence an AE, is present.

4. Patients with DNR orders or subjects receiving experimental treatment

For "Do Not Resuscitate" cases, AE and negligence determinations apply as usual with appropriate allowance for the DNR status. Please note these DNR cases on the AE analysis form in section 5.1.

A patient undergoing experimental therapy (approved, of course, by a human subjects committee) might, suffer an AE unrelated to the experimental therapy. It should be treated as it is in a patient who is not in an experimental program. An AE related to the experimental therapy should be noted in section 5.1 of the AE analysis form. If you believe that the

experimental therapy was not appropriate, the injury might be considered to result from negligence. For example, if the treating physician chose the experimental therapy based on the results of an erroneous diagnostic test improperly performed, then the therapy would be regarded as an adverse event caused by negligence. Or, the therapy could be appropriate, but negligently performed. If the diagnosis was correct, then our review is limited to an assessment of the execution of therapy rather than to its selection.

5. Health care system errors

We are interested not only in the errors made by physicians, nurses, and other personnel, but also those resulting from system shortcomings. AEs resulting from equipment failures and from problems in communication, such as a tardy delivery of a laboratory result, are in this category. Limits on the availability of diagnostic tests over weekends or inadequate numbers in hospital staffing of professional personnel are system issues that could cause AEs. We do not, however, include the negligence resulting from subsequently recognized product liability problems, such as the injuries suffered by the offspring of women who took DES in the early 1950's. However, when a product is generally known to be defective or dangerous for a particular use and that knowledge is part of accepted medical information, injury from use of such a product is an AE and probably negligence as well. For example, it is now

generally known that some patients are especially susceptible to severe liver damage from the anesthetic agent Halothane. If shortly after a first administration of Halothane a patient developed mild jaundice, but on reoperation the patient was again administered Halothane and developed serious and disabling liver damage, the disability would be an AE and the result of negligence.

6. Patient compliance

Providers of care have a duty to determine a patient's ability to follow a treatment plan. Competency may relate to the disease under treatment or stem from an ongoing disability unrelated to the disease for which the patient is being hospitalized. If a competent patient willfully disregards a physician's advice, then a resulting injury is not an AE arising out of medical management. Noncompliance, however, is often associated with incompetence, making this an especially difficult issue. Also, if the hospital record contains evidence for inadequate instruction concerning dosage or side effects, that is strong evidence for an AE and possibly for negligence on the physician's part.

If a patient willfully disregards physician advice or orders, then his conduct is contributory. Patient conduct can change the way we think about an adverse event. Thus, after you have considered the negligence of the health care providers and

system, we ask you to consider the patient's possible role. The rating is again a matter of confidence in the evidence for the provider's negligence, which you arrive at considering the issue of the competency of the patient to make decisions.

Examples follow:	Confidence Score for the Evidence of Negligence
No evidence of patient incompetence	1
Evidence of patient's inability to comply, but appropriate steps taken	1-3
Some evidence of patient's inability to comply, and no steps taken or adequate instructions given	4-5
Clear history of patient's inability to comply, and no steps taken and no instructions given	6

7. **The scope of medical management**

In our review, we think of scope of medical management in a geographic fashion. Someone who fell in the hospital parking lot is not a victim of medical mismanagement. If the same person fell in the hospital two hours after an elective admission, then the fall was attributable to medical management. The difference is that once the person became a patient in the hospital, the medical care system, as distinguished from the entity operating the parking facility, is responsible for preventing such falls.

The person who takes a prescribed drug at home or in the hospital is being medically managed. In both situations, morbidity that might result from drug use is an AE. A person who suffers an injury from a drug purchased illicitly is not being medically managed and thus is not classified as having an AE.

F. INDEX HOSPITALIZATION

This study is based on a review of charts. Each chart will have an index hospitalization which will be identified for you. Your review will be focused on this hospitalization. Please look for AEs that 1) were a consequence of medical management prior to the index hospitalization and were discovered during the index hospitalization, or 2) occurred during the index hospitalization and were discovered during the index hospitalization, or 3) occurred during the index hospitalization and were not discovered until after discharge. For example, a child may suffer anoxic brain injury at birth and then have a long series of hospitalizations. We want to count this AE only once. If we counted this AE for every hospitalization that resulted from the anoxia, we would over-count and not have an unbiased estimate of the rate of AEs. The medical management, resultant AE, time of discovery (i.e. time of first recognition), and index hospitalization must fit into one of the three sequences given to be classified an AE case.

The same is true for records of subsequent hospitalizations. Review these only to see whether there is evidence that medical management causing an AE occurred in the index hospitalization and that the AE was not discovered at the time. In this manner we will estimate the incidence of AEs more accurately.

Figure 2 displays the relationship between the time of medical management causing an AE and the time of discovery of the AE, and identifies those AEs to be included in this Study. This figure and legend may help you understand the selection process.

SECTION II. THE ADVERSE EVENT ANALYSIS FORM

The following is a point by point discussion of the adverse event analysis form. It is designed to anticipate your questions and to standardize the responses of physician-reviewers. We ask you to study the form and these directions closely and encourage you to refer to this section frequently when questions arise in your chart review.

CASE NO. refers to the case number assigned to this case, NOT THE MEDICAL RECORD UNIT NUMBER. This case number appears at the top of the Hospital Record Screen.

1. **REVIEWER'S ID NUMBER:** The number assigned to you by the study.

2. **DATE OF REVIEW:** today's date

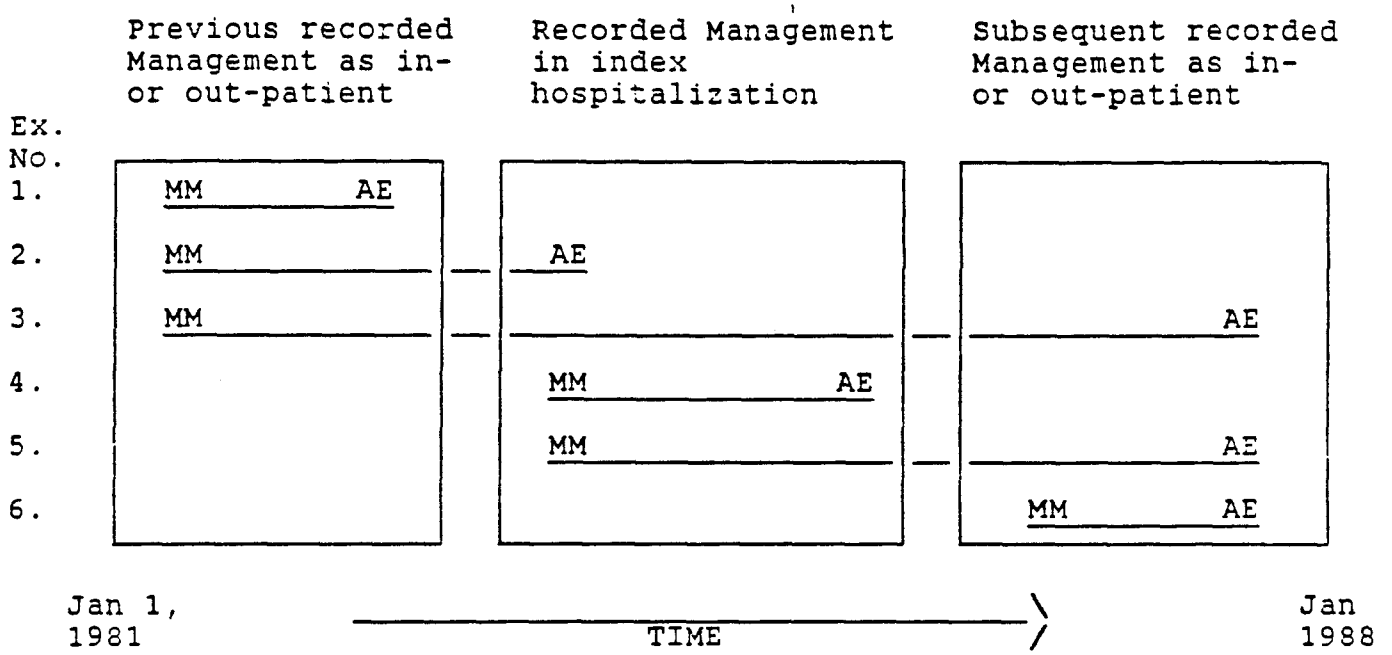
3. **CONFIRMATION OF AE:** Do you agree with the MRA's finding that there is possibly an AE? Review the Hospital Record Screen and the pertinent part(s) of the patient record before answering this question.

3.1 **IF NO AE:** IF you do not agree with the MRA finding, you must complete this section indicating your reason. For example, you may go through the chart and on cursory review

FIGURE 2

TIMING OF MEDICAL MANAGEMENT AND ADVERSE EVENT

MEDICAL PRACTICE STUDY



MM = Medical management causing adverse event (AE)

AE = Initial discovery of adverse event (not previously discoverable, i.e., not capable of being discovered by a knowledgeable patient or physician)

The possible combinations of MM and AE necessarily occurring in this order in 3 time periods are detailed above. The middle block represents the information available from the record of the index hospitalization. This study is limited in its ascertainment to examples 2, 4 and 5. Because of the impossibility of identifying cases of type 5 when an AE is discovered in a different hospital, we are including type 2 to compensate for this limitation.

find that the variation was not the result of an AE. You need not go through the entire adverse event form, but can simply check the appropriate box in 3.1. Note that if there is no criterion checked by the MRA, it means that the record was pulled because the length of stay was excessive. You must then determine whether that was because of an AE. The choices under 3.1 are fairly self-evident. Note that if the criterion is inappropriate you are asked to explain why. An inconsequential finding is an injury due to medical management that did not prolong hospitalization or did not persist following the hospitalization. Note that we are not interested in cases which involve primarily psychiatric illnesses.

4. **DETERMINATION OF ADVERSE EVENT:** We have designed these questions to facilitate consistent thinking about causation. After you answer 4.1-4.7, you should be better able to answer 4.8, the question which defines your confidence that an AE did occur. Please note that not all of the following questions pertain to each case; only answer those that are relevant.

4.1 **SUGGESTIVE NOTE:** A note in the chart may state or suggest that an injury was caused by medical management. Such a note is considered strong evidence that there was an adverse event.

4.2 PREDICTIVE NOTE: If a note in the chart predicts the injury in question as a result of a disease process, causation by medical management is less likely.

4.3 TIMING: If the timing of an event or treatment is consistent with a causal connection, this increases your confidence in the finding of causation.

4.4 OTHER EXPLANATIONS: If there is only one causal chain reasonably imaginable and that chain includes the medical management and the injury, then your confidence in causation is high. If there are several causal chains that could explain the injury, including both medical management and the disease process, your confidence that there was an AE will be less. This question forces you to judge the strength of these competing explanations.

4.5 PREVENTION OPPORTUNITY: self-explanatory.

4.6 RECOGNIZED COMPLICATION: self-explanatory.

4.7 RESPONSE TO TREATMENT: If the injury responded to management designed to counter the effect of the management you think caused the injury, it is presumptive evidence of causation. For example, effective use of protamine to reverse the effects of heparin therapy is additional evidence that a

hemorrhage was caused by the anticoagulation.

4.8 CONFIDENCE THAT MEDICAL MANAGEMENT CAUSED THE AE: You should now be able to score your confidence in causation. Remember that at this point we are not asking you to consider negligence; rather, we are focusing on the issue of the relation of medical management to the injury. Please choose the appropriate category 1 to 6.

The score 1 is critical. If your confidence score is greater than 1, then we consider the disability to represent an adverse event at the minimum level of confidence required to proceed with the analysis. We regard the threshold of 1 as needed to eliminate a large number of questionable and improbable situations irrelevant to our study. Note that there is no mid point, or 50-50, confidence judgment.

4.91 AE DESCRIPTION: Describe the injury. Be careful to distinguish it from the morbidity which you attribute to the patient's disease process. Please use no more than 75 words.

4.92 RELATION OF AE TO MANAGEMENT: How did medical management cause the injury? If appropriate, describe how you distinguish management causation from the disease

process as the source of the additional morbidity.

STOP POINT: If your AE confidence score is 1, proceed directly to question 11. The study is not concerned with events for which the evidence for management causation is slight. If your confidence score is 2 or greater, then continue with question 5.1, special situations.

5.1 SPECIAL SITUATIONS: This is a list of types of AEs in which the Study has a special interest. The questions that follow relate to these.

5.21-5.23 DRUG REACTION: Self-explanatory.

5.24 PRESCRIBE ANYWAY? Is this the kind of drug which a competent physician would prescribe in this situation even if he knew there would be a reaction? I.e., Is the reaction tolerable considering the need to use the drug in this situation?

5.31 PATIENT CONTRIBUTION TO AE: A positive reply indicates that there is documentation in the record of patient's actions which contributed to the AE. We refer to acts which counter or disregard medical management, or those of one who is mentally incompetent.

5.32 **PATIENT COMPETENCE:** Again, look for evidence in the record that the patient was incompetent and unable to make a rational decision with regard to his role in medical management. For instance, was the patient unable to act responsibly when a fall occurred in the hospital? This issue is most likely to come up with regard to falls and prescription drug cases.

5.33 **CONFIDENCE IN PATIENT CONTRIBUTION TO AE:** Complete only if both factors, action and incompetence, are present. This is a confidence rating, i.e., how sure you are of the evidence, not a measure of degree of involvement.

6. **DISABILITY**

6.1 **HOSPITALIZATION PROLONGED?** Please make a judgment about this even if you are not sure from the evidence in the record.

6.15 **NUMBER OF DAYS:** Self-explanatory. Must be completed.

6.2 **ORGAN SYSTEM:** Self-explanatory.

6.3 **DISABILITY CAUSED BY THE AE:** Estimate the additional morbidity caused by the AE. The first four choices refer to temporary disability, the next four to permanent disability. Please distinguish the morbidity caused by the AE from the morbidity attributable to the underlying disease process.

6.41 WHEN DID MANAGEMENT OCCUR WHICH CAUSED AE: Please disregard adverse events that occurred during previous hospitalizations and were discovered prior to the index hospitalization unless treated for the first time during the index admission (such as repair of an incisional hernia). Adverse events that were noted in hospitalizations subsequent to the index hospitalization are included only if the medical management responsible for the AE occurred in the index hospitalization. Ignore any AE due to medical management prior to 1981.

6.42, 6.43 DATES: Self-explanatory. Dates must be accurate.

6.5 WHERE MANAGEMENT OCCURRED: Example: if drugs were mixed incorrectly in the pharmacy and this led to an injury, then the location is the pharmacy. If a nurse switched medications inadvertently before administering them to the patient, then the culpable management is considered to have occurred in the patient's room.

6.6 SPECIALTY RESPONSIBLE: This refers to the specialty of the person responsible for the AE, not the service on which it occurred. For example, an internist might be responsible for monitoring a patient while that patient is in the radiology suite. An adverse event caused by lack of

monitoring during this period would be attributed to the internist, thus, an answer of internal medicine.

7. EVIDENCE FOR NEGLIGENCE: 7.1 - 7.8 ask you to evaluate and classify negligence, if present. Negligence involves any variation from an accepted standard of care. A negligent act can be a mistake, an oversight, or very rarely, deliberate.

7.1 WAS THERE AN ERROR? This is a threshold question. If there is no error, there can be no negligence. If you conclude there was even a possibility of error, answer 7.1, "YES", and proceed with the remainder of the form. Expressing your confidence in your judgment of negligence comes later. If you are certain there was no error, check 0, "NO", and proceed to question 11. For example, in a situation in which a patient without a history of drug sensitivity suffered an AE as a result of a reaction to a correctly selected antibiotic, the adverse event clearly did not involve negligence. There is no error and it is unnecessary for you to rate negligence. On the other hand, if the patient had a history of drug sensitivity and had not been questioned about it, that would have been an error in management and the same AE would be a consequence of negligence. The determination of negligence must not be influenced by hindsight, but must be based only on

information obtainable at the time of the medical management in question.

7.2. **CLASSIFICATION OF ERROR:** Pick one or more of the six categories. Errors of diagnosis do not include technical errors causing AEs that occur as a result of performance of diagnostic procedures. These would be performance errors. Prevention errors are restricted to neglect of accepted preventive measures, such as failure to immunize against pneumococcus for patients with sickle cell anemia, failure to provide prophylactic anticoagulation after hip surgery or failure to give prophylactic antibiotics in patients with cardiac valve prostheses undergoing dental surgery.
A drug treatment error involves mistakes in the selection, administration and monitoring of drug therapy (not whether or not it was given as in the previous example).
A system error is an error that is not readily traced to a single provider. Such system errors are failures to communicate, mix-ups of results, mislabeling of samples, equipment failures, and errors in pharmacy or blood bank. In each case a reasonable argument can often be made that the error was one "waiting to happen" because of a systems problem rather than because of the negligence of an individual. The class "other" is reserved for errors that do not readily fit into the preceding groups.

We realize that there may be more than one type of negligence in certain cases. In these cases, we ask you to rank the types of negligence with #1 being most significant by using numbers instead of checks in the appropriate boxes.

7.3- 7.7 **ERROR SPECIFICS:** After you have classified the error, go to the appropriate list of specifics for each class indicated in section 7.2.

7.3 **DIAGNOSTIC ERROR:** If there is an obvious failure to diagnose, but the reason for this failure is not apparent from the record review, then please check category 7.37. If there is more than one subtype of error, check as many as are appropriate.

7.4 **PREVENTION ERROR:** These are much the same in terms of subtypes as diagnostic errors. In these cases, however, there is no category for 'reason inapparent', as we expect the prevention strategy to be fairly clear, and thus the error readily categorized.

7.5 **PERFORMANCE ERROR:** These are the errors associated with invasive procedures and operations. A technical error is a failure in actual execution of the procedure, as opposed to judgment or knowledge errors that result in an AE following

a technically acceptable procedure. These issues are sometimes inseparable from one another, but one predominates in most cases.

7.6 DRUG TREATMENT ERROR: Self-explanatory

7.7 SYSTEM ERROR: There are many choices under systems error. If none is appropriate, check 7.79 "Other" and describe briefly the error.

8. MITIGATING AND AGGRAVATING CIRCUMSTANCES: Sections 8.1 to 8.3 should assist the reviewer in determining in general the impact on the universe of care of the type of error found in the particular case under review.

8.1 DEVIATION FROM NORMS: A substantial deviation from accepted treatment norms suggests that the treatment might be in error or represent poor judgment.

8.2 DEGREE OF ADDITIONAL MORBIDITY: The potential for a great deal of morbidity for the typical patient who might suffer from such an AE increases the degree of negligence. We say the "typical patient" because here we want to consider not what happened to this individual patient, but what would happen to the average patient of similar age, diagnosis, and morbidity who suffered this sort of adverse event. As such,

your grading of the magnitude of additional morbidity is not determined by the fact that the individual in the case at hand might have had a lucky outcome (minor AE) or an unusually serious complication (major AE).

8.3 NUMBER OF PATIENTS: We would like you to consider the proportion of the population at risk for such an adverse event. An adverse event that occurs in a strange or atypical setting or is associated with a rare disease may be judged as not so negligent as one which could affect a large portion of the patient population.

8.4 - 8.7 MITIGATING CIRCUMSTANCES: Sections 8.4 to 8.7 raise factors which either mitigate or intensify the case for negligence. Emergency cases, complicated cases, cases involving a great deal of co-existing morbidity, and cases involving care that lacks consensus mitigate or lessen the severity of any accompanying negligence.

8.8 PRESENCE OF NEGLIGENCE: After considering the factors in 8.1- 8.7, evaluate whether negligence was present assuming that all the alleged facts and reasonable inferences ARE ACCEPTED AS TRUE. If, after considering all the evidence you conclude that there was no negligence, check response "No negligence" and do not answer questions 8.9, 9 and 10.

8.9 **SEVERITY OF NEGLIGENCE:** If after considering the factors in 8.1- 8.7 you determihe that negligence was present, please give a global evaluation of the degree of negligence assuming that all the alleged facts and reasonable inferences ARE ACCEPTED AS TRUE.

9. **LEVEL OF CONFIDENCE IN EVIDENCE FOR NEGLIGENCE:** Give your assessment of your confidence that negligence occurred, after you have considered all the relevant sections in questions 7 and 8, and after you have weighed all the facts, alleged facts, and reasonable inferences. The categories 1 to 6 are similar to those you used for assessing confidence in causation.

For example, consider a patient who is put on a three drug antibiotic regimen when the available clinical information supports the use of only a single agent. The patient subsequently develops a symptomatic rash that delays discharge - clearly an AE. If we knew that the rash was a consequence of the superfluous antibiotics, we would have established negligence with certainty. The rash could be a consequence of the one indicated drug, however, in which case there would be no negligence. Our inability to identify the offending drug reduces our level of confidence in the presence of negligence. Alternatively, an acknowledged technical error in an operative note, such as

the inadvertent severing of a motor nerve, would support the finding of negligence at a very high level of confidence.

10. **DESCRIBE THE NEGLIGENCE:** Give a brief description of your thinking on your confidence in the determination of negligence in this case. Convey to another physician reviewer the logic you followed in less than 75 words.

11. **ADDITIONAL AEs PRESENT:** Was there an additional AE present that contributed to the patient's ultimate disability and involved negligence that was not described in questions 1-10?

11.1 **ADDITIONAL AEs:** This section offers you an opportunity to describe the additional adverse event that contributes to the patient's ultimate disability and involves negligence. Where multiple AEs are linked (see case illustration # 22), the reviewer can use this section to capture additional facets of a complex set of causes for the patient's injury.

12. **NEED FOR SPECIALIST CONSULTATION:** Is your judgment limited due to a lack of subspecialty knowledge? If this is true, then a consultation with a specialist is required in order to accurately complete this review.

12.1 **WHICH SPECIALTY:** If you have found a need for a specialist consultation then indicate the appropriate specialty. You may list as many as necessary.

12.2 **AREA LACKING KNOWLEDGE & CLINICAL QUESTION FOR SPECIALIST:** This section allows you to state the area in which your lack of subspecialty knowledge has hampered your review. We also ask you to state the question that you are proposing to the specialist. Please be specific and include all relevant information in your question.

12.3 **SPECIALIST'S RESOLUTION:** Describe the specialist's resolution to your question noted above. After obtaining this information, be sure to re-evaluate your answers to previous questions, as this new information may alter your thinking on earlier issues.

12.4 **SPECIALIST'S ID NUMBER:** You must consult with a specialist provided by the Medical Practice Study or your physician-supervisor. All participants in the study have IDs assigned to them which should be used exclusively on the Adverse Event Analysis Forms.

12.5 **SPECIALIST'S ID NUMBER:** This second ID question is to be utilized in the event that two specialists are needed for consultation on a particular case.

SECTION III. ILLUSTRATIVE CLINICAL EXAMPLES

The following cases are designed to illustrate the scoring system for causation, disability, and negligence, and to elucidate some of the concepts described in sections I and II of this manual.

The first two cases are analyzed more extensively than the remaining ones in order to guide the reader in the thinking which leads to specific scores.

As a reference for the reader we have reproduced below the scoring system from the variation analysis form.

Confidence in management as cause of AE:

1___ Little or no evidence for management causation
2___ Slight to modest evidence for management causation
3___ Management causation not quite likely; less than 50-50 but close call.
4___ Management causation more likely than not; more than 50-50 but close call.
5___ Strong evidence for management causation.
6___ Virtually certain evidence for management causation.

Excess disability caused by AE:

1___ Minimal impairment (functional, cosmetic) followed by almost complete recovery within 1 month of sustaining AE.
2___ Moderately incapacitating impairment (functional, cosmetic) followed by almost complete recovery in more than 1 month but within 3 months of sustaining AE.
3___ Same as 2 with almost complete recovery in more than 3 months but within 6 months of sustaining AE
4___ Moderately incapacitating impairment (functional, sensory, cosmetic) followed by almost complete recovery in more than 6 months or incomplete recovery not interfering significantly with employment or leisure activity
5___ Disability causing 1% to 50% permanent decrease in employment or leisure activity
6___ Disability causing 51% to 100% permanent decrease in employment or leisure activity
7___ Requires personal and/or nursing support permanently
8___ Death
9___ Cannot reasonably judge disability from medical record

Severity of negligence:

1___ Slight
2___ Moderate
3___ Grave

Confidence in evidence of negligence:

1___ Little or no evidence for negligence
2___ Slight to modest evidence for negligence
3___ Negligence not quite likely; less than 50-50 but close call
4___ Negligence more likely than not; more than 50-50 but close call
5___ Strong evidence for negligence
6___ Virtually certain negligence

1. A 93 y.o. disoriented terminally ill man was admitted to the emergency room because of pneumonia. While in the ER, he fell from the stretcher and sustained a fractured hip. He had not been restrained and the rails on the stretcher were left down. He died 10 days after hip surgery.

   Scores:

   Confidence in management as cause of AE = 6

   The fractured hip was caused by the fall, which in turn, resulted from the lack of proper protection (side rails, restraints, etc.).

   Excess disability caused by AE = 8

   The death following hip surgery can be directly attributed to the AE.

   Severity of negligence = 3

   Lack of proper restraint in disoriented patients, including the terminally ill or DNR patients, is a major deviation from the standard of care.

   Confidence in evidence of negligence = 6

   There is little doubt that the standard of care had not been followed.

2. An 85 y.o. nursing home resident with chronic renal failure treated with digoxin and diuretics was transferred to the hospital with ventricular dysrhythmia. On admission her creatinine was 6.0 (baseline 2.3) and digoxin 4.0. She responded to treatment and was discharged seven days later.

Scores:

Confidence in management as cause of AE = 6

The dysrhythmia would not have occurred without digoxin.

Excess disability caused by AE = 1

She was in the hospital for seven days as a result of the AE.

Severity of negligence = 3

Failure to monitor her digoxin and creatinine levels in the nursing home was severe negligence since the potential morbidity of digoxin toxicity is substantial.

Confidence in evidence of negligence = 4

While complete information on tests done in the nursing home is lacking, it is likely that monitoring was inadequate otherwise the episode would not have occurred.

3. A 75 y.o. man underwent planned simultaneous repair of an abdominal aortic aneurysm and 4-vessel coronary artery bypass graft. In the recovery room, although coagulation factors were normal, he required transfusion of 8 units of blood, ascribed to intra-abdominal bleeding. He developed respiratory failure, adult respiratory distress syndrome, and renal failure. After a protracted downhill course, he died.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 8
Severity of negligence	= 3
Confidence in evidence of negligence	= 5

Comment: Postoperative complications and death are by definition AEs. There were no explanations in the chart for the failure to re-explore the patient to stop the bleeding, so this inaction was

judged to be negligent. Confidence in this judgment is less than 6 because of the lack of details regarding possible mitigating circumstances such as other risk factors.

4. A 49 y.o. male underwent a balloon mitral valvuloplasty at cardiac catheterization. The balloon broke, leading to an embolus which caused a cerebral vascular accident with hemiplegia. The procedure was experimental and had been approved by the Human Subjects Review Committee. The patient had signed a permission form which clearly stated the risks involved, including death, and that because the procedure was new, the investigators did not know the extent of the risk.

   Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 6
Severity of negligence	= NA
Confidence in evidence of negligence	= NA

   Comment: The fact that this was an experimental procedure carried out with permission of the Human Subjects Review Committee and the patient, and after full disclosure of the risks, does not alter the fact that it was an AE, since the complication resulted from the treatment. There is no evidence that the physicians did not use all due care in performing the procedure, so there is no negligence.

5. A 34 y.o. woman with a known affective disorder developed tremulousness secondary to lithium, which she had administered to herself in excessive dosage. She had been warned previously to decrease the dosage with early symptoms but had not done so. In this case there was no evidence of cognitive defect or failure to understand the physician's warning.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 1
Severity of negligence	= NA
Confidence in evidence of negligence	= NA

COMMENT: The AE was due to treatment, since it wouldn't have happened in its absence. However, the doctor appropriately discharged his responsibility by repeatedly warning her of the potential consequences, so there is no negligence. The patient clearly bears some responsibility for her own care. It may be difficult to separate out mental disability (for which the physician must take necessary precautions) from willful stubbornness or just plain disagreement, which a patient has every right to exercise. NB: if the patient had taken the medicine without a physician's recommendation (left-over medications, for example) there would be no AE, since it would not be medical treatment.

6. A 54 y.o. man with a history of several thromboembolic episodes underwent a 4 vessel coronary artery bypass graft. Postoperatively he had bleeding secondary to a protamine reaction and required reoperation to relieve pericardial tamponade. Subsequently he developed a sternal wound dehiscence. Anticoagulants were stopped to prepare him for reoperation to close the dehiscence. Clotting factors returned to normal three days later. For reasons which are not clear from the chart, the operation was delayed another 5 days, and on the night before planned operation he suffered a massive pulmonary embolus and died.

Scores:

Confidence in management as cause of AE	= 5
Excess disability caused by AE	= 8
Severity of negligence	= 3
Confidence in evidence of negligence	= 5

COMMENT: The terminal event could be ascribed to the patient's disease, but on balance the reviewers thought that its likelihood was significantly increased by his management; hence the AE score of 5. Since he was known to be at high risk for thromboembolic complications, delay of his operation after his clotting parameters returned to normal was considered a negligent error in management that contributed to his demise.

7. A 65 y.o. man with alcoholic cirrhosis, congestive heart failure, and coronary artery disease was admitted to the hospital with chest pain and a history of coughing up bloody sputum. Chest xray demonstrated a wedge-shaped density suggestive of a pulmonary embolus. His PT and PTT were elevated due to his cirrhosis. An inferior vena cava filter was placed to prevent further emboli. Six hours later he suffered a massive hematemesis and died. Autopsy revealed large esophageal varices.

Scores:

Confidence in management as cause of AE	= 1
Excess disability caused by AE	= NA
Severity of negligence	= NA
Confidence in evidence of negligence	= NA

COMMENT: The question here is whether death from bleeding esophageal varices was an adverse event, due to failure to make the diagnosis of varices (potentially a management error of omission). The reviewers thought not, since the doctors appear to have fulfilled a reasonable standard of care in linking the bloody sputum to a typical symptom complex and radiologic findings consistent with pulmonary embolus. It is hard to see how the filter placement was related to his exsanguination.

8. A 54 y.o. male with a history of tobacco abuse, half-flight dyspnea, and chronic obstructive pulmonary disease was admitted to the hospital with pleuritic chest pain and shortness of breath. Chest xray revealed a 10% pneumothorax on the left side. His symptoms improved, and in the morning he expressed the wish to go home. Physical examination was unchanged, and a chest xray showed no change in the pneumothorax. He was discharged.

   Ten hours later he returned to the hospital in extremis, with a 60% pneumothorax. He required intubation and the placement of a chest tube. He recovered and was discharged two weeks later.

   Scores:

Confidence in management as cause of AE	= 5
Excess disability caused by AE	= 1
Severity of negligence	= 3
Confidence in evidence of negligence	= 6

   COMMENT: This patient had severely compromised respiratory function prior to the onset of the pneumothorax. Increase in the pneumothorax is, therefore, a significant risk to his life. Thus, the second hospitalization and chest tube insertion are considered to be an adverse event secondary to a management error of failing to keep the patient in the hospital under close observation until the pneumothorax resolved.

9. A 47 y.o. woman with symptoms consistent with recurrent cholecystitis was admitted to the hospital. Ultrasound examination revealed gallstones. During cholecystectomy, common duct exploration was performed. The cholangiogram in the operating room was interpreted as normal, but it was difficult to read because of air bubbles. On the seventh postoperative day T-tube cholangiogram revealed a retained stone. A second procedure was required to remove the stone.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 1
Severity of negligence	= 2
Confidence in evidence of negligence	= 6

COMMENT: The retained stone is an AE because it resulted from an error in management: failure of the surgeon to obtain a satisfactory cholangiogram in the operating room.

10. A nurse gave insulin to the wrong patient, producing an AE of hypoglycemic shock and prolonged hospitalization.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 1
Severity of negligence	= 3
Confidence in evidence of negligence	= 6

11. An infection developed in a clean herniorrhaphy incision in an otherwise healthy adult with no explanation identified. The hospitalization was prolonged two days by this AE.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 1
Severity of negligence	= 1
Confidence in evidence of negligence	= 2

COMMENT: Confidence in cause is high because an infection could not have developed without an operation. Negligence is rated as 2 as per the policy protocol concerning wound infections.

12. Same as Example 11 except that it was discovered after the operation that the surgical sterilizer had been defective and had not provided the required high temperatures and pressure. Same AE as Example 11.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 1
Severity of negligence	= 3
Confidence in evidence of negligence	= 6

COMMENT: Severity of negligence is rated high because of implication of breach of sterile technique in other operations.

13. A 74 y.o. patient with a history of recent myocardial infarction was admitted to the coronary intensive care unit with chest pain and EKG changes suggestive of anterior myocardial infarction. No antiarrhythmic drug was prescribed. He subsequently suffered ventricular fibrillation and cardiac arrest, was intubated, resuscitated, and had a prolonged hospitalization.

Scores:

Confidence in management as cause of AE	= 4
Excess disability caused by AE	= 1
Severity of negligence	= 2
Confidence in evidence of negligence	= 3

COMMENT: The patient's AE was the episode of ventricular fibrillation, which might have been prevented with lidocaine. The use of antiarrhythmic drugs in patients over the age of 70 is somewhat controversial; this is reflected in the confidence rating of negligence. This case illustrates how causation and negligence decisions may be closely linked.

14. A physician ordered a transfusion for an Rh-negative patient. At a time of unusually heavy workload in the blood bank, an inexperienced medical student sent an Rh-positive unit to the hospital floor. The nurse matched the blood by name and unit number and gave the transfusion. The patient had a mild transfusion reaction and hemoglobulinuria which delayed discharge.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 1
Severity of negligence	= 3
Confidence in evidence of negligence	= 6

COMMENT: The AE was the transfusion reaction which occurred because the blood bank technician failed to check for Rh compatibility. This AE was a "system error" because the blood bank should have experienced back- up personnel to avoid errors by novice technicians.

15. A surgeon resected the sigmoid colon for the treatment of diverticulitis and completed an anastomosis low in the pelvis with difficulty and with concerns as to the adequacy of the colonic blood supply. Because he decided the anastomosis would heal he did not perform a protective transverse colostomy. A pelvic abscess developed post-operatively necessitating a traverse colostomy.

Scores:

Confidence in management as cause of AE	= 4
Excess disability caused by AE	= 3
Severity of negligence	= 2
Confidence in evidence of negligence	= 4

COMMENT: The probable AE was the pelvic sepsis which may have been avoided had a traverse colostomy been performed at the first

operation. Confidence in causation was only 4 because the diverticulitis may have contributed to the complication.

16. An unexplained infection developed in a clean, open renal biopsy incision in a uremic, malnourished, and immunosuppressed patient being treated for rejection of kidney transplant. Several other skin infections were present. The AE was the 3-week delay in healing.

    Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 1
Severity of negligence	= 1
Confidence in evidence of negligence	= 1

    COMMENT: Because several infections were noted elsewhere in the patient, confidence in cause was scored as 6.

17. An 80 y.o. male patient recovering from a cholecystectomy experienced difficulty with urination. His prostate was normal in size and the urology consultant recommended a course of phenoxybenzamine. This helped with bladder emptying, but caused postural hypotension. The patient developed slight dizziness, but the staff did not restrain him or limit his activity because early discharge was planned. He fell and fractured his right hip.

    Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 5
Severity of negligence	= 2
Confidence in evidence of negligence	= 5

COMMENT: The AE followed the administration of phenoxybenzamine (an error of commission). The absence of restraints or control over his movements was evidence for negligence. The confidence in negligence level was reduced slightly because the planned early discharge was presumably a factor in his not being restrained (an error of omission).

18. A drug reaction, which prolonged hospitalization, occurred because the physician in charge had neglected to obtain a history of the drug sensitivities.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 1
Severity of negligence	= 2
Confidence in evidence of negligence	= 6

19. Same as Example 18 except that the physician in charge had obtained a complete history and found no evidence for sensitivity to the offending drug.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 1
Severity of negligence	= NA
Confidence in evidence of negligence	= NA

20. An obese 50 y.o. female had an hysterectomy to treat endometrial cancer. The record contained no evidence for prophylactic therapy for pulmonary embolism including compression bandages to the legs or anticoagulation. She developed a pulmonary embolus prolonging her hospitalization by five weeks.

Scores:

Confidence in management as cause of AE	= 2
Excess disability caused by AE	= 2
Severity of negligence	= 1
Confidence in evidence of negligence	= 5

COMMENT: The AE was possibly due to the omission of preventive measures. Confidence in management causation is slight since there were several risk factors involved. On the other hand, failure to provide prophylactic treatment is a deviation from accepted standards.

21. A 49 y.o. man suffered contusions in a fight. His clouded sensorium was thought to be due to his head trauma and to chronic alcoholism. He improved slowly and was carefully monitored by the nursing staff. On the 15th hospital day, he obtained a cigarette from another patient, and inadvertently ignited his bedclothes. He sustained 20% body burns and was hospitalized for 4 additional months.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 5
Severity of negligence	= 2
Confidence in evidence of negligence	= 2

COMMENT: We score causation as 6 because the accident occurred while he was hospitalized. The confidence in negligence score is only 2, because the nursing staff did monitor the patient and could not reasonably have been expected to prevent all such incidents. Of note, the patient's own irresponsibility plays a role in the low negligence score.

22. A 74 y.o. woman suffered a major anterior myocardial infarction. She stabilized. On the fifth hospital day a nurse left a 25 mg tablet of captopril in her room, although the doctor's order was for 6.25 mg. The tablet was given to the patient by a relative who was not aware that the nurse had planned to split it. After taking the captopril, the patient suffered an acute drop in blood pressure. A central venous line was placed and supportive treatment was given. The patient had a rocky course with ischemic renal failure and recurrent fevers. The central line tip grew staphylococcus, and the patient became septic. She had another MI and died.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 8
Severity of negligence	= 3
Confidence in evidence of negligence	= 6

COMMENT: In this case there were two AEs: the captopril incident and the septic complication from the central line. If they had been independent, the central line sepsis would have been chosen as the more important, since it ultimately resulted in death. However, the two AEs formed a causal chain: the central line was placed because of the captopril incident. Therefore, the error in captopril administration was considered to be the cause of the ultimate outcome, the causation and negligence scores refer to it.

23. A 39 y.o. woman had a hysterectomy for fibroids. Post-operatively the antecubital intravenous line infiltrated and the patient was noted to have trouble flexing the arm at the elbow. This problem persisted and several weeks later a neurologist diagnosed a brachial plexus injury that must have occurred at the time of operation.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 5
Severity of negligence	= 2
Confidence in evidence of negligence	= 6

COMMENT: Both negligence and causation scores are 6. A true cause may be widely separated in time from the apparent cause of a disability. This underscores the importance of reviewing the medical record for post-discharge information.

24. According to the nurses' notes, pus drained from the operative site in a 41 y.o. woman on the fourth postoperative day after uneventful elective cholecystectomy, without common duct exploration. No wound culture was obtained. The doctors diagnosed fat necrosis, but prescribed intravenous antibiotics. Hospitalization was prolonged by five days.

Scores:

Confidence in management as cause of AE	= 6
Excess disability caused by AE	= 1
Severity of negligence	= 1
Confidence in evidence of negligence	= 2

COMMENT: This case illustrates that a judgment of negligence is made only when an AE has occurred. The fact that antibiotics were given is strong evidence that the physician believed that the wound was infected. The resulting prolonged hospital stay is the AE. Since the infection followed a clean operation with no mitigating factors, a confidence of negligence score of 2 is given, as per the policy protocol. In addition, there were two treatment errors that could be considered negligent: failure to obtain a wound culture in the presence of pus, and use of intravenous antibiotics without a culture. Since neither of these errors caused an adverse event, they were not evaluated in this study.

IF FOUND, PLEASE RETURN TO DIRECTOR OF MEDICAL RECORDS.

Directions:

Please verify that the preprinted information is correct. If you find an error, cross out the incorrect information and write in the correction alongside or below, or check the appropriate entry.

Place a check in the space___ beside the appropriate response and write the response or note in the spaces provided.

Case no: 1 MRA id: __ __ __

Med Record No:

Admission No:

Date admit: Date discharge:

Patient last name:_____

Patient first name:_____

Patient middle name:_____

Address:

Phone no: (1) ( )-____-_____ (2) ( )-____-_____

DOB:

Sex: F age: 0

Race: white Wht/Blk/Hisp/Asian/Indian/Other

Marital status: 1__S 2__M 3__ D 4__Sep
5__ Wid 6__Unknown

Employment status: 1___employed 5___homemaker
2___retired 6___unempl worker
3___student 7___other (specify)
4___disabled 8___unknown

Occupation: _____

Social Security No:_____-____-_____

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Patient's most recent employer:

Employer name:_____

Location:_____

Phone: (____)_____-_____

Next of kin_____
Last , First MI

Relationship to PT:_____ Phone: ( )___-____

Address:

NOK employer:_____Phone: ( )___-_____

Employer Address:_____

Guarantor (if different from patient or next of kin):

_____
Last First MI
Phone: ( ) ____-_____

Address: _____

Guarantor's employer:_____

Address:_____

Phone: _____

Other patient information (check all that apply):

1__Non-custodial parent:_____

2__Non-English speaking (language)_____
3__Literacy problem 4__Mentally retarded
5__Hearing inpaired 6__Vision impaired
7__Died post-discharge 8__Confined to nursing home
9__Other (specify):

Case no: 1

Medical record technician/administrator ID:___ ___ ___

Date record reviewed:__ __/__ __/__ __
mm dd yy

Medical record no.

Admission no.

License No.

Attending physician:

Other physician: 0

Operating physician: 0

Admission status: sched

DRG: 391

Length stay (LOS): 3

DRG outlier LOS: 5.8 NOT AN OUTLIER

Principal diagnosis: V300

Diagnosis 2:

Diagnosis 3:

Diagnosis 4:

Diagnosis 5:

Principal procedure:

Procedure 2:

Procedure 3:

Procedure 4:

Procedure 5:

*Injury the result of accident: not applic

Transfer to this hosp: not a transf

1__acute care hosp 2__long term facil
3__other inst 4__not a transfer

Disp of patient: home

1__acute care hosp 2__SNF 3__ICF/MRF
4__other inst 5__home 6__home hlth serv
7__against med advice 8__died
9__chron psych inst

Alternate care: 0

Primary reimbursement: self pay

Secondary reimbursement: 0

Medicare no: 000000000000

blue cross no 1: 000000000000000 Plan No 1: 000
blue cross no 2: 000000000000000 Plan No 2: 000

Commercial ins co: 000000000000000
Commercial ins no.: 000000000000000

*Cmrcl ins WC/AUTO NF? 0

Medicaid no: 00000000000

*Info from SPARCS; reviewers disregard

Case no: 1

Screening criteria: Circle nos. of all that apply. Note the reason(s) with specific reference to criteria + exceptions.

1. Prior hospitalization within 1 year patient less than 65 yrs old; if greater than 65 within 6 months

Note:_____

_____

2. Subsequent admission any hospital, post this discharge

Note:_____

_____

3. Prior failure or untoward results of med mgmt

Note:_____

_____

4. Hospital-incurred trauma

Note:_____

_____

5. Untoward drug reaction in hospital

Note:_____

_____

6. Transfer from genl care to special care unit

Note:_____

_____

7. Transfer to another acute care hospital

Note:_____

_____

8. Return to O.R. this admission

Note:_____

_____

9. Tx or Op for diag organ subseq to invasive procedure

Note:_____

_____

10. Acute MI, CVA or PE during/post invasive procedure

Note:_____

_____

11. Neurologic deficit at discharge

Note:_____

_____

12. Death

Note:_____

_____

13. Temp > 101 F (38.3 C) on day of or prior to disch

Note:_____

_____

14. Cardiac/respiratory arrest, incl 5 min Apgar <6

Note:_____

_____

15. Obstetrical mishap/complication of abort/labor-deliv

Note:_____

_____

16. Other undesirable outcomes

Note:_____

_____

17. Correspondence indicating litigation

Note:_____

_____

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MEDICAL PRACTICE STUDY:
ADVERSE EVENT ANALYSIS FORM

Directions:

Complete this form only if the record review by medical record administrators or other staff has found that a screening criterion is fulfilled.
DO NOT WRITE MEDICAL RECORD NUMBERS ON THIS FORM.

Place your answers in the space or box beside the appropriate section.
PLEASE PRINT OR WRITE RESPONSES OR NOTES LEGIBLY.

"AE" means adverse event.

CASE NO. ☐☐☐☐☐☐☐

(Copy from the top of the 3-page Hospital Record Screen)

IF FOUND, PLEASE RETURN TO DIRECTOR OF MEDICAL RECORDS

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1. Reviewer's ID number: ☐☐☐

2. Date this review: ☐☐ ☐☐ 88
mm dd yy

3. DO YOU CONFIRM THE MEDICAL RECORD ADMINISTRATOR'S POSSIBLE AE FINDING?

1 ☐ Yes
0 ☐ No

IF YOU ANSWERED "YES" TO Q. 3 GO TO Q. 4, *DETERMINATION OF ADVERSE EVENT*

3.1. IF YOU ANSWERED NO TO Q. 3, INDICATE IN BOX AT RIGHT THE REASON FOR YOUR ANSWER.

1. criterion error (criterion not fulfilled, no AE)
2. criterion inappropriate (criterion fulfilled, no AE);
   Explain: _____
   _____
3. inconsequential finding (no prolongation of hospitalization, no significant disability at discharge)
4. inadequate documentation (causation indeterminate due to deficiencies in record)
5. other (specify) _____
   _____

SCORE ☐

IF NO POSSIBLE AE FOUND, STOP: END OF ADVERSE EVENT FORM, THANK YOU.

THIS SPACE FOR MPS STAFF USE ONLY

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4. DETERMINATION OF ADVERSE EVENT

In your best judgment, is there evidence that medical management caused the patient's injury? In answering this question, consider when relevant the following questions and CHECK THE APPROPRIATE BOXES IN COLUMN AT RIGHT:

4.1. Is there a note in the medical record which indicates or suggests that medical management caused the injury?	1 ☐ No (suggests no AE) 2 ☐ Yes (suggests AE)
4.2. Is there a note in the medical record which predicts the possibility of an injury from the patient's disease?	1 ☐ Yes (suggests no AE) 2 ☐ No (suggest AE)
4.3. Does the timing of events suggest that the injury was related to the treatment?	1 ☐ Unlikely 2 ☐ Possibly 3 ☐ Likely
4.4. Are there other reasonable explanations for the cause of the injury?	1 ☐ Many competing explanations 2 ☐ Some competing explanations 3 ☐ Few competing explanations
4.5. Was there an opportunity prior to the occurrence of the injury for intervention which might have prevented it?	1 ☐ No (suggests no AE) 2 ☐ Possibly 3 ☐ Yes (suggests AE)
4.6. Is there recognition that the intervention in question causes this kind of an injury?	1 ☐ No 2 ☐ Recognized by specialists 3 ☐ Widely recognized
4.7. Did the adverse event respond to new management to neutralize or modify effects of former management?	1 ☐ No such response (suggests no AE) 2 ☐ Suggestive response 3 ☐ Convincing response (suggests AE)

CONSIDER EACH OF THE ABOVE QUESTIONS PRIOR TO CONTINUING WITH Q. 4

4.8. After due consideration of the clinical details of the patient's management, AND YOUR RESPONSES TO Q. 4.1-4.7, what level of confidence do you have that the MEDICAL MANAGEMENT CAUSED THE INJURY? (Indicate one score in box at right)

Confidence Score

1. Little or no evidence for management causation
2. Slight to modest evidence for management causation
3. Management causation not quite likely; less than 50-50 but close call
4. Management causation more likely than not; more than 50-50 but close call
5. Strong evidence for management causation
6. Virtually certain evidence for management causation

SCORE ☐

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AE DESCRIPTION:

4.91. Please describe briefly the adverse event (not how it occurred):

_____

_____

_____

_____

_____

4.92. Please describe briefly the relation of AE to medical management and the disease process:

_____

_____

_____

_____

_____

IF YOUR CONFIDENCE SCORE FOR CAUSATION IN 4.8 IS 2 OR GREATER, THEN PROCEED TO QUESTION 5.1, *SPECIAL SITUATIONS*. IF YOUR CONFIDENCE SCORE IS 1, THEN PROCEED TO QUESTION 11.

5.1. Special situations (Check all that apply):

Was the AE:

- 1 ☐ a drug reaction or drug side effect?
- 2 ☐ a fall?
- 3 ☐ a wound infection?
- 4 ☐ the result of a failure/delay in diagnosis?
- 5 ☐ the result of an omission of appropriate therapy?
- 6 ☐ the result of experimental medical treatment approved by a human subjects committee?
- 7 ☐ the result of a defective device or product?
- 8 ☐ involving a DNR (do not resuscitate) patient?

IF YOU CHECKED 1, DRUG REACTION OR SIDE EFFECT, THEN ANSWER Q. 5.21-5.24

5.21. Was the drug (Indicate one drug in box at right):

1. antibiotic
2. antineoplastic agent
3. anti-seizure medication
4. diabetes drug
5. cardiovascular agent
6. asthmatic agent
7. sedative, hypnotic
8. peptic ulcer medication
9. antihypertensive
10. antidepressant
11. antipsychotic
12. analgesics
13. other (specify)_____

DRUG ☐

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5.22. What was the drug? _____

5.23. What was the side effect? _____

5.24. Would a physician using reasonable medical judgment prescribe the drug even with knowledge beforehand that this side effect would occur?

1 ☐ Yes
0 ☐ No

PATIENT CONTRIBUTION TO AE:

5.31. Is there evidence that patient conduct contributed in important measure to this AE?

1 ☐ Yes
0 ☐ No

IF YOU HAVE ANSWERED "NO" TO Q. 5.31 THEN SKIP TO Q. 6.1, *DISABILITY*

5.32. Is there evidence that the patient was not competent to make rational decisions with regard to medical therapy or management?

1 ☐ Yes
0 ☐ No

IF YOU HAVE ANSWERED "YES" TO Q. 5.32 THEN SKIP TO Q. 6.1, *DISABILITY*

5.33. If you have answered YES to Q. 5.31 and NO to Q. 5.32 THEN rate on a 6 point scale your confidence in your judgment that the patient contributed to the AE. (Indicate one score in box at right)

Confidence Score

1. Little or no confidence
2. Slight to modest confidence
3. Patient contribution not quite likely; less than 50-50 but close call
4. Patient contribution more likely than not; more than 50-50 but close call
5. Strong confidence
6. Virtually certain

SCORE ☐

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6. DISABILITY

6.1. Was the patient's length of hospitalization extended because of this adverse event?

1 ☐ Yes
0 ☐ No

6.15. If YES, estimate the number of days of increased hospital stay because of the adverse event.

DAYS ☐☐☐

6.2. Check the organ system(s) or bodily function(s) involved as part of the AE. (Check all that apply)

- 6.2a ☐ central nervous/cognitive
- 6.2b ☐ central nervous/sensory
- 6.2c ☐ central nervous/motor
- 6.2d ☐ central nervous/psychiatric
- 6.2e ☐ peripheral nervous/sensory
- 6.2f ☐ peripheral nervous/motor
- 6.2g ☐ cranial nervous/sensory
- 6.2h ☐ cranial nervous/motor
- 6.2i ☐ vision
- 6.2j ☐ smell
- 6.2k ☐ taste
- 6.2l ☐ hearing
- 6.2m ☐ speech (larynx, tongue, vocal cords)
- 6.2n ☐ blood forming/hematologic
- 6.2o ☐ immune system
- 6.2p ☐ cardiovascular/circulation
- 6.2q ☐ endocrine (including breasts)
- 6.2r ☐ gastrointestinal
- 6.2s ☐ reproductive or genital
- 6.2t ☐ urinary/renal
- 6.2u ☐ respiratory
- 6.2v ☐ skin
- 6.2w ☐ musculoskeletal
- 6.2x ☐ other (specify)_____

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6.3. Degree of patient's disability caused by this AE over and above patient's disability from underlying disease. (Indicate one score in box at right)

1. Minimal impairment (functional, cosmetic) followed by almost complete recovery **within 1 month** of sustaining AE.

2. Moderately incapacitating impairment (functional, cosmetic) followed by almost complete recovery in more than 1 month but **within 3 months** of sustaining AE.

3. Same as 2 with almost complete recovery in more than 3 months but **within 6 months** of sustaining AE.

SCORE

4. Moderately incapacitating impairment (functional, cosmetic) followed by almost complete recovery in **more than 6 months** or incomplete recovery not interfering significantly with employment or leisure activity.

5. Disability causing **1% to 50% permanent** decrease in employment or leisure activity.

6. Disability causing **51% to 100% permanent** decrease in employment or leisure activity.

7. Requires personal and/or nursing **support permanently.**

8. **Death**

9. Cannot reasonably judge disability from medical record.

6.41. WHEN did medical management and the consequent AE occur in relation to the index hospitalization. (Indicate one score in box at right)

1. Medical management **during** index hospitalization; AE discovered **during** index hospitalization.

2. Medical management **during** index hospitalization; AE discovered **after** discharge and **during outpatient treatment** (e.g. ER visit which might or might not lead to hospitalization)

SCORE

3. Medical management **during** index hospitalization; AE discovered **after** discharge and **during subsequent hospitalization.**

4. Medical management in **outpatient treatment prior** to index hospitalization (but after Jan. 1, 1981); AE indication for index hospitalization or first discovered **during** index hospitalization.

5. Medical management during **hospitalization** at any institution **prior** to index hospitalization (but after Jan. 1, 1981); AE indication for index hospitalization or first discovered **during** index hospitalization.

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6.42. If causal medical management occurred prior to the index hospitalization, give date of management: (e.g., 01/83 for January 1983)

mm yy

6.43. If AE discovered after the index hospitalization, give date of AE:

mm yy

6.5. WHERE did the medical management event causing the AE occur? (Indicate one site in box at right)

SITE

Outside Hospital

1. Physician's office
2. Ambulatory care unit (including day surgery) outside hospital
3. Home
4. Home, labor and delivery
5. Nursing home
6. Other site outside of hospital (specify) _____

In Hospital

7. Patient's hospital room
8. OR
9. ICU
10. ER
11. Ambulatory care unit (including day surgery) inside hospital
12. Recovery room
13. Labor and delivery
14. Nursery
15. Radiology
16. Cardiac catheterization
17. Therapy/rehabilitation
18. Pathology
19. Laboratory (clinical)
20. Blood bank
21. Pharmacy
22. Hospital bathroom
23. Service areas (stairs, halls, elevator)
24. Procedure room
25. Other site in hospital (specify) _____

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6.6. SPECIALTY or category responsible for AE (Indicate one specialty from the following list in box at right):

SPECIALTY

Surgery

1. anesthesiology
2. cardiac surgery
3. colon/rectal surgery
4. general surgery
5. gynecology
6. neurosurgery
7. obstetrics
8. orthopedic surgery
9. pediatric surgery
10. plastic surgery
11. thoracic surgery
12. vascular surgery
13. urological surgery

Medicine

14. cardiology
15. dermatology
16. emergency medicine
17. endocrinology
18. family practice
19. gastroenterology
20. hematology
21. immunology and allergy
22. infectious diseases
23. intensivist (ICU)
24. internal medicine (not otherwise classified)
25. medical oncology
26. neonatology
27. nephrology
28. neurology
29. ophthalmology
30. otorhinolaryngology (ENT)
31. pathology
32. pediatrics
33. physical medicine
34. psychiatry
35. pulmonary disease
36. radiation therapy
37. radiology (diagnostic)
38. rheumatology
39. other (specify)_____

Non MD Specialty and Other Categories

40. dentistry/oral surgery
41. dietary
42. hospital physical plant
43. midwifery
44. nursing
45. osteopathy
46. pharmacy
47. physical or occupational therapy
48. podiatry
49. transportation support services
50. other (specify)_____

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7. IS THERE EVIDENCE FOR NEGLIGENCE?

1 ☐ Yes
0 ☐ No

7.1. Was this AE possibly due to a reasonably avoidable error, or carelessness by either an individual or medical care system, or both?

IF YOUR ANSWER IS NO, GO TO Q. 11. OTHERWISE CONTINUE WITH Q. 7.2.

7.2. CLASSIFY the error. In a few cases more than one error might be present. If that is the case, RANK IN ORDER OF IMPORTANCE (1=most important).

Rank		
7.21	☐	Error in DIAGNOSIS including failure to order or perform appropriate diagnostic procedures or tests.
7.22	☐	Error in PREVENTION of adverse event due to failure to employ accepted standards of management.
7.23	☐	Error in PERFORMANCE OF A PROCEDURE OR OPERATION.
7.24	☐	Error in DRUG TREATMENT.
7.25	☐	SYSTEM ERROR primarily caused by the medical care system.
7.26	☐	OTHER ERROR not related to above (specify)_____

7.3. If the AE resulted from a DIAGNOSTIC error, was it due to (Check as many as apply):

7.31	☐	Failure to employ indicated tests?
7.32	☐	Failure to act upon results of tests or findings?
7.33	☐	Use of inappropriate or outmoded diagnostic tests?
7.34	☐	Avoidable delay in diagnosis?
7.35	☐	Physician or other professional practicing outside area of expertise?
7.36	☐	Other diagnostic error (describe): _____
7.37	☐	Reason for error not apparent?

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7.4. If the AE resulted from an error in PREVENTION, was it due to (Check as many as apply):

7.41 ☐	Failure to take precaution to prevent accidental injury?
7.42 ☐	Failure to employ indicated tests?
7.43 ☐	Failure to act upon results of tests or findings?
7.44 ☐	Use of inappropriate or outmoded diagnostic tests?
7.45 ☐	Avoidable delay in treatment?
7.46 ☐	Physician or other professional practicing outside area of expertise?
7.47 ☐	Other prevention error (describe):_____

7.5. If the AE resulted from an error in the PERFORMANCE OF A PROCEDURE OR OPERATION, was it due to (Check as many as apply):

7.51 ☐	Inadequate preparation of patient before?
7.52 ☐	Technical error?
7.53 ☐	Inadequate monitoring of patient afterwards?
7.54 ☐	Use of inappropriate or outmoded form of therapy?
7.55 ☐	Avoidable delay in treatment?
7.56 ☐	Physician or other professional practicing outside area of expertise?
7.57 ☐	Other performance error (describe): _____

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7.6. If the AE resulted from an error in DRUG TREATMENT, was it due to (Check as many as apply):

7.61 ☐	Error in dose or method of use?
7.62 ☐	Failure to recognize possible antagonistic or complementary drug-drug interactions?
7.63 ☐	Inadequate follow-up of therapy?
7.64 ☐	Use of inappropriate drug?
7.65 ☐	Avoidable delay in treatment?
7.66 ☐	Physician or other professional practicing outside area of expertise?
7.67 ☐	Other drug treatment error (describe): _____

_____

7.7. If the AE resulted from a SYSTEM ERROR, was it due to (Check as many as apply):

7.71 ☐	Defective equipment or supplies?
7.72 ☐	Equipment or supplies not available?
7.73 ☐	Inadequate monitoring system?
7.74 ☐	Inadequate reporting or communications?
7.75 ☐	Inadequate training or supervision of MD or other personnel?
7.76 ☐	Delay in provision or scheduling of service (Xray, lab tests, follow-up visit, etc.)?
7.77 ☐	Inadequate staffing?
7.78 ☐	Inadequate functioning of hospital service (e.g., pharmacy, blood bank, housekeeping)?
7.79 ☐	Other system error (describe): _____

_____

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8. If any of the following possible MITIGATING or AGGRAVATING CIRCUMSTANCES were present, CHECK ONE STATUS IN BOXES AT RIGHT FOR EACH CIRCUMSTANCE.

8.1 Degree of deviation of treatment from accepted norms

1 ☐ little
2 ☐ moderate
3 ☐ severe

8.2 Degree of additional morbidity created for typical patient with similar age, diagnosis, and severity of illness, who is victim of this kind of negligence (i.e., not the specific degree of morbidity in the patient under consideration)

1 ☐ little
2 ☐ moderate
3 ☐ severe

8.3 Number of all patients who are at risk for this kind of negligence

1 ☐ small
2 ☐ moderate
3 ☐ large

8.4 Degree of emergency in management of case prior to occurrence of negligence

1 ☐ critical & very urgent
2 ☐ moderate
3 ☐ not urgent

8.5 Complexity of case in which negligence occurred

1 ☐ very complex
2 ☐ moderately complex
3 ☐ uncomplicated

8.6 Co-morbidity of case in which negligence occurred

1 ☐ very ill patient
2 ☐ moderately ill patient
3 ☐ no co-morbidity

8.7 Lack of consensus about correct therapy or diagnosis (even among experts)

1 ☐ very little consensus
2 ☐ some consensus
3 ☐ great deal of consensus

8.8. After having considered the factors in 8.1-8.7 you might have reassessed whether negligence occurred. If you feel there is NO negligence, CHECK THE SPACE ON THE RIGHT AND GO TO Q. 11.

NO NEGLIGENCE ☐

8.9. If you find that negligence did occur, what is the severity of this type of negligence? (Indicate one score in box at lower right)

Severity Score
1. Slight
2. Moderate
3. Grave

SCORE ☐

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9. If you have given a Severity Score of 1, 2, or 3, then rate on a 6 point scale your confidence in the evidence for negligence. (Indicate one score in box at right)

Confidence Score

1. Little or no evidence for negligence
2. Slight to modest evidence for negligence
3. Negligence not quite likely; less than 50-50 but close call
4. Negligence more likely than not; more than 50-50 but close call
5. Strong evidence for negligence
6. Virtually certain evidence for negligence

SCORE

10. PLEASE DESCRIBE BRIEFLY THE NEGLIGENCE:

ADDITIONAL AEs:

11. If you have identified an AE, is there an additional AE that contributed to the patient's disability, is attributable to provider negligence, and is not described in your responses to questions 1-10?

1 ☐ Yes
0 ☐ No

11.1 If YES, describe briefly the medical management, the AE, and the negligence:

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12. Reviewer's judgments limited or hampered by lack of subspecialty knowledge. (Check "Yes" if you think a specialist's review is necessary)

1 ☐ Yes
0 ☐ No

12.1 If YES, which specialty? (List as many as necessary)

_____ _____ _____

12.2 Describe the judgment which is limited or hampered by lack of subspecialty knowledge and the clinical question you would pose to a specialist.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

12.3 Describe the resolution of the question(s) posed following consultation with a specialist.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

12.4 Specialist's ID number: | | | |

12.5 Specialist's ID number: | | | |

END OF AE ANALYSIS, THANK YOU

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MEDICAL PRACTICE STUDY CONTACTS

In the event of questions or problems, the following people can be contacted at the Medical Practice Study Central Office. The phone number is (617)-732-5991.

PHYSICIAN SUPERVISORS

Dr. Benjamin A. Barnes

Dr. Troyen A. Brennan

Dr. Solomon Fleishman

Dr. Howard S. Frazier

Dr. Howard H. Hiatt

Dr. Lucian L. Leape

Dr. Lynn M. Peterson

MEDICAL PRACTICE STUDY CENTRAL OFFICE

Elaine Gebhardt
Clinical Data Coordinator

CASE ID

RECORD OF ATTEMPTS

Date	Time	Disp	Contact Person	Notes	Int ID

FINAL STATUS

0 Complete
21 Partial
22 Refusal
23 Can't Locate
24 Language
25 Unavailable
26 Ineligible
29 Other

INTERIM-TELEPHONE

1 Partial
2 1st Refusal
3 Appointment
4 Callback
5 No Answer/Busy
6 Searching
7 Language Barrier
8 Will Call
9 Other

10 Unable to Locate

INTERIM-FIELD

11 Partial
12 1st Refusal
13 Appointment
14 Callback
15 Not Home
16 Searching
17 Translation
18 Other

☐ CHECK BOX-SPANISH NEEDED

WEEKLY CALENDAR FOR 1984

DATES		WEEKS REMAINING	MONTHS REMAINING	START MONTH
JAN	1-7	51	12	July 1983
JAN	8-14	50		
JAN	15-21	49		
JAN	22-28	48	11	Aug 1983
JAN	29-31, FEB 1-4	47		
FEB	5-11	46		
FEB	12-18	45		
FEB	19-25, MAR 1-3	44	10	Sept 1983
MAR	4-10	43		
MAR	11-17	42		
MAR	18-24	41		
MAR	25-31	40	9	Oct 1983
APRIL	1-7	39		
APRIL	8-14	38		
APRIL	15-21	37		
APRIL	22-28	36		
APRIL	29-30, MAY 1-5	35	8	Nov 1983
MAY	6-12	34		
MAY	13-19	33		
MAY	20-26	32		
MAY	27-31, JUNE 1-2	31	7	Dec 1983
JUNE	3-9	30		
JUNE	10-16	29		
JUNE	17-23	28		
JUNE	24-30	27		
JULY	1-7	26	6	Jan 1983
JULY	8-14	25		
JULY	19-25	24		
JULY	25-31	23		
AUG	1-4	22	5	Feb 1984
AUG	5-11	21		
AUG	12-18	20		
AUG	19-25	19		
AUG	26-31 SEPT 1	18	4	March 1984
SEPT	2-8	17		
SEPT	9-15	16		
SEPT	16-22	15		
SEPT	23-29	14		
SEPT	30 OCT 1-6	13	3	April 1984
OCT	7-13	12		
OCT	14-20	11		
OCT	21-27	10		
OCT	28-31, NOV 1-3	9	2	May 1984
NOV	4-10	8		
NOV	11-17	7		
NOV	18-24	6		
NOV	25-30, DEC 1	5		
DEC	2-8	4	1	June 1984
DEC	9-15	3		
DEC	16-22	2		
DEC	23-29	1		
DEC	30-31	0		

HARVARD PROJECT
7768-003

NOTES:

SECTION 4

In the case of students (and/or other individuals) first entering the work force following the key hospitalization, we need to modify the questionnaire:

Q4.2 omit "return to"
Q4.3 same
Q4.4 same
Q4.6 write N/A and skip to Q4.7 for start date
Q4.8 write N/A
Q4.8 A same
Q4.8 B same
Q4.10 omit "return to"
Q4.11 omit "returning to" and change "work" to "working"
Q4.13 omit "returned to" and add "started"

continue to follow regular skips

Q2.36 (WOMEN ONLY)

if PATIENT is living with her husband, and no other adult relatives, code Q2.36 A 00 and go to Q2.37. Column B for Q2.36 should always have at least 2, if the answer to Q2.36 A is 01

Q10.20

if the answer is no, code 00 and to to Q10.20G (bottom of page) and follow skips from there

SCREENER DATE: |__|__| |__|__|
MONTH DAY

CASE I.D.: |__|__|__|__|__|__|__|__|

INTERVIEWER I.D.: |__|__|__|__|

HOSPITALIZATION STUDY SCREENER FOR ADULTS (BORN BEFORE 1968)

DISCHARGE:
[ ][ ]
MONTH/YEAR

INTRODUCTION

Hello, my name is _____. I'm calling for the New York State Commissioner of Health and Mathematica Policy Research. May I please speak with (NAME ON LABEL)?

PATIENT/PROXY NOT AVAILABLE.....(GO TO A)....01
PATIENT/PROXY AVAILABLE.....(GO TO B)....02
PATIENT DECEASED SINCE HOSPITALIZATION.....(GO TO C)....03
PATIENT DIED DURING KEY HOSPITALIZATION....(GO TO D)....04

SEE BACK COVER FOR ANSWERS TO RESPONDENT QUESTIONS.

A. RESPONDENT NOT AVAILABLE

When would be a good time to talk to (PATIENT)?
RECORD TIME ON CONTACT SHEET.

B. RESPONDENT OR PROXY AVAILABLE

B1. We recently sent (you/PATIENT) a letter explaining that Mathematica Policy Research is conducting a study for the New York State Commissioner of Health and Harvard University concerning the costs of illness to patients and their families. I'd like to take a few minutes to talk to you about (your/PATIENT's) hospitalization in 1984.

(Your/His/Her) name was selected from lists of patients treated in New York State hospitals during 1984. All your responses will be kept confidential and your participation is voluntary. Do you have any questions?

B2. INTERVIEWER, CODE TYPES OF QUESTIONS ASKED HERE. THEN CONTINUE WITH INTERVIEW.

NONE.....00
CONFIDENTIALITY.....01
LENGTH OF INTERVIEW.....02
HOW NAME WAS OBTAINED.....03
NEED TO CONSULT LAWYER.....04
TOPIC OF INTERVIEW/TYPES OF QUESTIONS.....05

B3. May we continue? CONTINUE WITH B4 OR SET APPOINTMENT.

VERIFICATION

B4. INTERVIEWER: IF YOU ARE CERTAIN THAT YOU ARE TALKING TO PATIENT OR KNOW PROXY'S RELATIONSHIP TO PATIENT, CODE WITHOUT ASKING.

What is your relationship to (PATIENT)?

PATIENT (SELF).....01
SPOUSE.....02
PARENT.....03
SON, DAUGHTER, SON-/DAUGHTER-IN-LAW...04
OTHER RELATIVE/FRIEND.....05
OTHER (SPECIFY).....09

B5. Before I begin the interview, I'd like to verify some information about (your/PATIENT's) hospitalization during 1984.

Our records indicate that (you were/[he/she] was) a patient at (HOSPITAL) from (ADMISSION DATE) to (DISCHARGE DATE). Is that correct?

YES.....(GO TO B.6).....01
NO.....(ASK A).....00
UNSURE.....(GO TO B.6).....02

A. (Were you/Was PATIENT) hospitalized in (HOSPITAL) during 1984?

YES.....(GO TO B.6).....01
NO.....(ASK B).....00
UNSURE.....(GO TO B.6).....02

B. When (were you/was [he/she]) discharged from (HOSPITAL)?

|__|__| |__|__| |__|__|
MONTH DAY YEAR

NEVER IN (HOSPITAL).....999999

} (GO TO B.10)

B6. What was the main reason for which (you/[he/she]) went into the hospital that time?

_____|_____|
CODER: ICD-9 CODE

B7. What is the highest grade of school (you/PATIENT) completed?

LESS THAN HIGH SCHOOL GRADUATE.....01 → |__|__| YRS
HIGH SCHOOL GRADUATE.....02
SOME COLLEGE.....03
VOCATIONAL/TECHNICAL.....04
COLLEGE DEGREE.....05
POST GRADUATE.....06
DON'T KNOW.....-1

B8. INTERVIEWER VERIFY: PATIENT'S SEX IS (SEX)?

IF SEX IS BLANK, ASK.

CORRECT ON CONTACT SHEET.....01
NOT CORRECT ON CONTACT SHEET.....00

B8A. INTERVIEWER: IF RACE IS BLANK ON THE CONTACT SHEET, ASK: What is (your/PATIENT's) race?

BLACK.....01
WHITE.....02
HISPANIC.....03
ASIAN.....04
OTHER (SPECIFY).....05

_____

REFUSED.....-3

B9. Just before (your/PATIENT's) hospitalization on (ADMISSION DATE), (were you/was [he/she]):

Married, or living as married.....01
Separated.....02
Widowed.....03
Divorced, or.....04
Single never married?.....05
REFUSED.....-3

* * * GO TO F.1 * * *

B10. INELIGIBLE ENDING:

Thank you. Those are all the questions I have right now. We may need to call you at another time with some additional questions.

IF PROXY: May I have your name please?

PROXY NAME: _____

END INTERVIEW

C. PATIENT DIED SINCE HOSPITALIZATION

C1. I'm so sorry. May I take a minute to describe the study we are conducting for the New York State Commissioner of Health and Harvard University concerning the costs of illness to patients and their families. (PATIENT's) name was selected from lists of patients and their families treated in hospitals in New York State during 1984. A letter describing the study was sent to (his/her) address. We would appreciate your answering a few questions related to (PATIENT's) illness. All of your responses will be kept confidential and your participation is voluntary. Do you have any questions?

C2. INTERVIEWER, CODE TYPES OF QUESTIONS ASKED HERE. THEN CONTINUE WITH INTERVIEW.

NONE.....00
CONFIDENTIALITY.....01
LENGTH OF INTERVIEW.....02
HOW NAME WAS OBTAINED.....03
NEED TO CONSULT LAWYER.....04
TOPIC OF INTERVIEW/TYPES OF QUESTIONS....05

C3. When did (PATIENT) pass away?

|__|__|/|__|__| → RECORD DATE ON FACE SHEET
MONTH YEAR

C4. What is the name of the hospital or nursing home where (PATIENT) died?

_____ (GO TO C5)

DIED AT HOME.....(GO TO C.6).....99
DON'T KNOW.....(GO TO C.6).....-1

C5. What city and state is that in?

_____

C6. May we continue? CONTINUE WITH SECTION E OR SET APPOINTMENT.

D. PATIENT DIED DURING INDEX HOSPITALIZATION

D1. We recently sent you a letter explaining that Mathematica Policy Research is conducting a study for the New York State Commissioner of Health and Harvard University concerning the costs of illness to patients and their families. (PATIENT's) name was selected from lists of patients treated in New York State hospitals during 1984.

We would appreciate it if you could take a few minutes to answer some questions related to (his/her) illness. All your responses will be kept confidential and your participation is voluntary. Do you have any questions?

D2. INTERVIEWER, CODE TYPES OF QUESTIONS ASKED HERE. THEN CONTINUE WITH INTERVIEW.

NONE.....00
CONFIDENTIALITY.....01
LENGTH OF INTERVIEW.....02
HOW NAME WAS OBTAINED.....03
NEED TO CONSULT LAWYER.....04
TOPIC OF INTERVIEW/TYPES OF QUESTIONS.....05

D3. May we continue? CONTINUE WITH SECTION E OR SET APPOINTMENT.

E1. INTERVIEWER: IF YOU ARE CERTAIN THAT YOU KNOW PROXY'S RELATIONSHIP TO PATIENT, CODE WITHOUT ASKING.

What is your relationship to (PATIENT)?

SPOUSE.....02
PARENT.....03
SON/DAUGHTER, SON-/DAUGHTER-IN-LAW....04
OTHER RELATIVE/FRIEND.....05
OTHER (SPECIFY).....09

_____

E2. Before I begin the interview, I'd like to verify some information about (PATIENT's) hospitalization during 1984.

Our records indicate that (he/she) was a patient at (HOSPITAL) from (ADMISSION DATE) to (DISCHARGE DATE). Is that correct?

YES.....(GO TO E.4).....01
NO.....(ASK E.3).....00
UNSURE.....(GO TO E.4).....02

E3. Was (PATIENT) hospitalized in (HOSPITAL) during 1984?

YES.....(GO TO E.4)....01
NOT IN THAT HOSPITAL.....02 } (GO TO E.8)
NOT IN 1984.....03 }
IN HOSPITAL, BUT DIDN'T DIE THERE....(GO TO E.4)....04

E4. What was the <u>main reason</u> for which (PATIENT) went into the hospital that time?

_____|_____|
CODER: ICD-9 CODE

E5. What is the highest grade of school (PATIENT) completed?

LESS THAN HIGH SCHOOL GRADUATE.....01 → |__|__| YRS
HIGH SCHOOL GRADUATE.....02
SOME COLLEGE.....03
VOCATIONAL/TECHNICAL.....04
COLLEGE DEGREE.....05
POST GRADUATE.....06
DON'T KNOW.....-1

E6. INTERVIEWER VERIFY: PATIENT'S SEX IS (FILL SEX)?

IF SEX IS BLANK, ASK.

CORRECT ON CONTACT SHEET.....01
NOT CORRECT ON CONTACT SHEET.....00

E6A. INTERVIEWER: IF RACE IS BLANK ON THE CONTACT SHEET, ASK:
What is (PATIENT's) race?

BLACK.....01
WHITE.....02
HISPANIC.....03
ASIAN.....04
OTHER (SPECIFY).....05

_____

REFUSED.....-3

E7. Just before (PATIENT's) hospitalization on (ADMISSION DATE), (was [he/she]):

Married, or living as married.....01
Separated.....02
Widowed.....03
Divorced, or.....04
Single never married?.....05
REFUSED.....-3

*** * * GO TO SECTION F * * ***

E8. INELIGIBLE ENDING:

Thank you. Those are all the questions I have right now. We may need to call you at another time with some additional questions.

IF PROXY: May I have your name please?

PROXY NAME: _____

END INTERVIEW

F. AGE AND LABOR FORCE VERIFICATION

F1. (Were you/Was PATIENT) born on (DATE OF BIRTH)?

YES.....(GO TO F.2).....01
NO.....00
DON'T KNOW.....-1

A. When (were you/was PATIENT) born?

|__|__| |__|__| |__|__|
MONTH DAY YEAR

B. INTERVIEWER: WAS PATIENT BORN 1968-1984?

YES.....(GO TO FORM C).....01
NO.....(CONTINUE WITH F.2).....00

F2. During the six months before (you/PATIENT) went into the hospital on (ADMISSION DATE) (were you/was [he/she]) primarily working or not working?

WORKING.....(GO TO F.5).....01
NOT WORKING.....(ASK F.3).....00

F3. During the six months before (you were/PATIENT was) hospitalized, (were you/was [he/she]) in a nursing home or other long term care facility for most of the time?

YES.....01
NO.....00

F4. I am going to read you a list of employment categories. Please tell me which one best describes (your/PATIENT's) employment status during the six months before (you were/[he/she] was) hospitalized.

(Were you/was [he/she])...

Unemployed.....01 → (F5)

Unable to work because of ill health or disability.....02 → (F5)

Retired because of ill health.....03 → (FORM NLF)

Retired because of age.....04 → (FORM NLF)

WOMEN ONLY: Keeping house exclusively/ not looking for work.....05 → (FORM NLF)

A student.....06 → (F5)

F5. DID PATIENT DIE DURING KEY HOSPITALIZATION?

YES.....(GO TO FORM W/D).....01
NO.....(GO TO FORM W).....00

ANSWERS TO QUESTIONS

READ ONLY IF RESPONDENT REQUESTS MORE INFORMATION

Why me/PATIENT?

We are interviewing a random sample of people discharged from New York state hospitals during 1984.

I'm not interested:

Let me reassure you that we are not selling anything. The purpose of the study is to examine some of the economic consequences of hospitalizations on families. We are looking for a wide range of experiences, and as such, your participation in the study is very important.

Length of interview:

Interviews average between fifteen and thirty minutes. We can do the interview now, or we can call you back at a more convenient time.

How was name obtained?

(Your/PATIENT's) name was randomly selected from hospital records from the year 1984. Access to the records was granted by the New York State Commissioner of Health for the purpose of this study, with the understanding that participation is voluntary and all information will be kept confidential.

Confidentiality:

Any information you give me will be held in the strictest confidence by my company, and will be used only for the purposes of this study. (Your/PATIENT's) name will never be used in reporting the results of the study.

Topic of interview/Types of questions:

We are obtaining information about costs of hospitalizations to patients and their families. Topics include:

a. Follow-up medical care needed after hospitalization.

b. Your/PATIENT's work history, both before and after hospitalization.

c. The economic impact of the hospitalization on other family members.

Need to consult lawyer, doctor, etc.:

All responses are strictly confidential. The results of the study will be reported in statistical summary form. (Your/PATIENT's) name will never be associated with (your/his/her) responses nor will the name be used in reporting the results of the study. However, if you need to consult with someone before the interview, we can call back at a more convenient time.

HOSPITALIZATION STUDY

FORM W

WORKERS

INTERVIEW MODE

TELEPHONE.....01

IN-PERSON.....02

INTERVIEW WITH

RESPONDENT.....01

PROXY.....02

CASE ID |__|__|__|__|__|__|__|__|

INTERVIEWER ID |__|__|__|__|

DATE INTERVIEW BEGAN: |__|__| |__|__|
MO DAY

TIME INTERVIEW BEGAN: |__|__|:|__|__| AM PM

SECTION 1. MEDICAL CARE (LIVE AT DISCHARGE)

1.1 (Were you/Was PATIENT) admitted to (HOSPITAL) on (ADMISSION DATE) <u>from</u> another hospital or nursing home?

YES.....01
NO.....00
DON'T KNOW.....-1

1.1A DATA ENTRY: ENTER 00 AND CONTINUE WITH 1.2.

1.2 And, when (you were/PATIENT was) discharged from (HOSPITAL), (were you/was [he/she]) <u>sent to</u> another hospital or a nursing home?

YES.....(GO TO Q1.4)....01
NO.....(ASK Q1.3).....00
DON'T KNOW.....(ASK Q1.3).....-1

1.3 Did (you/PATIENT) stay in a hospital or nursing home overnight as a patient at any time since (DISCHARGE DATE) when (you were/[he/she] was) discharged from (HOSPITAL)?

YES.....(ASK Q1.4).....01
NO.....(GO TO Q1.7)....00
DON'T KNOW....(GO TO Q1.7)....-1

1.4 (Were you/Was [he/she]) in a hospital or nursing home continuously since (DISCHARGE MONTH)?

YES.....01
NO.....(GO TO Q1.5).....00

A. Was this because of health problems or conditions related to (your/his/her) hospitalization in (HOSPITAL) in (DISCHARGE MONTH)?

YES.....01
NO.....00

B. (Were you/Was PATIENT) in the <u>same</u> hospital or nursing home since (DISCHARGE DATE)?

YES.....(ASK C).....01
NO.....(GO TO Q1.5).....00

C. What is the name of the hospital or nursing home (you are/PATIENT is) in?

_____

D. What city and state is (NAME OF HOSPITAL) in?

_____
CITY

_____
STATE

* * * GO TO Q1.11 * * *

1.5 How many different hospital or nursing home stays (have you/has PATIENT) had since (DISCHARGE DATE FROM FACE SHEET)?

NUMBER OF DIFFERENT STAYS: |__|__|

NO STAYS.....(GO TO Q1.7).....00
DON'T KNOW.....-1

A. How many of these stays were because of health problems or conditions related to (your/his/her) hospitalization in (HOSPITAL) in (DISCHARGE MONTH)?

NUMBER OF DIFFERENT STAYS: |__|__|

NONE.....(GO TO Q1.7).....00
DON'T KNOW.....-1

1.6 I would like to ask you a little more about (that/each) hospital or nursing home stay which was due to health problems or conditions related to (your/his/her) hospitalization in (HOSPITAL) which ended on (DISCHARGE DATE).

READ IF MORE THAN ONE STAY:

Think of the (first/next) hospital or nursing home (you/he/she) stayed in after (DISCHARGE DATE).

- RECORD FIRST HOSPITAL NAME IN COLUMN (a), AND ADDRESS IN COLUMN (b).
- THEN RECORD START DATE AND LENGTH OF STAY FOR EACH VISIT IN COLUMN (c).
- IF RESPONDENT CANNOT LIST EACH VISIT, ASK FOR THE NUMBER OF DAYS (HE/SHE) WAS IN THAT HOSPITAL EACH YEAR (COLUMN d).
- THEN GO ON TO NEXT HOSPITAL.
- IF NO NEXT HOSPITAL, GO TO Q1.7.

PROBE: Please tell me only about stays due to health problems or conditions related to (your/his/her) hospitalization which ended on (DISCHARGE DATE).

RECORD EACH VISIT AND LENGTH OF STAY IN COLUMNS (c1) AND (c2). IF RESPONDENT CANNOT LIST VISITS, COLLECT AGGREGATE DAYS PER YEAR IN COLUMN (d2).

(a)	(b)	(c)		(d)	
				It is difficult for many people to remember the dates of hospitalization. Please tell me approximately how many days (YEAR) (you/he/she) was in (NAME). Was it...	
1.6A		(c1)	(c2)	(d1)	(d2)
What is the (first/next) (hospital's/ nursing home's) name?	What city and state is (NAME) in? RECORD FOREIGN COUNTY OR STATE LINE.	In what month and year did (your/his/her) (first/next) visit start?	How long was that stay?	YEAR	DAYS IN HOSPITAL
	CITY	CANNOT ANSWER....-1 → (GO TO COLUMN (d))		in 1984 after (your/his/her) discharge on (DISCHARGE DATE).	1-10 days.....01 11-20 days.....02 21-30 days.....03 31-60 days.....04 61-90 days.....05 More than 91 days..06 DON'T KNOW.....-1
	STATE	1st __/__/____ MO YR	→ ___ DAYS....01 WEEKS...02 DK.....-1		
		2nd __/__/____ MO YR	→ ___ DAYS....01 WEEKS...02 DK.....-1	in 1985	1-10 days.....0 11-20 days.....0 21-30 days.....0 31-60 days.....0 61-90 days.....0 More than 91 days..0 DON'T KNOW.....-
		3rd __/__/____ MO YR	→ ___ DAYS....01 WEEKS...02 DK.....-1		
		4th __/__/____ MO YR	→ ___ DAYS....01 WEEKS...02 DK.....-1	in 1986	1-10 days.....0 11-20 days.....0 21-30 days.....0 31-60 days.....0 61-90 days.....0 More than 91 days..0 DON'T KNOW.....-
		5th __/__/____ MO YR	→ ___ DAYS....01 WEEKS...02 DK.....-1		
		6th __/__/____ MO YR	→ ___ DAYS....01 WEEKS...02 DK.....-1	in 1987	1-10 days.....0 11-20 days.....0 21-30 days.....0 31-60 days.....0 61-90 days.....0 More than 91 days..0 DON'T KNOW.....
		7th __/__/____ MO YR	→ ___ DAYS....01 WEEKS...02 DK.....-1		
		8th __/__/____ MO YR	→ ___ DAYS....01 WEEKS...02 DK.....-1	through June 30 of 1988	1-10 days..... 11-20 days..... 21-30 days..... 31-60 days..... 61-90 days..... More than 91 days.. DON'T KNOW.....
		9th __/__/____ MO YR	→ ___ DAYS....01 WEEKS...02 DK.....-1		

PROBE: Please tell me only about stays due to health problems or conditions related to (your/his/her) hospitalization which ended on (DISCHARGE DATE).

RECORD EACH VISIT AND LENGTH OF STAY IN COLUMNS (c1) AND (c2). IF RESPONDENT CANNOT LIST VISITS, COLLECT AGGREGATE DAYS PER YEAR IN COLUMN (d2).

(a)	(b)	(c)		(d)	
				It is difficult for many people remember the dates of hospitaliz Please tell me approximately how days (YEAR) (you/he/she) was in Was it...	
1.68		(c1)	(c2)	(d1)	(d2)
What is the next (hospital's/nursing home's) name?	What city and state is (NAME) in? RECORD FOREIGN COUNTY OR STATE LINE.	In what month and year did (your/his/her) (first/next) visit start?	How long was that stay?	YEAR	DAYS IN HOSPI
	CITY	CANNOT ANSWER....-1 → (GO TO COLUMN (d))		in 1984 after (your/his/her) discharge on (DISCHARGE DATE).	1-10 days.....
	STATE	1st |_|_|/|_|_| → |_|_|	DAYS....01		11-20 days.....
		MO YR	WEEKS...02		21-30 days.....
			DK.....-1		31-60 days.....
		2nd |_|_|/|_|_| → |_|_|	DAYS....01		61-90 days.....
		MO YR	WEEKS...02		More than 91 da
			DK.....-1		DON'T KNOW.....
		3rd |_|_|/|_|_| → |_|_|	DAYS....01	in 1985	1-10 days.....
		MO YR	WEEKS...02		11-20 days.....
			DK.....-1		21-30 days.....
		4th |_|_|/|_|_| → |_|_|	DAYS....01		31-60 days.....
		MO YR	WEEKS...02		61-90 days.....
			DK.....-1		More than 91 day
		5th |_|_|/|_|_| → |_|_|	DAYS....01		DON'T KNOW.....
		MO YR	WEEKS...02	in 1986	1-10 days.....
			DK.....-1		11-20 days.....
		6th |_|_|/|_|_| → |_|_|	DAYS....01		21-30 days.....
		MO YR	WEEKS...02		31-60 days.....
			DK.....-1		61-90 days.....
		7th |_|_|/|_|_| → |_|_|	DAYS....01		More than 91 day
		MO YR	WEEKS...02		DON'T KNOW.....
			DK.....-1	in 1987	1-10 days.....
		8th |_|_|/|_|_| → |_|_|	DAYS....01		11-20 days.....
		MO YR	WEEKS...02		21-30 days.....
			DK.....-1		31-60 days.....
		9th |_|_|/|_|_| → |_|_|	DAYS....01		61-90 days.....
		MO YR	WEEKS...02		More than 91 day
			DK.....-1		DON'T KNOW.....
				through June 30 of 1988	1-10 days.....
					11-20 days.....
					31-30 days.....
					31-60 days.....
					61-90 days.....
					More than 91 day
					DON'T KNOW.....

PROBE: Please tell me only about stays due to health problems or conditions related to (your/his/her) hospitalization which ended on (DISCHARGE DATE).

RECORD EACH VISIT AND LENGTH OF STAY IN COLUMNS (c1) AND (c2). IF RESPONDENT CANNOT LIST VISITS, COLLECT AGGREGATE DAYS PER YEAR IN COLUMN (d2).

(a)	(b)	(c)		(d)	
				It is difficult for many people to remember the dates of hospitalization. Please tell me approximately how many days (YEAR) (you/he/she) was in (NAME). Was it...	
1.6C		(c1)	(c2)	(d1)	(d2)
What is the next (hospital's/nursing home's) name?	What city and state is (NAME) in? RECORD FOREIGN COUNTY OR STATE LINE.	In what month and year did (your/his/her) (first/next) visit start?	How long was that stay?	YEAR	DAYS IN HOSPITAL
	CITY	CANNOT ANSWER....-1 → (GO TO COLUMN (d))		in 1984 after (your/his/her) discharge on (DISCHARGE DATE).	1-10 days.....01 11-20 days.....02 21-30 days.....03 31-60 days.....04 61-90 days.....05 More than 91 days..06 DON'T KNOW.....-1
	STATE	1st |_|_|/|_|_| → |_|_| (MO / YR)	DAYS....01 WEEKS...02 DK.....-1	in 1985	1-10 days.....01 11-20 days.....02 21-30 days.....03 31-60 days.....04 61-90 days.....05 More than 91 days..06 DON'T KNOW.....-1
		2nd |_|_|/|_|_| → |_|_| (MO / YR)	DAYS....01 WEEKS...02 DK.....-1		
		3rd |_|_|/|_|_| → |_|_| (MO / YR)	DAYS....01 WEEKS...02 DK.....-1		
		4th |_|_|/|_|_| → |_|_| (MO / YR)	DAYS....01 WEEKS...02 DK.....-1		
		5th |_|_|/|_|_| → |_|_| (MO / YR)	DAYS....01 WEEKS...02 DK.....-1		
		6th |_|_|/|_|_| → |_|_| (MO / YR)	DAYS....01 WEEKS...02 DK.....-1		
		7th |_|_|/|_|_| → |_|_| (MO / YR)	DAYS....01 WEEKS...02 DK.....-1		
		8th |_|_|/|_|_| → |_|_| (MO / YR)	DAYS....01 WEEKS...02 DK.....-1		
		9th |_|_|/|_|_| → |_|_| (MO / YR)	DAYS....01 WEEKS...02 DK.....-1		
				in 1986	1-10 days.....01 11-20 days.....02 21-30 days.....03 31-60 days.....04 61-90 days.....05 More than 91 days..06 DON'T KNOW.....-1
				in 1987	1-10 days.....01 11-20 days.....02 21-30 days.....03 31-60 days.....04 61-90 days.....05 More than 91 days..06 DON'T KNOW.....-1
				through June 30 of 1988	1-10 days.....01 11-20 days.....02 31-30 days.....03 31-60 days.....04 61-90 days.....05 More than 91 days..06 DON'T KNOW.....-1

PROBE: Please tell me only about stays due to health problems or conditions related to (your/his/her) hospitalization which ended on (DISCHARGE DATE).

RECORD EACH VISIT AND LENGTH OF STAY IN COLUMNS (c1) AND (c2). IF RESPONDENT CANNOT LIST VISITS, COLLECT AGGREGATE DAYS PER YEAR IN COLUMN (d2).

(a)	(b)	(c)		(d)	
				It is difficult for many people t remember the dates of hospitaliza Please tell me approximately how days (YEAR) (you/he/she) was in (Was it...	
1.60		(c1)	(c2)	(d1)	(d2)
What is the next (hospital's/nursing home's) name?	What city and state is (NAME) in? RECORD FOREIGN COUNTY OR STATE LINE.	In what month and year did (your/his/her) (first/next) visit start?	How long was that stay?	YEAR	DAYS IN HOSPIT
	CITY	CANNOT ANSWER....-1 → (GO TO COLUMN (d))		In 1984 after (your/his/her) discharge on (DISCHARGE DATE).	1-10 days..... 11-20 days..... 21-30 days..... 31-60 days..... 61-90 days..... More than 91 day DON'T KNOW.....
	STATE	1st __/____ (MO/YR)	→ __ DAYS....01 WEEKS...02 DK.....-1		
		2nd __/____ (MO/YR)	→ __ DAYS....01 WEEKS...02 DK.....-1	In 1985	1-10 days..... 11-20 days..... 21-30 days..... 31-60 days..... 61-90 days..... More than 91 day DON'T KNOW.....
		3rd __/____ (MO/YR)	→ __ DAYS....01 WEEKS...02 DK.....-1		
		4th __/____ (MO/YR)	→ __ DAYS....01 WEEKS...02 DK.....-1	In 1986	1-10 days..... 11-20 days..... 21-30 days..... 31-60 days..... 61-90 days..... More than 91 day DON'T KNOW.....
		5th __/____ (MO/YR)	→ __ DAYS....01 WEEKS...02 DK.....-1		
		6th __/____ (MO/YR)	→ __ DAYS....01 WEEKS...02 DK.....-1	In 1987	1-10 days..... 11-20 days..... 21-30 days..... 31-60 days..... 61-90 days..... More than 91 day DON'T KNOW.....
		7th __/____ (MO/YR)	→ __ DAYS....01 WEEKS...02 DK.....-1		
		8th __/____ (MO/YR)	→ __ DAYS....01 WEEKS...02 DK.....-1		
		9th __/____ (MO/YR)	→ __ DAYS....01 WEEKS...02 DK.....-1	through June 30 of 1988	1-10 days..... 11-20 days..... 31-30 days..... 31-60 days..... 61-90 days..... More than 91 day DON'T KNOW.....

1.7 INTERVIEWER: WAS PATIENT HOSPITALIZED CONTINUOUSLY (Q1.4=YES)?

YES....(GO TO Q1.11)....01
NO.....00

1.8 In addition to treatment in hospitals or nursing homes, people often need to continue their treatment in outpatient settings.

After (your/his/her) discharge from (HOSPITAL) on (DISCHARGE DATE), did (you/PATIENT) require outpatient care by a doctor <u>because of a health problem or condition related to that hospitalization</u>?

YES.....01 → (ASK A)
NO.....00 → (GO TO Q1.9)
DON'T KNOW.....-1 → (GO TO Q1.9)

A. What type of a doctor was that?

RECORD TYPE OF DOCTOR IN A, THEN ASK B-H. THEN GO TO Q1.8(b).

IF PATIENT DIED SINCE HOSPITALIZATION, CODE -4 IN YEAR FOLLOWING DEATH.

	A DOCTORS	B REQUIRED?	C How many (TYPE OF CARE) visits did (you/he/she) require in 1984 after (DISCHARGE DATE)?	D And, how many in 1985?
1.8a	What type of doctor was that? TYPE OF DOCTOR _____ (C)		|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1 PATIENT DEAD.....-4
1.8b	Any other type of doctor? TYPE OF DOCTOR _____	YES.....01 (C)--->* NO.....00 (Q1.9) DON'T KNOW...-1 (Q1.9)	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1 PATIENT DEAD.....-4
1.8c	Any other type of doctor? TYPE OF DOCTOR _____	YES.....01 (C)--->* NO.....00 (Q1.9) DON'T KNOW...-1 (Q1.9)	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1 PATIENT DEAD.....-4

E (How many) in 1986?	F (How many) in 1987?	G And in 1988 through the end of June?	H How much (were you/was [he/she]) charged the last time (you/he/she) saw (TYPE OF PROVIDER)?
|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	$ |__|__|__|.|__|__| (Q1.8b) DON'T KNOW.....-1
|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	$ |__|__|__|.|__|__| (Q1.8c) DON'T KNOW.....-1
|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	$ |__|__|__|.|__|__| (Q1.9) DON'T KNOW.....-1

1.9 After (your/his/her) discharge from (HOSPITAL) on (DISCHARGE DATE), did (you/PATIENT) require outpatient care by a therapist, such as a physical rehabilitation or radiation therapist <u>because of a health problem or condition related to that hospitalization</u>?

YES.....01 → (ASK A)
NO.....00 → (GO TO Q1.10)
DON'T KNOW.....-1 → (GO TO Q1.10)

A. What type of therapist was that?

RECORD TYPE OF THERAPIST IN A, THEN ASK B-H. THEN GO TO Q1.9(b).

IF PATIENT DIED SINCE HOSPITALIZATION, CODE -4 IN YEAR FOLLOWING DEATH.

	A THERAPISTS	B REQUIRED?	C How many (TYPE OF CARE) visits did (you/he/she) require in 1984 after (DISCHARGE DATE)?	D And, how many in 1985?
1.9a	What type of therapist was that? TYPE OF THERAPIST _____ (C)		|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1 PATIENT DEAD.....-4
1.9b	Any other type of therapist? TYPE OF THERAPIST _____	YES.....01 (C)—→ NO.....00 (Q1.10) DON'T KNOW...-1 (Q1.10)	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1 PATIENT DEAD.....-4
1.9c	Any other type of therapist? TYPE OF THERAPIST _____	YES.....01 (C)—→ NO.....00 (Q1.10) DON'T KNOW...-1 (Q1.10)	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1 PATIENT DEAD.....-4

E (How many) in 1986?	F (How many) in 1987?	G And in 1988 through the end of June?	H How much (were you/was [he/she]) charged the last time (you/he/she) saw (TYPE OF PROVIDER)?
|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	$ |__|__|__|.|__|__| (Q1.9b) DON'T KNOW.....-1
|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	$ |__|__|__|.|__|__| (Q1.9c) DON'T KNOW.....-1
|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	$ |__|__|__|.|__|__| (Q1.10) DON'T KNOW.....-1

1.10 After (your/his/her) discharge from (HOSPITAL) on (DISCHARGE DATE), did (you/PATIENT) require outpatient care by any other health care professional who came to your home such as a visiting nurse or home health aid <u>because of a health problem or condition related to that hospitalization</u>?

YES.....01 → (ASK A)
NO.....00 → (GO TO Q1.11)
DON'T KNOW.....-1 → (GO TO Q1.11)

A. What type of other health care professional was that?

RECORD TYPE OF OTHER HEALTH CARE PROFESSIONAL IN A, THEN ASK B-H. THEN GO TO Q1.10(b).

IF PATIENT DIED SINCE HOSPITALIZATION, CODE -4 IN YEAR FOLLOWING DEATH.

PROVIDER	B REQUIRED?	C How many (TYPE OF CARE) visits did (you/he/she) require in 1984 after (DISCHARGE DATE)?	D And, how many in 1985?
1.10a What type of (other) health care professional was that? TYPE OF PROVIDER _____ (C)		|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1 PATIENT DEAD.....-4
1.10b Any others? TYPE OF PROVIDER _____	YES.....01 (B)—→ NO.....00 (Q1.11) DON'T KNOW...-1 (Q1.11)	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1	|__|__| OR ___ visits every ___ ___ visits every ___ DON'T KNOW.....-1 PATIENT DEAD.....-4

E (How many) in 1986?	F (How many) in 1987?	G And in 1988 through the end of June?	H How much (were you/was [he/she]) charged the last time (you/he/she) saw (TYPE OF PROVIDER)?
|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	$ |__|__|__|.|__|__| (Q1.10b) DON'T KNOW.....-1
|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	|__|__| OR __ visits every __ __ visits every __ DON'T KNOW.....-1 PATIENT DEAD....-4	$ |__|__|__|.|__|__| (Q1.11) DON'T KNOW.....-1

1.11 PATIENT...

IS ALIVE.....01

DIED AFTER KEY HOSPITALIZATION....(GO TO Q1.22)....02

1.12 (Are you/Is PATIENT) covered by Medicare Part A which covers hospital care?

PROBE: Federal insurance for people 65 or older and some people under 65 who are disabled.

YES.....(ASK A).....01
NO.....(GO TO Q1.14).....00

A. When (were you/was [he/she]) first eligible for Medicare Part A?

INTERVIEWER: IF RESPONDENT IS UNCERTAIN, PROBE FOR AGE WHEN (PATIENT) WAS FIRST ELIGIBLE.

|__|__| |__|__|
MO YR

OR

|__|__| AGE OF PATIENT

B. Before (you were/PATIENT was) eligible for Medicare, did (you/he/she) receive Social Security Disability Insurance?

PROBE: Persons who receive SSDI for work disabilities are also eligible for Medicare after a waiting period.

YES.....(ASK C).....01
NO.....(GO TO Q1.13).....00
DON'T KNOW.....(GO TO Q1.13).....-1

C. What type of disability qualified (you/him/her) for this insurance?

1.13 (Are you/Is PATIENT) covered by Medicare Part B supplemental insurance for doctor visits?

YES.....01
NO.....00

1.14 (Are you/Is PATIENT) covered by Medicaid?

PROBE: A state program which offers health benefits to low income persons on public assistance.

YES.....(ASK A).....01
NO.....(GO TO Q1.15)...00
DON'T KNOW....(GO TO Q1.15)...-1

A. In what month and year (were you/was [he/she]) first eligible for Medicaid?

INTERVIEWER: IF RESPONDENT IS UNCERTAIN, PROBE FOR AGE WHEN (PATIENT) WAS FIRST ELIGIBLE.

|__|__| |__|__|
MO YR

OR

|__|__| AGE OF RESPONDENT

DON'T KNOW.....-1 → GO TO Q1.15

B. (Are you/Is PATIENT) covered by Medicaid because of income, a disability or some other reason?

INCOME.....(GO TO Q1.15)....01
DISABILITY.....(ASK C).....02
OTHER (SPECIFY)....(GO TO Q1.15)....09

DON'T KNOW.....(GO TO Q1.15).....-1

C. What type of disability qualified (you/PATIENT) for Medicaid?

1.15 (Are you/Is PATIENT) covered by CHAMPUS or CHAMPVA?

PROBE: Health insurance for military personnel, their families and veterans.

YES.....(ASK A).....01
NO.....(GO TO Q1.16)...00
DON'T KNOW....(GO TO Q1.16)...-1

A. In what month and year (were you/was [he/she]) first eligible for CHAMPUS/CHAMPVA?

INTERVIEWER: IF RESPONDENT IS UNCERTAIN, PROBE FOR AGE WHEN (HE/SHE) WAS FIRST ELIGIBLE.

|__|__| |__|__|
MO YR

OR

|__|__| AGE OF RESPONDENT

DON'T KNOW.....-1 → GO TO Q1.16

B. (Are you/Is PATIENT) covered by CHAMPUS/CHAMPVA because of a disability or for some other reason?

DISABILITY.....(ASK C).....01
ACTIVE/RETIRED MILITARY FAMILY.....02
OTHER (SPECIFY).....09
_____
DON'T KNOW.....-1
} (GO TO Q1.16)

C. What type of disability qualified (you/PATIENT) for CHAMPUS or CHAMPVA?

_____

1.16 (Are you/Is PATIENT) now covered by any other health insurance plan which pays for any part of (your/his/her) hospital bills, doctor bills, or surgeon bills?

YES.....(ASK Q1.17)....01
NO.....(GO TO Q1.21)...00
DON'T KNOW....(GO TO Q1.21)...-1

1.17 People get private health insurance from different sources.

Since (DISCHARGE DATE), (have you/has PATIENT) received health insurance through (SOURCE)?

ASK B-E FOR ALL SOURCES CODED YES IN COLUMN A.

SOURCE	A HAS HAD INSURANCE FROM SOURCE	B Who was the insurer? USE CATEGORIES AS PROBES IF NECESSARY. CODE ONLY ONE.	C In what year did this insurance coverage begin?	D (Do you/Does PATIENT still have this insurance?	E When did the coverage end?
1.17 a present or past employer?	YES.....01 (B)----> NO.....00 (Q1.18) DON'T KNOW.....-1 (Q1.18)	BLUE CROSS/BLUE SHIELD...01 METROPOLITAN.....02 PRUDENTIAL.....03 TRAVELERS.....04 PREPAID HEALTH PLAN/HIP..05 OTHER (SPECIFY).....09 _____ DON'T KNOW.....-1	19 |__|__| DON'T KNOW.....-1	YES...(GO TO Q1.18A)..01 NO.....(ASK E).....00	19 |__|__| DON'T KNOW....-
1.18 any other present or past employer (of [yours/PATIENT's] or [your/his/her] spouse)?	YES.....01 (B)----> NO.....00 (Q1.19) DON'T KNOW.....-1 (Q1.19)	BLUE CROSS/BLUE SHIELD...01 METROPOLITAN.....02 PRUDENTIAL.....03 TRAVELERS.....04 PREPAID HEALTH PLAN/HIP..05 OTHER (SPECIFY).....09 _____ DON'T KNOW.....-1	19 |__|__| DON'T KNOW.....-1	YES...(GO TO Q1.19A)..01 NO.....(ASK E).....00	19 |__|__| DON'T KNOW....-1
1.19 any union or other work related insurance?	YES.....01 (B)----> NO.....00 (Q1.20) DON'T KNOW.....-1 (Q1.20)	BLUE CROSS/BLUE SHIELD...01 METROPOLITAN.....02 PRUDENTIAL.....03 TRAVELERS.....04 PREPAID HEALTH PLAN/HIP..05 OTHER (SPECIFY).....09 _____ DON'T KNOW.....-1	19 |__|__| DON'T KNOW.....-1	YES...(GO TO Q1.20A)..01 NO.....(ASK E).....00	19 |__|__| DON'T KNOW....-1
1.20 some other arrangement? SPECIFY: _____ _____	YES.....01 (B)----> NO.....00 (Q1.21) DON'T KNOW.....-1 (Q1.21)	BLUE CROSS/BLUE SHIELD...01 METROPOLITAN.....02 PRUDENTIAL.....03 TRAVELERS.....04 PREPAID HEALTH PLAN/HIP..05 OTHER (SPECIFY).....09 _____ DON'T KNOW.....-1	19 |__|__| DON'T KNOW.....-1	YES...(GO TO Q1.21)...01 NO.....(ASK E).....00	19 |__|__| DON'T KNOW....-1

1.21 INTERVIEWER: DOES PATIENT HAVE ANY HEALTH INSURANCE: (Qs. 1.12, 1.13, 1.14, 1.15, 1.16 1.17D, 1.18D, 1.19D OR 1.20D, CODED YES (01)?

YES.....(GO TO Q2.0).....01
NO.....00

A. You told me that (you are/PATIENT is) not covered by any type of health or medical insurance. I will now read some reasons others have given us as to why they have no health insurance coverage. Please listen to the list and then tell me which best describes the reason why (you are/[he/she]) is) not covered by any health insurance. (READ ALL CATEGORIES AND CODE ONE ONLY.)

Unemployment (layoff, job loss, or any other reason for unemployment).....01

Cannot obtain insurance because of poor health.....02

Too expensive, cannot afford health insurance....03

Eligible for care at VA or military hospital....04

Covered by some other health plan, or.....05

Some other reason? (SPECIFY).....09

---

* * * GO TO Q2.0 * * *

PATIENTS WHO DIED AFTER KEY HOSPITALIZATION

1.22 At the time of (his/her) death, was (PATIENT) covered by Medicare Part A which covers hospital care?

PROBE: Federal insurance for people 65 or older and some people under 65 who are disabled.

YES.....01
NO.....(GO TO Q1.24)....00
DON'T KNOW...(GO TO Q1.24)....-1

1.23 And at the time of (his/her) death, was (PATIENT) covered by Medicare Part B supplemental insurance for doctor visits?

YES.....01
NO.....00
DON'T KNOW.....-1

1.24 Was (PATIENT) covered by Medicaid?

PROBE: A state program which offers health benefits to low income persons on public assistance.

YES.....(ASK A).....01
NO.....(GO TO Q1.25)...00
DON'T KNOW....(GO TO Q1.25)...-1

A. Was (he/she) covered by Medicaid because of income, a disability or some other reason?

INCOME.....(GO TO Q1.25)....01
DISABILITY.....(ASK B).....02
OTHER (SPECIFY)....(GO TO Q1.25)....09

DON'T KNOW.....(GO TO Q1.25).....-1

B. What type of disability qualified (him/her) for Medicaid?

1.25 Was (PATIENT) covered by CHAMPUS or CHAMPVA?

PROBE: Health insurance for military personnel, their families and veterans.

YES.....(ASK A).....01
NO.....(GO TO Q1.26)...00
DON'T KNOW....(GO TO Q1.26)...-1

A. Was (he/she) covered by CHAMPUS/CHAMPVA because of a disability or for some other reason?

DISABILITY.....(ASK B).....01
ACTIVE/RETIRED MILITARY FAMILY.....02 → GO TO Q1.26
OTHER (SPECIFY)....(GO TO Q1.26)....09

DON'T KNOW.....(GO TO Q1.26)....-1

B. What type of disability qualified (him/her) for CHAMPUS or CHAMPVA?

1.26 And at the time of (his/her) death, was (PATIENT) covered by any other health insurance plan which pays for any part of (his/her) hospital bills, doctor bills, or surgeon bills?

YES.....01
NO.....00
DON'T KNOW.....-1

1.27 INTERVIEWER: DID PATIENT HAVE ANY HEALTH INSURANCE: (Qs. 1.22, 1.23, 1.24, 1.25 OR 1.26, CODED YES (01)?

YES.....(GO TO Q2.0).....01
NO.....00

1.28 You told me that (PATIENT) was not covered by any type of health or medical insurance. I will now read some reasons others have given us as to why they have no health insurance coverage. Please listen to the list and then tell me which best describes the reason why (he/she) was not covered by any health insurance. (READ ALL CATEGORIES AND CODE ONE ONLY.)

Unemployment (layoff, job loss, or any other reason for unemployment).....01

Cannot obtain insurance because of poor health.....02

Too expensive, cannot afford health insurance....03

Eligible for care at VA or military hospital.....04

Covered by some other health plan, or.....05

Some other reason? (SPECIFY).....09

* * * GO TO SECTION 2 * * *

NO Q1.29-1.33 IN THIS FORM.

SECTION 2. OTHER EXPENSES FOR PATIENTS CURRENTLY ALIVE

2.0 DATA ENTRY: ENTER 00 AND CONTINUE WITH 2.1.

2.1 INTERVIEWER: PATIENT DIED SINCE KEY HOSPITALIZATION?

YES.....(GO TO Q2.25).....01
NO.....00

2.1A INTERVIEWER: WAS PATIENT IN A HOSPITAL OR NURSING HOME CONTINUOUSLY SINCE DISCHARGE (Q1.4=01)?

YES...(GO TO INTRO TO Q2.17)...01
NO.....00

2.2 Many people with health conditions need housekeeping assistance or home health care in addition to medical care. (Do you/Does PATIENT) need any such help because of a health problem or condition related to (your/his/her) hospitalization on (ADMISSION DATE)?

YES.....(ASK A).....01
NO.....(GO TO Q2.13).....00

A. How often (do you/does PATIENT) need help from others to perform daily activities such as dressing, eating or other types of housekeeping or home health care? (READ CATEGORIES BELOW AND CODE ONE ONLY.)

Every day.....01

Almost every day.....02

3-4 times a week.....03

Once a week.....04

Less than once a week but more than once a month.....05

Less than once a month.....06

2.3 (Do you/Does PATIENT) pay anyone to help (you/him/her) with these activities?

YES.....01
NO.....(GO TO Q2.4).....00

A. Altogether how much (do you/does PATIENT) pay for help? CODE TIME PERIOD.

PROBE: Is that per hour, day, week or what?

PROBE: Your best estimate.

$ |__|__|__|__|.|__|__|
DOLLARS CENTS

per hour.....01
per day.....02
per week.....03
per month.....04
Other (SPECIFY).....09

REFUSED.....-3
DON'T KNOW.....-1

2.4 (In addition to paid helpers), does anyone (else) usually help (you/PATIENT) with these activities?

YES.....(ASK A).....01
NO.....(GO TO Q2.13).....00

A. Who helps (you/PATIENT) most of the time? CODE ONLY ONE.

SPOUSE.....01

DAUGHTER, SON, DAUGHTER-IN-LAW, SON-IN-LAW.....02

PARENT.....03

OTHER RELATIVE.....04

VISITING NURSE, HOUSEHOLD AIDS, OR OTHER PERSON FROM A PUBLIC AGENCY.....05

OTHER (SPECIFY).....09

_____

2.5 INTERVIEWER: IS Q2.4A CODED HELP BY A RELATIVE (01-04)?

YES.....01
NO.....(GO TO Q2.13).....00

2.6 Did (RELATIVE) have to quit (his/her) job, reduce (his/her) hours of work, or not have to do either of these in order to help care for (you/PATIENT) at home?

Quit job.....(GO TO Q2.7)....01

Reduced hours of work.....(GO TO Q2.7)....02

Neither.....(SKIP TO Q2.13).....03

DON'T KNOW.....(SKIP TO Q2.13).....-1

2.7 What were (RELATIVE's) usual weekly earnings before (he/she) made that change? CODE TIME PERIOD.

PROBE: Before (he/she) (quit [his/her] job/reduced [his/her] hours of work).

$ |__|__|,|__|__|__|.|__|__|
DOLLARS CENTS

per hour.....01	GO TO Q2.8
per day.....02	
per week.....03	
per month.....04	
per year.....05	
REFUSED.....-3	(GO TO Q2.9)
DON'T KNOW.....-1	

2.8 How many weeks a year was (MAIN HELPER) usually employed at this job before this change?

PROBE: Include paid vacations as time employed.

|__|__| NO. OF WEEKS

WHOLE YEAR.....52
DON'T KNOW.....-1

2.9 INTERVIEWER: DID RELATIVE REDUCE WORK HOURS (Q2.6 = 02)?

YES.....01
NO.....(GO TO Q2.12).....00

2.10 What was (RELATIVE's) usual earnings from the job after (he/she) reduced (his/her) hours of work? CODE TIME PERIOD.

$ |__|__|,|__|__|__|.|__|__|
DOLLARS CENTS

per hour.....01
per day.....02
per week.....03
per month.....04
per year.....05
} (ASK Q2.11)

OR

RECORD VERBATIM _____ (ASK Q2.1

OR

REFUSED.....-3
DON'T KNOW.....-1
} GO TO Q2.12

2.11 How many hours a week did (he/she) usually work after this change?

|__|__| NUMBER OF HOURS

DON'T KNOW.....-1

2.12 And since then, has (RELATIVE) returned to a job or increased (his/her) hours of work?

YES.....(ASK A).....01
NO.....(GO TO Q2.13)...00
DON'T KNOW....(GO TO Q2.13)...~~01~~ -1

A. In what month and year was that?

|__|__| 19 |__|__|
MONTH YEAR

2.13 At any time since (DISCHARGE DATE), (have you/has PATIENT) needed to use special transportation service because of a health problem or condition related to that hospitalization? This would be transportation for people who are unable to use regular public transportation or drive their own car.

YES.....01
NO.....(GO TO Q2.14).....00

A. On average, how much did this service cost (you/him/her) in an average month?

$ |__|__|__|__|

B. For how many months (have you/has PATIENT) needed this service because of a health problem or condition related to that hospitalization?

|__|__| MONTHS

STILL USING.....98
UNTIL PATIENT'S DEATH.....99

2.14 At any time since (DISCHARGE DATE), (have you/has PATIENT) needed to use special medical equipment at home because of a health problem or condition related to that hospitalization? For example, (have you/has [he/she]) needed any equipment such as a wheelchair, hospital bed, suction apparatus, or a dialysis machine?

YES.....01
NO.....(GO TO Q2.15).....00

A. What equipment (have you/has [he/she]) needed (because of a health problem or condition related to that hospitalization)? CIRCLE 01 IN COLUMN A FOR ALL EQUIPMENT NAMED. USE LIST AS PROBES IF NECESSARY.

FOR EACH TYPE OF EQUIPMENT NAMED, ASK QUESTIONS B-D)

	A NEEDED	B Was (EQUIPMENT) bought, rented or provided free of charge?	C How much (did/does) it cost?	D For how many months did (you/he/she) need (EQUIPMENT) between (DISCHARGE DATE) and June of 1988?
a) A wheelchair	01	Bought....01 ——> Rented....02 ——> Free.....03 (D)	$\_\_\_\_$ (b) OR $\_\_\_$ PER MONTH	MONTHS → STILL USING.....98 UNTIL DEATH.....99
b) A walker	01	Bought....01 ——> Rented....02 ——> Free.....03 (D)	$\_\_\_\_$ (c) OR $\_\_\_$ PER MONTH	MONTHS → STILL USING.....98 UNTIL DEATH.....99
c) Corrective shoes	01	Bought....01 ——> Rented....02 ——> Free.....03 (D)	$\_\_\_\_$ (d) OR $\_\_\_$ PER MONTH	MONTHS → STILL USING.....98 UNTIL DEATH.....99
d) A hospital bed	01	Bought....01 ——> Rented....02 ——> Free.....03 (D)	$\_\_\_\_$ (e) OR $\_\_\_$ PER MONTH	MONTHS → STILL USING.....98 UNTIL DEATH.....99
e) A motorized vehicle	01	Bought....01 ——> Rented....02 ——> Free.....03 (D)	$\_\_\_\_$ (f) OR $\_\_\_$ PER MONTH	MONTHS → STILL USING.....98 UNTIL DEATH.....99
f) An assist chair	01	Bought....01 ——> Rented....02 ——> Free.....03 (D)	$\_\_\_\_$ (g) OR $\_\_\_$ PER MONTH	MONTHS → STILL USING.....98 UNTIL DEATH.....99
g) A respirator	01	Bought....01 ——> Rented....02 ——> Free.....03 (D)	$\_\_\_\_$ (h) OR $\_\_\_$ PER MONTH	MONTHS → STILL USING.....98 UNTIL DEATH.....99
h) Suction apparatus	01	Bought....01 ——> Rented....02 ——> Free.....03 (D)	$\_\_\_\_$ (i) OR $\_\_\_$ PER MONTH	MONTHS → STILL USING.....98 UNTIL DEATH.....99
i) Dialysis machine	01	Bought....01 ——> Rented....02 ——> Free.....03 (D)	$\_\_\_\_$ (Q2.15) OR $\_\_\_$ PER MONTH	MONTHS → STILL USING.....98 UNTIL DEATH.....99

2.15 At any time since (DISCHARGE DATE), (have you/has PATIENT) needed to obtain medical supplies other than prescription drugs because of a health problem or condition related to that hospitalization? For example, (have you/has [he/she]) needed syringes, oxygen, or tracheostomy supplies?

YES.....01
NO.....(GO TO Q2.16).....00

A. What medical supplies (have you/has [he/she]) needed (because of a health problem or condition related to that hospitalization)? **CIRCLE 01 IN COLUMN A FOR ALL SUPPLIES NAMED. USE LIST AS PROBES IF NECESSARY.**

FOR EACH TYPE OF SUPPLIES NAMED, ASK QUESTIONS B-C

	A NEEDED	B How much (do/did) (SUPPLIES) cost in an average month?	C For how many months (do/did) (you/he/she) need (SUPPLIES) between (DISCHARGE DATE) and June of 1988?
a) Syringes	01	$|__|__|__| PER MONTH	|__|__| MONTHS STILL USING.....98 UNTIL DEATH.....99
b) Catheters	01	$|__|__|__| PER MONTH	|__|__| MONTHS STILL USING.....98 UNTIL DEATH.....99
c) Oxygen	01	$|__|__|__| PER MONTH	|__|__| MONTHS STILL USING.....98 UNTIL DEATH.....99
d) Medical dressings or bandages	01	$|__|__|__| PER MONTH	|__|__| MONTHS STILL USING.....98 UNTIL DEATH.....99
e) Tracheostomy supplies	01	$|__|__|__| PER MONTH	|__|__| MONTHS STILL USING.....98 UNTIL DEATH.....99
f) Ostomy supplies	01	$|__|__|__| PER MONTH	|__|__| MONTHS STILL USING.....98 UNTIL DEATH.....99

2.16 INTERVIEWER: ARE ANY TYPES OF EQUIPMENT OR SERVICE CODED YES (ANY Q2.13-2.15 = 01)?

YES.....(ASK A).....01
NO.....(GO TO Q2.17).....00

A. Is there any insurance plan that pays for (your/his/her) equipment or services?

YES.....(ASK A).....01
NO.....(GO TO Q2.17).....00

B. What insurance plans pay for (your/PATIENT's) equipment or services? Any others?

CODE ALL THAT APPLY

A. MEDICARE.....01
B. MEDICAID.....01
C. CHAMPUS/CHAMPVA.....01
D. EMPLOYER/UNION PROVIDED INSURANCE.....01
E. OTHER PRIVATE INSURANCE.....01
F. OTHER (SPECIFY).....01

Now I would like to ask you about (your/PATIENT's) ability to do certain activities, with the use of special aids if (you/he/she) need them.

2.17 (Do you/Does [he/she]) hear well enough to understand normal conversation (with a hearing aid if (you/he/she) usually wear(s) one)?

YES.....(GO TO Q2.18).....01
NO.....00

A. Is (PATIENT) able to hear at all?

YES.....01
NO.....00

B. Is this hearing trouble related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00

2.18 (Do you/Does [he/she]) see well enough to read ordinary newsprint, with glasses, if (you/he/she) usually wear(s) them?

YES.....(GO TO Q2.19).....01
NO.....00

A. (Are you/Is PATIENT) able to see at all?

YES.....01
NO.....00

B. Is this vision trouble related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00

2.19 (Do you/Does [he/she]) have any trouble walking up or down a flight of stairs?

PROBE: That is about 12 steps.

YES.....01
NO.....(GO TO Q2.20).....00

A. (Are you/Is PATIENT) able to walk up or down steps at all?

YES.....01
NO.....00

B. Is this trouble related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00

2.20 (Do you/Does [he/she]) have any trouble walking about three city blocks without resting?

PROBE: That is about 400 yards.

YES.....01
NO.....(GO TO Q2.21).....00

A. (Are you/Is PATIENT) able to walk at all?

YES.....01
NO.....00

B. Is this trouble related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00

2.21 (Do you/Does [he/she]) have any trouble standing for long periods of time, that is, more than 20 minutes?

YES.....01
NO.....(GO TO Q2.22).....00

A. (Are you/Is PATIENT) able to stand at all?

YES.....01
NO.....00

B. Is this trouble related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00

2.22 (Do you/Does [he/she]) have any trouble stooping or kneeling down?

YES.....01
NO.....(GO TO Q2.23).....00

A. (Are you/Is PATIENT) able to stoop or kneel at all?

YES.....01
NO.....00

B. Is this trouble related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00

2.23 (Do you/Does [he/she]) have any trouble carrying objects that weigh about 10 pounds for a short distance, for example, carrying a bag of groceries from the curb to a house?

YES.....01
NO.....(GO TO Q2.24).....00

A. (Are you/Is PATIENT) able to carry objects that weigh about 10 pounds at all?

YES.....01
NO.....00

B. Is this trouble related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00

2.24 (Do you/Does [he/she]) have any trouble using your fingers to grasp or handle things?

YES.....01
NO.....(GO TO Q2.31).....00

A. (Are you/Is PATIENT) able to grasp things at all?

YES.....01
NO.....00

B. Is this trouble related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00

* * * GO TO Q2.31 * * *

SECTION 2A. OTHER EXPENSES FOR PATIENTS WHO DIED SINCE KEY HOSPITALIZATION

2.25 Many people with health conditions need housekeeping assistance or home health care in addition to medical care. At the time of (his/her) death, did (PATIENT) need any such help?

YES.....(ASK A).....01
NO.....(GO TO Q2.27).....00

A. At the time of (his/her) death, how often did (PATIENT) need help from others to perform daily activities such as dressing, eating or other types of housekeeping or home health care? (READ CATEGORIES BELOW AND CODE ONE ONLY.)

Every day.....01

Almost every day.....02

3-4 times a week.....03

Once a week.....04

Less than once a week but more than once a month.....05

Less than once a month.....06

2.26 Did (PATIENT) pay anyone to help (him/her) with these activities?

YES.....01
NO.....(GO TO Q2.27).....00

A. Altogether how much did (PATIENT) pay for help just before (his/her) death? CODE TIME PERIOD.

PROBE: Was that per hour, day, week or what?

PROBE: Your best estimate.

$ |__|__|__|__|.|__|__|
DOLLARS CENTS

per hour.....01
per day.....02
per week.....03
per month.....04
Other (SPECIFY).....09

_____

REFUSED.....-3
DON'T KNOW.....-1

2.27 At any time after (DISCHARGE DATE), did (PATIENT) need to use special transportation service because of a health problem or condition related to that hospitalization? This would be transportation for people who are unable to use regular public transportation or drive their own car.

YES.....01
NO.....(GO TO Q2.28).....00

A. On average, how much did this service cost (him/her) per month?

$ |__|__|__|__|

B. For how many months did (PATIENT) need this service because of a health problem or condition related to that hospitalization?

|__|__| MONTHS

UNTIL PATIENT'S DEATH.....99

2.28 At any time after (DISCHARGE DATE), did (PATIENT) need to use special medical equipment at home because of a health problem or condition related to that hospitalization? For example, did (he/she) need any equipment such as a wheelchair, hospital bed, suction apparatus, or a dialysis machine?

YES.....01
NO.....(GO TO Q2.29).....00

A. What equipment did (he/she) need (because of a health problem or condition related to that hospitalization)? CIRCLE 01 IN COLUMN A FOR ALL EQUIPMENT NAMED. USE LIST AS PROBES IF NECESSARY.

FOR EACH TYPE OF EQUIPMENT NAMED, ASK QUESTIONS B-D)

	A NEEDED	B Was (EQUIPMENT) bought, rented or provided free of charge?	C How much did it cost?	D For how many months did (he/she) need (EQUIPMENT) between (DISCHARGE DATE) and (DEATH DATE)?
a) A wheelchair	01	Bought....01 -----> Rented....02 -----> Free.....03 (D)	$\|\_\|\_\|\_\|\_\|\_\|$ (b) OR $\|\_\|\_\|\_\|$ PER MONTH	|_|_|_| MONTHS UNTIL DEATH.....99
b) A walker	01	Bought....01 -----> Rented....02 -----> Free.....03 (D)	$\|\_\|\_\|\_\|\_\|\_\|$ (c) OR $\|\_\|\_\|\_\|$ PER MONTH	|_|_|_| MONTHS UNTIL DEATH.....99
c) Corrective shoes	01	Bought....01 -----> Rented....02 -----> Free.....03 (D)	$\|\_\|\_\|\_\|\_\|\_\|$ (d) OR $\|\_\|\_\|\_\|$ PER MONTH	|_|_|_| MONTHS UNTIL DEATH.....99
d) A hospital bed	01	Bought....01 -----> Rented....02 -----> Free.....03 (D)	$\|\_\|\_\|\_\|\_\|\_\|$ (e) OR $\|\_\|\_\|\_\|$ PER MONTH	|_|_|_| MONTHS UNTIL DEATH.....99
e) A motorized vehicle	01	Bought....01 -----> Rented....02 -----> Free.....03 (D)	$\|\_\|\_\|\_\|\_\|\_\|$ (f) OR $\|\_\|\_\|\_\|$ PER MONTH	|_|_|_| MONTHS UNTIL DEATH.....99
f) An assist chair	01	Bought....01 -----> Rented....02 -----> Free.....03 (D)	$\|\_\|\_\|\_\|\_\|\_\|$ (g) OR $\|\_\|\_\|\_\|$ PER MONTH	|_|_|_| MONTHS UNTIL DEATH.....99
g) A respirator	01	Bought....01 -----> Rented....02 -----> Free.....03 (D)	$\|\_\|\_\|\_\|\_\|\_\|$ (h) OR $\|\_\|\_\|\_\|$ PER MONTH	|_|_|_| MONTHS UNTIL DEATH.....99
h) Suction apparatus	01	Bought....01 -----> Rented....02 -----> Free.....03 (D)	$\|\_\|\_\|\_\|\_\|\_\|$ (i) OR $\|\_\|\_\|\_\|$ PER MONTH	|_|_|_| MONTHS UNTIL DEATH.....99
i) Dialysis machine	01	Bought....01 -----> Rented....02 -----> Free.....03 (D)	$\|\_\|\_\|\_\|\_\|\_\|$ (Q2.29) OR $\|\_\|\_\|\_\|$ PER MONTH	|_|_|_| MONTHS UNTIL DEATH.....99

2.29 At any time after (DISCHARGE DATE), did (PATIENT) need to obtain medical supplies other than prescription drugs because of a health problem or condition related to that hospitalization? For example, did (he/she) need syringes, oxygen, or tracheostomy supplies?

YES.....01
NO.....(GO TO Q2.30).....00

A. What medical supplies did (he/she) need (because of a health problem or condition related to that hospitalization)? CIRCLE 01 IN COLUMN A FOR ALL SUPPLIES NAMED. USE LIST AS PROBES IF NECESSARY.

FOR EACH TYPE OF SUPPLIES NAMED, ASK QUESTIONS B-C)

	A NEEDED	B How much did (SUPPLIES) cost in an average month?	C For how many months did (he/she) need (SUPPLIES) between (DISCHARGE DATE) and (DEATH DATE)?
a) Syringes	01	$\|_\|_\|_\|$ PER MONTH	|__|__| MONTHS UNTIL DEATH.....99
b) Catheters	01	$\|_\|_\|_\|$ PER MONTH	|__|__| MONTHS UNTIL DEATH.....99
c) Oxygen	01	$\|_\|_\|_\|$ PER MONTH	|__|__| MONTHS UNTIL DEATH.....99
d) Medical dressings or bandages	01	$\|_\|_\|_\|$ PER MONTH	|__|__| MONTHS UNTIL DEATH.....99
e) Tracheostomy supplies	01	$\|_\|_\|_\|$ PER MONTH	|__|__| MONTHS UNTIL DEATH.....99
f) Ostomy supplies	01	$\|_\|_\|_\|$ PER MONTH	|__|__| MONTHS UNTIL DEATH.....99

2.30 INTERVIEWER: ARE ANY TYPES OF EQUIPMENT OR SERVICE CODED YES (ANY Q2.27-2.29 = 01)?

YES.....(ASK A).....01
NO.....(GO TO Q2.31).....00

A. Did any insurance plan pay for (his/her) equipment or services?

YES.....(ASK B).....01
NO.....(GO TO Q2.31).....00

B. What insurance plans paid for (PATIENT's) equipment or services? Any others?

CODE ALL THAT APPLY

A. MEDICARE.....01
B. MEDICAID.....01
C. CHAMPUS/CHAMPVA.....01
D. EMPLOYER/UNION PROVIDED INSURANCE.....01
E. OTHER PRIVATE INSURANCE.....01
F. OTHER (SPECIFY).....01

SECTION 2B. HOMEMAKER

INTERVIEWER: START DATE (6 MONTHS PRIOR TO ADMISSION DATE): _____

ADMISSION DATE: _____

2.31 INTERVIEWER: IS PATIENT A FEMALE?

YES.....01
NO.....(GO TO SECTION 3).....00

2.31A INTERVIEWER: WAS PATIENT INSTITUTIONALIZED BEFORE KEY HOSPITALIZATION? (SCREENER F3 = 01)?

YES....(GO TO SECTION 3).....01
NO/F3 NOT ASKED.....00

The next part of the questionnaire concerns (your/PATIENT's) daily activities around the house during the six months before (your/her) hospitalization on (ADMISSION DATE) and for several time periods after that.

2.32 Which of the following activities did (you/PATIENT) perform in an average week during the six months prior to (your/her) hospitalization on (ADMISSION DATE)?

PROBE: If your health changed during those six months, think of the time before that change.

(READ EACH CATEGORY BELOW AND CODE "YES", "NO", OR "DON'T KNOW" FOR EACH.)

		YES	NO	DON'T KNOW	NOT APPLICABLE
A.	Preparing meals?.....	01	00	-1	
B.	Laundry/ironing?.....	01	00	-1	
C.	Shopping?.....	01	00	-1	
D.	Managing the family budget?...	01	00	-1	
E.	After meal cleanup?.....	01	00	-1	
F.	Regular house cleaning?.....	01	00	-1	
G.	Child care?.....	01	00	-1	-4
H.	Care of other family members?.	01	00	-1	-4

And, from (START DATE) to (ADMISSION DATE), did (you/PATIENT) (LIVING ARRANGEMENT)? FOR EACH LIVING ARRANGEMENT CODED YES IN SECTION A, FOLLOW SKIPS TO NEXT QUESTION OR B AND C.

	A			B	C
	YES	NO	DK		
2.33 ... live alone?	01 (Q2.37)	00 (Q2.34)	-1 (Q2.37)	X	X
2.34 ... live with (your/her) spouse (or significant other)?	01 (Q2.35)	00 (Q2.35)	-1 (Q2.35)	X	X
2.35 ... live in a household with children?	01 (B)	00 (Q2.36)	-1 (Q2.36)	How many children lived in the household at that time? |__|__| ASK (C) --->	What (were their ages/was the child's age) at that time? USE CATEGORIES AS PROBES. RECORD NUMBER FOR EACH AGE GROUP. PROBE: How many of them were... NUMBER / NONE / DK Under 2 years of age? |__|__| 00 -1 2 to 5? |__|__| 00 -1 6 to 11? |__|__| 00 -1 12 to 17? |__|__| 00 -1 Are you unsure of their age? |__|__| 00 -1
2.36 ... live in a household with (other) adult relatives?	01 (B)	00 (Q2.37)	-1 (Q2.37)	(Including [your/her] husband), how many adult relatives lived in the household at that time? |__|__| ASK (C) --->	What (were their ages/was that person's age) at that time? USE CATEGORIES AS PROBES. RECORD NUMBER FOR EACH AGE GROUP. PROBE: And, how many of them were... NUMBER / NONE / DK Under 25 years of age? |__|__| 00 -1 25 to 39? |__|__| 00 -1 40 to 54? |__|__| 00 -1 55 or older? |__|__| 00 -1 Any others whose age you're not sure of? |__|__| 00 -1

2.37 During the six months prior to (your/PATIENT's) hospitalization, who generally helped (you/her) with the housework or meal preparation--was it a household member, someone else, or did (you/she) not receive any help?

Household member.....(GO TO Q2.39)...01

Someone else.....(ASK Q2.38)....02

Did not receive help....(GO TO Q2.39)...03

DON'T KNOW.....(GO TO Q2.39)...-1

2.38 Was the person who generally helped (you/PATIENT) a paid employee, relative, friend, or someone else?

PROBE: Count significant other as relative.

Paid employee.....(ASK A).....01

Relative.....(GO TO Q2.39).....02

Friend.....(GO TO Q2.39).....03

Someone else.....(GO TO Q2.39).....04

A. How much did (you/PATIENT) pay this assistant?
CODE TIME PERIOD.

$ |__|__|__|.|__|__|

per hour.....01
per weekday.....02
per week.....03
per month.....04
OTHER (SPECIFY).....09

DON'T KNOW.....-1
REFUSED.....-3

2.39 DATA ENTRY: ENTER 00 AND CONTINUE WITH 2.40.

2.40 Who did most of the housework while (you were/PATIENT was) in (HOSPITAL) from (ADMISSION DATE) to (DISCHARGE DATE)? (CODE ONE ONLY.)

Paid employee.....01

Relative.....02

Friend.....03

Someone else.....04

DON'T KNOW.....-1

NOT APPLICABLE (LIVED ALONE).....-4

2.41 In what month and year (were you/was PATIENT) first able to resume some of (your/her) household work after leaving the hospital?

|__|__| MO |__|__| YR → (Q2.42)

IMMEDIATELY AFTER DISCHARGE.....(GO TO Q2.42).....97

NEVER ABLE TO RESUME - PATIENT ALIVE....(Q2.44)....98

NEVER ABLE TO RESUME - PATIENT NOW DECEASED.....(GO TO SECTION 3).....99

DON'T KNOW.....(Q2.44).....-1

2.42 INTERVIEWER: PATIENT DIED SINCE KEY HOSPITALIZATION?

YES.....(GO TO SECTION 3).....01
NO.....00

2.42A INTERVIEWER: WAS PATIENT IN A HOSPITAL OR NUSING HOME CONTINUOUSLY SINCE DISCHARGE (Q1.4=01)?

YES.....(GO TO SECTION 3).....01
NO.....00

2.43 Can (you/PATIENT) do as much or more household work now as (you/she) did before going into the hospital on (ADMISSION DATE)?

YES.....(SKIP TO SECTION 3).....01

NO.....(ASK A).....00

DON'T KNOW....(SKIP TO SECTION 3).....-1

A. Why (are you/is PATIENT) not able to do the same amount or kind of housework (you/she) did before? (CODE ONE ONLY.)

Illness.....01 → (ASK B)

Age.....02

Other (SPECIFY).....09

_____

DON'T KNOW.....-1

GO TO Q2.44

B. Is (your/PATIENT's) illness related to (your/her) hospitalization on (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

I'm going to list some household tasks. For each one, please tell me who typically does it these days--(you/PATIENT), a paid helper or someone else?

		PATIENT	PAID HELPER	SOMEONE ELSE	DON'T KNOW	NOT APPLICABLE
2.44	Who prepares meals—(you/PATIENT), a paid helper or someone else?.....	01	02	03	-1	
2.45	Who manages the family budget?.....	01	02	03	-1	
2.46	(Who) does the laundry and ironing?.....	01	02	03	-1	
2.47	(Who) does the after meal cleanup?.....	01	02	03	-1	
2.48	(Who) shops?.....	01	02	03	-1	
2.49	(Who) does regular house cleaning?.....	01	02	03	-1	
2.50	(Who) cares for children?.....	01	02	03	-1	-4
2.51	(Who) cares for other family members?.....	01	02	03	-1	-4

2.52 INTERVIEWER: ARE ANY QUESTIONS (Q2.44-Q2.51) CODED PAID HELPER (CODE 02)?

YES.....(ASK A).....01
NO.....(GO TO SECTION 3).....00

A. Altogether, how much (do you/does PATIENT) pay each week for help with (LIST PAID ITEMS)? CODE TIME PERIOD.

$ |__|__|__|.|__|__|
DOLLARS CENTS

per hour.....01
per day.....02
per week.....03
per month.....04
OTHER (SPECIFY).....09

DON'T KNOW.....-1
REFUSED.....-3

SECTION 3. WORK AND WAGES

3.0 DATA ENTRY: ENTER 01 AND CONTINUE WITH 3.1.

INTERVIEWER: START DATE (6 MONTHS PRIOR TO ADMISSION DATE): _____

ADMISSION DATE: _____

3.1 INTERVIEWER: PRIOR TO KEY HOSPITALIZATION, PATIENT WAS (SCREENER QF.2 and QF.4)

EMPLOYED (F2, CODE 01).....(GO TO Q3.7).....01
UNEMPLOYED/UNABLE TO WORK (F4, CODE 01-02)...(ASK Q3.2)...02
A STUDENT (F4, CODE 06).....(GO TO SECTION 4)....03

3.2 What was the main reason (you/he/she) did not work between (START DATE) and (ADMISSION DATE)? (CODE ONE ONLY.)

Illness/Disabled/Unable to work....01 → (GO TO Q3.3)
Care of home/Family/Pregnant.....02
School.....03
Could not find work.....04
Doing something else (SPECIFY).....05

(GO TO Q3.5)

_____

Temporary layoff.....06
Other (SPECIFY).....09

_____

3.3 What was the nature of the illness or injury that prevented (you/PATIENT) from working during the time from (START DATE) to (ADMISSION DATE)? RECORD VERBATIM.

_____

_____

DON'T KNOW.....-1

3.4 Was the illness or injury the reason for (your/PATIENT's) hospitalization on (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

3.5 When did (you/he/she) last work prior to (ADMISSION DATE)?

IF PATIENT LAST WORKED IN 1978 OR EARLIER, CODE 99 AND GO TO SECTION 4.

RECORD YEAR: 19 |__|__| → ASK Q3.6

DIDN'T WORK PRIOR TO HOSPITALIZATION/
PRIOR TO 1978.....(GO TO SECTION 4).....99

DON'T KNOW.....(ASK A).....-1

A. Did (you/he/she) <u>ever</u> work?

YES.....01
NO.....(GO TO SECTION 4).....00

B. Did (you/PATIENT) work at any time between 1978 and (ADMISSION DATE)?

YES.....01
NO.....(GO TO SECTION 4).....00

3.6 What was the main reason that (you/PATIENT) left that job? (CODE ONE ONLY.)

LAYOFF.....01
FIRED.....02
ILL/DISABLED/UNABLE TO WORK.....03
RETIRED.....04
CARE OF HOME/FAMILY/PREGNANCY.....05
SCHOOL.....06
COULD NOT FIND WORK.....07
DOING SOMETHING ELSE (SPECIFY).....08

_____

OTHER (SPECIFY).....09

_____

DON'T KNOW.....-1

3.7 What was the name of the employer where (you/PATIENT) worked the most hours (during the six months prior to ADMISSION DATE/during the LAST YEAR WORKED IN Q3.5)?

EMPLOYER NAME: _____ (ASK A)

SELF-EMPLOYED.....9 → (ASK Q3.8)
DON'T KNOW.....-1 → (GO TO Q3.12)

A. In what city is (EMPLOYER) located?

CITY NAME: _____

3.8 What kind of business or industry is that?
(FOR EXAMPLE: TV AND RADIO MFG, RETAIL SHOE STORE, DOCTOR'S OFFICE)

_____

_____

3.9 SELF-EMPLOYED, SKIP TO Q3.12.

What kind of work (were you/was PATIENT) doing for that job? RECORD VERBATIM.

IF MORE THAN ONE KIND OF WORK, PROBE: What kind of work (were you/was [he/she]) doing for the most hours?

OFFICE CODE |__|__|

3.10 How many years had (you/he/she) worked for (EMPLOYER FROM Q3.7) before (ADMISSION DATE/LAST YEAR WORKED IN Q3.5)?

NUMBER OF YEARS: |__|__|

LESS THAN ONE YEAR.....00
DON'T KNOW.....-1

3.11 (Were you/Was PATIENT) a member of a labor union [when (you/PATIENT) worked for (EMPLOYER FROM Q3.7)] during this period?

YES.....(ASK A).....01

NO.....00 } (SKIP TO Q3.12)
DON'T KNOW.....-1 }

A. What is the name of the labor union? (RECORD NAME BELOW.)

DON'T KNOW.....-1

B. What is the number of the labor union local to which (you/PATIENT) belonged?

RECORD UNION NUMBER: |__|__|__|__|

DON'T KNOW.....-1

3.12 Altogether, how many hours per week did (you/PATIENT) usually work (during the 6 months prior to ADMISSION DATE/during YEAR IN Q3.5)?

|__|__| HOURS

DON'T KNOW.....-1

3.13 What did (you/PATIENT) earn in an average month from wages and salaries, before taxes and deductions, from all jobs during (that 6 month period/YEAR IN Q3.5)?

$ |__|__|,|__|__|__|.|__|__|

per hour.....01
per week.....02
per month.....03
per year.....04
} (GO TO Q3.14)

REFUSED.....(ASK A).....-3
DON'T KNOW.....(ASK A).....-1

A. We just need to know which category (your/PATIENT's) income was in. Would you say (your/PATIENT's) average monthly income at that time was over $3,000 per month, or less than $3,000 per month?

More than $3,000 per month....(GO TO B)...01
Less than $3,000 per month....(GO TO C)...02

DON'T KNOW.....-1
REFUSED.....-3
} (GO TO Q3.14)

B. Would you say it was....

between $3,001 to $3,500 (per month).....01
between $3,501 to $4,000 (per month).....02
between $4,001 to $5,000 (per month).....03
between $5,001 to $7,000 (per month).....04
More than $7,001 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

*** * * GO TO Q3.14 * * ***

C. Would you say it was...

between $ 500 to $1,000 (per month).....01
between $1,001 to $1,500 (per month).....02
between $1,501 to $2,000 (per month).....03
between $2,001 to $2,500 (per month).....04
between $2,501 to $3,000 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

3.14 INTERVIEWER: WAS PATIENT WORKING DURING 6 MONTHS PRIOR TO ADMISSION MONTH (Q3.1=01 YES)?

YES.....(GO TO Q3.16).....01
NO.....(ASK Q3.15).....00

3.15 During (YEAR IN Q3.5), for how many of those 52 weeks (were you/was [he/she]) actually working? Include paid vacation but do not include weeks missed because of illness, unemployment or layoff.

|__|__| WEEKS

DON'T KNOW.....-1

* * * GO TO Q4.1 * * *

3.16 Thinking of the 26 weeks between (START DATE) and (ADMISSION DATE), please tell me about how many weeks (you/he/she) spent working (including paid vacation), and how many weeks (you/he/she) missed because of illness, layoff or strikes and for other reasons. USE CATEGORIES AS PROBES. ANSWERS SHOULD TOTAL 26.

	WEEKS	DON'T KNOW
A. WORKING INCLUDING PAID VACATION	|__|__|	-1
B. MISSED BECAUSE OF ILLNESS OR INJURY . . .	|__|__|	-1
C. LAYOFF OR STRIKE.	|__|__|	-1
D. OTHER REASONS (SPECIFY)	|__|__|	-1
_____	26 TOTAL	

3.17 INTERVIEWER: ARE ANY WEEKS CODED IN Q3.16B (ILLNESS OR INJURY)?

YES.....(ASK Q3.18).....01
NO.....(GO TO Q4.1).....00

3.18 What was the nature of the illness or medical problem that prevented (you/PATIENT) from working during those weeks? (RECORD VERBATIM.) CODE PREGNANCY 99 AND SKIP TO Q3.20.

(ASK A)

PREGNANT.....99
DON'T KNOW.....-1
} (GO TO Q4.1)

A. Was (your/PATIENT's) hospitalization on (ADMISSION DATE) for the treatment of that illness?

YES.....01
NO.....00
DON'T KNOW.....-1

SECTION 4. RETURN TO WORK

4.1 DATA ENTRY: ENTER 01 AND CONTINUE WITH 4.2.

4.2 Following (your/PATIENT's) hospitalization on (ADMISSION DATE), did (you/he/she) ever return to work?

PROBE: Either full- or part-time?

YES.....(GO TO Q4.6).....01
NO.....00

4.3 What was the main reason (you/PATIENT) did not return to work? (CODE ONE ONLY.)

Ill/Disabled/Unable to work.....01 → (ASK Q4.4)
Retired due to ill health.....02 → (ASK Q4.4)
Retired.....03
Care of home/Family/Pregnant.....04
School.....05
Could not find work.....06
Doing something else (SPECIFY).....07 (GO TO SECTION 10)

_____

Died soon after discharge.....08
Other (SPECIFY).....09

_____

4.4 What was the nature of the illness or injury that prevented (you/PATIENT) from returning to work? (RECORD VERBATIM)

_____

_____

DON'T KNOW.....-1

4.5 Was (ILLNESS IN Q4.4) related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

*** * * GO TO SECTION 10 * * ***

4.6 Was the type of work (you/PATIENT) did when (you/he/she) returned to work the same as before (you/he/she) went into the hospital on (ADMISSION DATE) or did (you/he/she) do a different type of work?

SAME TYPE OF WORK....(GO TO Q4.7).....01

DIFFERENT TYPE OF WORK....(ASK A).....02

DON'T KNOW.....(GO TO Q4.7).....-1

A. What was the main reason (you/PATIENT) did a different type of work at this time? (CODE ONE ONLY.)

HEALTH PREVENTED FROM DOING THE SAME WORK.....01
PROMOTION.....02
WORK NOT AVAILABLE.....03
OTHER (SPECIFY).....04

DON'T KNOW.....-1

4.7 When did (you/PATIENT) return to work following (DISCHARGE DATE)?

PROBE: Either full- or part-time.

|__|__| 19 |__|__| → RECORD DATE ON FACE SHEET
MONTH YEAR

4.8 Did (your/PATIENT's) employer continue to pay all, some or none of (your/his/her) wages between (ADMISSION DATE) and (RETURN TO WORK MONTH IN Q4.7)?

ALL.....(GO TO Q4.9).....01
SOME.....(ASK A).....02
NONE.....(GO TO Q4.9).....03
DON'T KNOW.....(GO TO Q4.9).....-1

A. For how many months did (your/his/her) employer continue to pay (you/him/her)?

RECORD NUMBER OF MONTHS OR DATE WHEN PAYMENT STOPPED.

|__|__| MONTHS

OR

UNTIL |__|__| |__|__|
MO YR

B. What percent of (your/his/her) regular wage did (you/he/she) receive?

|__|__|__| %

4.9 INTERVIEWER: IS RETURN TO WORK DATE (Q4.7) MORE THAN ONE MONTH AFTER DISCHARGE DATE?

YES.....(ASK Q4.10).....01

NO.....(GO TO Q4.13).....00

4.10 What was the main reason (you/PATIENT) did not return to work before then? (CODE ONE ONLY.)

Ill/Disabled/Unable to work.....01	(ASK Q4.11)
Retired due to ill health.....02	
Retired.....03	(GO TO Q4.13)
Care of home/Family/Pregnant.....04	
School.....05	
Could not find work.....06	
Doing something else (SPECIFY).....07	
_____	
Other (SPECIFY).....09	
_____	

4.11 What was the nature of the illness or injury that prevented (you/PATIENT) from returning to work before (MONTH AND YEAR IN Q4.7)? (RECORD VERBATIM.)

_____

_____

4.12 Was this illness or injury related to (your/PATIENT's) hospitalization on (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

4.13 Next, I'll be asking you questions about (your/PATIENT's) employment after (you/he/she) returned to work in (RETURN TO WORK MONTH AND YEAR FROM Q4.9).

4.14 INTERVIEWER: PATIENT RETURNED TO WORK IN (Q4.7):

1984 ----> GO TO SECTION 5.....01
1985 ----> GO TO SECTION 6.....02
1986 ----> GO TO SECTION 7.....03
1987 ----> GO TO SECTION 8.....04
1988 ----> GO TO SECTION 9.....05

SECTION 5. WAGES AND WORK HISTORY, FIRST POST-HOSPITAL INTERVAL (TO END OF 1984)

5.1 DID RESPONDENT DIE IN 1984?

YES.....01 ASK TIME REFERENCE ONLY THROUGH DEATH DATE

NO.....00

5.2 In 1984 after (you/PATIENT) returned to work, how many hours per week did (you/he/she) usually work at all jobs?

|__|__| HOURS

DON'T KNOW.....-1

5.3 What (were your/was PATIENT's) earnings from wages and salaries each month, before taxes and deductions, from all jobs during the rest of 1984? CODE TIME PERIOD.

IF NECESSARY, PROBE: Is that per hour, day, week or what?

$ |__|__|,|__|__|__|.|__|__|
DOLLARS CENTS

Per hour.....01
day.....02
week.....03
month.....04
year.....05
} GO TO Q5.4

REFUSED.....(ASK A).....-3
DON'T KNOW.....(ASK A).....-1

A. We just need to know which category (your/PATIENT's) income was in. Would you say (your/PATIENT's) average monthly income at that time was over $3,000 per month, or less than $3,000 per month?

More than $3,000 per month....(GO TO B)....01
Less than $3,000 per month....(GO TO C)....02

DON'T KNOW.....-1
REFUSED.....-3
} (GO TO Q5.4)

B. Would you say it was....

between $3,001 to $3,500 (per month).....01
between $3,501 to $4,000 (per month).....02
between $4,001 to $5,000 (per month).....03
between $5,001 to $7,000 (per month).....04
More than $7,001 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

* * * GO TO Q5.4 * * *

C. Would you say it was...

between $ 500 to $1,000 (per month).....01
between $1,001 to $1,500 (per month).....02
between $1,501 to $2,000 (per month).....03
between $2,001 to $2,500 (per month).....04
between $2,501 to $3,000 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

5.4 Still thinking of the (WEEKS IN 1984 AFTER RETURN TO WORK) weeks in 1984 after (you/he/she) returned to work, please tell me about how many weeks (you/he/she) spent working (including paid vacations), and how many weeks (you/he/she) missed because of illness, layoff or strikes, and for other reasons. USE CATEGORIES AS PROBES.

ANSWERS SHOULD TOTAL WEEKS IN 1984 AFTER RETURN TO WORK.

	WEEKS	DON'T KNOW
A. WORKING INCLUDING PAID VACATION	|___|___|	-1
B. MISSED BECAUSE OF ILLNESS OR INJURY . . .	|___|___|	-1
C. LAYOFF OR STRIKE.	|___|___|	-1
D. OTHER REASONS (SPECIFY)	|___|___|	-1
_____	|___|___|	TOTAL

5.5 INTERVIEWER: ARE ANY WEEKS CODED IN Q5.4B (ILLNESS OR INJURY)?

YES.....(ASK Q5.6).....01
NO.....(GO TO Q5.9).....00

5.6 What was the nature of the illness or other medical problem that prevented (you/PATIENT) from working during those weeks? (RECORD VERBATIM.) RECORD PREGNANCY AS CODE 99 AND SKIP TO Q5.9.

_____

_____ (ASK Q5.7)

PREGNANT.....99 → (SKIP TO Q5.9)
DON'T KNOW.....-1 → (ASK Q5.7)

5.7 Was this (illness/medical problem) caused by an accident or injury?

YES.....(ASK A).....01

NO.....(SKIP TO Q5.8).....00

DON'T KNOW.....(SKIP TO Q5.8).....-1

A. Where did the accident or injury take place? Was it... (READ CATEGORIES 01-03 ONLY.) (CODE ONE ONLY.)

On the job?.....01
During service in the Armed Forces, or...02
In (your/PATIENT's) home?.....03
SOMEWHERE ELSE (SPECIFY).....09
} (GO TO Q5.8)

IN THE HOSPITAL.....04 (ASK B)

REFUSED.....-3
DON'T KNOW.....-1
} (GO TO Q5.9)

B. What is the name of the hospital where the accident or injury took place?

_____|__|__|__|

REFUSED.....-3
DON'T KNOW.....-1

5.8 Was (your/PATIENT's) illness related to (your/his/her) hospitalization on (ADMISSION DATE)?

YES.....01

NO.....00

DON'T KNOW.....-1

5.9 DID PATIENT DIE IN 1984?

YES.....(GO TO SECTION 10)....01

NO.....00

SECTION 6. WAGES AND WORK HISTORY, 1985

6.1 INTERVIEWER: DID RESPONDENT DIE IN 1985?

YES.....01 — ASK TIME REFERENCE ONLY THROUGH DEATH DATE

NO.....00

6.2 During the period from January 1985 through December 1985, did (you/PATIENT) work at all, either full- or part-time?

YES.....(GO TO Q6.4).....01
NO.....(ASK Q6.3).....00
DON'T KNOW.....(ASK Q6.3).....-1

6.3 What was the main reason (you/he/she) did not work? (CODE ONE ONLY.)

Ill/Disabled/Unable to work.....01 → (ASK A)
Retired due to ill health.....02 → (ASK A)
Retired.....03 → GO TO SECTION
Care of home/Family/Pregnant.....04
School.....05
Could not find work.....06
Doing something else (SPECIFY).....07
(GO TO Q6.14)

_____

Other (SPECIFY).....09

_____

A. What was the nature of the illness that prevented (you/PATIENT) from working (during 1985/until RESPONDENT's death)? (RECORD VERBATIM.)

_____

_____

B. Was this illness related to (your/PATIENT's) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

* * * GO TO Q6.14 * * *

6.4 INTERVIEWER: DID PATIENT WORK IN 1984 FOLLOWING HOSPITAL DISCHARGE (SECTION 5 ASKED)?

YES.....01
NO.....(GO TO Q6.7).....00

6.5 Was the type of work (you/PATIENT) did during 1985 the same as what (you/he/she) did in 1984 when (you/he/she) returned to work?

YES.....(GO TO Q6.6)....01
NO.....(ASK A).....00
DON'T KNOW....(GO TO Q6.6)....-1

A. What was the main reason (you/PATIENT) changed the type of work (you/he/she) did? (CODE ONE ONLY.)

HEALTH PREVENTED FROM DOING THE SAME WORK.....01
PROMOTION.....02
WORK NOT AVAILABLE.....03 GO TO Q6.6
OTHER (SPECIFY).....09

_____

DON'T KNOW.....-1

6.6 You mentioned that (you/PATIENT) worked an average of (NUMBER OF HOURS IN Q5.2) hours per week in 1984. Did (you/PATIENT) work the same number of hours per week in 1985?

YES.....(GO TO Q6.8)....01
NO.....(ASK A).....00
DON'T KNOW....(GO TO Q6.8)....-1

A. What was the main reason (you/PATIENT) changed the number of hours (you/he/she) worked? (CODE ONE ONLY.)

FELT BETTER, WORKED MORE.....01
HEALTH PROBLEM, WORKED LESS...02
OTHER (SPECIFY).....09

_____

DON'T KNOW.....-1

6.7 Altogether, how many hours per week did (you/PATIENT) usually work at all (your/his/her) jobs in 1985?

RECORD NUMBER OF HOURS: |__|__|

DON'T KNOW.....-1

6.8 What (were your/was PATIENT's) monthly earnings from wages and salaries, before taxes and deductions, from all jobs during 1985? CODE TIME PERIOD.

IF NECESSARY, PROBE: Is that per hour, day, week or what?

$ |__|__|,|__|__|__|.|__|__|
DOLLARS CENTS

Per hour.....01
day.....02
week.....03
month.....04
year.....05
} GO TO Q6.9

REFUSED.....(ASK A).....-3
DON'T KNOW.....(ASK A).....-1

A. We just need to know which category (your/PATIENT's) income was in. Would you say (your/PATIENT's) average monthly income at that time was over $3,000 per month, or less than $3,000 per month?

More than $3,000 per month....(GO TO B)....01
Less than $3,000 per month....(GO TO C)....02

DON'T KNOW.....-1
REFUSED.....-3
} (GO TO Q6.9)

B. Would you say it was....

between $3,001 to $3,500 (per month).....01
between $3,501 to $4,000 (per month).....02
between $4,001 to $5,000 (per month).....03
between $5,001 to $7,000 (per month).....04
More than $7,001 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

* * * GO TO Q6.9 * * *

C. Would you say it was...

between $ 500 to $1,000 (per month).....01
between $1,001 to $1,500 (per month).....02
between $1,501 to $2,000 (per month).....03
between $2,001 to $2,500 (per month).....04
between $2,501 to $3,000 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

6.9 Please tell me about how many weeks (you/he/she) spent working (including paid vacations) in 1985, and how many weeks (you/he/she) missed because of illness, layoff or strikes, and for other reasons. USE CATEGORIES AS PROBES. ANSWERS SHOULD TOTAL 52 UNLESS THE PATIENT DIED.

	WEEKS	DON'T KNOW
A. WORKING INCLUDING PAID VACATION	|__|__|	-1
B. MISSED BECAUSE OF ILLNESS OR INJURY . . .	|__|__|	-1
C. LAYOFF OR STRIKE.	|__|__|	-1
D. OTHER REASONS (SPECIFY)	|__|__|	-1
_____	52 TOTAL	

6.10 INTERVIEWER: ARE ANY WEEKS CODED IN Q6.9B (ILLNESS OR INJURY)?

YES.....(ASK Q6.11).....01
NO.....(GO TO Q6.14).....00

6.11 What was the nature of the illness (or other medical problem) that prevented (you/PATIENT) from working during those weeks? (RECORD VERBATIM.) RECORD PREGNANCY AS CODE 99 AND SKIP TO Q6.14.

_____

_____ (ASK Q6.12)

PREGNANCY.....99 → (GO TO Q6.14)
DON'T KNOW.....-1 → (ASK Q6.12)

6.12 Was this caused by an accident or injury?

YES.....(ASK A).....01
NO.....(GO TO Q6.13)....00
DON'T KNOW.....(GO TO Q6.13)....-1

A. Where did the accident or injury take place? Was it... (READ CATEGORIES 01-03 ONLY.) (CODE ONE ONLY.)

On the job?.....01
During service in the Armed Forces, or...02
In (your/PATIENT's) home?.....03
SOMEWHERE ELSE (SPECIFY).....09
(GO TO Q6.13)

IN THE HOSPITAL.....04 (ASK B)

REFUSED.....-3
DON'T KNOW.....-1
(GO TO Q6.14)

B. What is the name of the hospital where the accident or injury took place?

_____|__|__|__|

REFUSED.....-3
DON'T KNOW.....-1

6.13 Was (your/PATIENT's) illness (or other medical problem) related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

6.14 DID PATIENT DIE OR RETIRE IN 1985?

YES.....(GO TO SECTION 10)....01
NO.....00

SECTION 7. WAGES AND WORK HISTORY, 1986

7.1 INTERVIEWER: DID RESPONDENT DIE IN 1986?

YES.....01 — ASK TIME REFERENCE ONLY THROUGH DEATH DATE

NO.....00

7.2 During the period from January 1986 through December 1986, did (you/PATIENT) work at all, either full- or part-time?

YES.....(GO TO Q7.4).....01
NO.....(ASK Q7.3).....00
DON'T KNOW.....(ASK Q7.3).....-1

7.3 What was the main reason (you/he/she) did not work? (CODE ONE ONLY.)

Ill/Disabled/Unable to work.....01 → (ASK A)
Retired due to ill health.....02 → (ASK A)
Retired.....03 → GO TO SECTION
Care of home/Family/Pregnant.....04
School.....05
Could not find work.....06
Doing something else (SPECIFY).....07
_____
Other (SPECIFY).....09
_____
(GO TO Q7.14)

A. What was the nature of the illness that prevented (you/PATIENT) from working (during 1986/until RESPONDENT's death)? (RECORD VERBATIM.)

_____

_____

B. Was this illness related to (your/PATIENT's) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

* * * GO TO Q7.14 * * *

7.4 INTERVIEWER: DID PATIENT WORK IN 1985 FOLLOWING HOSPITAL DISCHARGE (SECTION ~~5~~ 6 ASKED)?

YES.....01
NO.....(GO TO Q7.7).....00

7.5 Was the type of work (you/PATIENT) did during 1986 the same as what (you/he/she) did in 1985?

YES.....(GO TO Q7.6)....01
NO.....(ASK A).....00
DON'T KNOW....(GO TO Q7.6)....-1

A. What was the main reason (you/PATIENT) changed the type of work (you/he/she) did? (CODE ONE ONLY.)

HEALTH PREVENTED FROM DOING THE SAME WORK...01
PROMOTION.....02
WORK NOT AVAILABLE.....03 → GO TO Q7.6
OTHER (SPECIFY).....09

_____

DON'T KNOW.....-1

7.6 You mentioned that (you/PATIENT) worked an average of (NUMBER OF HOURS IN Q6.7) hours per week in 1985. Did (you/PATIENT) work the same number of hours per week in 1986?

YES.....(GO TO Q7.8)....01
NO.....(ASK A).....00
DON'T KNOW....(GO TO Q7.8)....-1

A. What was the main reason (you/PATIENT) changed the number of hours (you/he/she) worked? (CODE ONE ONLY.)

FELT BETTER, WORKED MORE.....01
HEALTH PROBLEM, WORKED LESS...02
OTHER (SPECIFY).....09

_____

DON'T KNOW.....-1

7.7 Altogether, how many hours per week did (you/PATIENT) usually work at all (your/his/her) jobs in 1986?

RECORD NUMBER OF HOURS: |__|__|

DON'T KNOW.....-1

7.8 What (were your/was PATIENT's) monthly earnings from wages and salaries, before taxes and deductions, from all jobs during 1986? CODE TIME PERIOD.

IF NECESSARY, PROBE: Is that per hour, day, week or what?

$ |__|__|,|__|__|__|.|__|__|
DOLLARS CENTS

Per hour.....01
day.....02
week.....03
month.....04
year.....05
} GO TO Q7.9

REFUSED.....(ASK A).....-3
DON'T KNOW.....(ASK A).....-1

A. We just need to know which category (your/PATIENT's) income was in. Would you say (your/PATIENT's) average monthly income at that time was over $3,000 per month, or less than $3,000 per month?

More than $3,000 per month....(GO TO B)....01
Less than $3,000 per month....(GO TO C)....02

DON'T KNOW.....-1
REFUSED.....-3
} (GO TO Q7.9)

B. Would you say it was....

between $3,001 to $3,500 (per month).....01
between $3,501 to $4,000 (per month).....02
between $4,001 to $5,000 (per month).....03
between $5,001 to $7,000 (per month).....04
More than $7,001 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

* * * GO TO Q7.9 * * *

C. Would you say it was...

between $ 500 to $1,000 (per month).....01
between $1,001 to $1,500 (per month).....02
between $1,501 to $2,000 (per month).....03
between $2,001 to $2,500 (per month).....04
between $2,501 to $3,000 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

7.9 Please tell me about how many weeks (you/he/she) spent working (including paid vacations) in 1986, and how many weeks (you/he/she) missed because of illness, layoff or strikes, and for other reasons. USE CATEGORIES AS PROBES. ANSWERS SHOULD TOTAL 52 UNLESS THE PATIENT DIED.

	WEEKS	DON'T KNOW
A. WORKING INCLUDING PAID VACATION	|__|__|	-1
B. MISSED BECAUSE OF ILLNESS OR INJURY . . .	|__|__|	-1
C. LAYOFF OR STRIKE.	|__|__|	-1
D. OTHER REASONS (SPECIFY)	|__|__|	-1
	52 TOTAL	

7.10 INTERVIEWER: ARE ANY WEEKS CODED IN Q7.9B (ILLNESS OR INJURY)?

YES.....(ASK Q7.11).....01
NO.....(GO TO Q7.14).....00

7.11 What was the nature of the illness (or other medical problem) that prevented (you/PATIENT) from working during those weeks? (RECORD VERBATIM.) RECORD PREGNANCY AS CODE 99 AND SKIP TO Q7.14.

_____

(ASK Q7.12)

PREGNANCY.....99 → (GO TO Q7.14)
DON'T KNOW.....-1 → (ASK Q7.12)

7.12 Was this caused by an accident or injury?

YES.....(ASK A).....01
NO.....(GO TO Q7.13)....00
DON'T KNOW.....(GO TO Q7.13)....-1

A. Where did the accident or injury take place? Was it... (READ CATEGORIES 01-03 ONLY.) (CODE ONE ONLY.)

On the job?.....01
During service in the Armed Forces, or...02
In (your/PATIENT's) home?.....03 } (GO TO Q7.13)
SOMEWHERE ELSE (SPECIFY).....09

IN THE HOSPITAL.....04 (ASK B)

REFUSED.....-3 } (GO TO Q7.14)
DON'T KNOW.....-1

B. What is the name of the hospital where the accident or injury took place?

_____|__|__|__|

REFUSED.....-3
DON'T KNOW.....-1

7.13 Was (your/PATIENT's) illness (or other medical problem) related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

7.14 DID PATIENT DIE OR RETIRE IN 1986?

YES.....(GO TO SECTION 10)....01
NO.....00

8.1 INTERVIEWER: DID RESPONDENT DIE IN 1987?

YES.....01 ASK TIME REFERENCE ONLY THROUGH DEATH DATE

NO.....00

8.2 During the period from January 1987 through December 1987, did (you/PATIENT) work at all, either full- or part-time?

YES.....(GO TO Q8.4).....01
NO.....(ASK Q8.3).....00
DON'T KNOW.....(ASK Q8.3).....-1

8.3 What was the main reason (you/he/she) did not work? (CODE ONE ONLY.)

Ill/Disabled/Unable to work.....01 → (ASK A)
Retired due to ill health.....02 → (ASK A)
Retired.....03 → GO TO SECTION 1
Care of home/Family/Pregnant.....04
School.....05
Could not find work.....06
Doing something else (SPECIFY).....07
_____ (GO TO Q8.14)
Other (SPECIFY).....09
_____

A. What was the nature of the illness that prevented (you/PATIENT) from working (during 1987/until RESPONDENT's death)? (RECORD VERBATIM.)

_____

_____

B. Was this illness related to (your/PATIENT's) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

*** * * GO TO Q8.14 * * ***

8.4 INTERVIEWER: DID PATIENT WORK IN 1986 FOLLOWING HOSPITAL DISCHARGE (SECTION 5 ASKED)?

YES.....01
NO.....(GO TO Q8.7).....00

8.5 Was the type of work (you/PATIENT) did during 1987 the same as what (you/he/she) did in 1986?

YES.....(GO TO Q8.6)....01
NO.....(ASK A).....00
DON'T KNOW....(GO TO Q8.6)....-1

A. What was the main reason (you/PATIENT) changed the type of work (you/he/she) did? (CODE ONE ONLY.)

HEALTH PREVENTED FROM DOING THE SAME WORK...01
PROMOTION.....02
WORK NOT AVAILABLE.....03 → GO TO Q8.6
OTHER (SPECIFY).....09

_____

DON'T KNOW.....-1

8.6 You mentioned that (you/PATIENT) worked an average of (NUMBER OF HOURS IN Q7.7) hours per week in 1986. Did (you/PATIENT) work the same number of hours per week in 1987?

YES.....(GO TO Q8.8)....01
NO.....(ASK A).....00
DON'T KNOW....(GO TO Q8.8)....-1

A. What was the main reason (you/PATIENT) changed the number of hours (you/he/she) worked? (CODE ONE ONLY.)

FELT BETTER, WORKED MORE.....01
HEALTH PROBLEM, WORKED LESS...02
OTHER (SPECIFY).....09

_____

DON'T KNOW.....-1

8.7 Altogether, how many hours per week did (you/PATIENT) usually work at all (your/his/her) jobs in 1987?

RECORD NUMBER OF HOURS: |__|__|

DON'T KNOW.....-1

8.8 What (were your/was PATIENT's) monthly earnings from wages and salaries, before taxes and deductions, from all jobs during 1987? CODE TIME PERIOD.

IF NECESSARY, PROBE: Is that per hour, day, week or what?

$ |__|__|,|__|__|__|.|__|__|
DOLLARS CENTS

Per hour.....01
day.....02
week.....03
month.....04
year.....05
} GO TO Q8.9

REFUSED.....(ASK A).....-3
DON'T KNOW.....(ASK A).....-1

A. We just need to know which category (your/PATIENT's) income was in. Would you say (your/PATIENT's) average monthly income at that time was over $3,000 per month, or less than $3,000 per month?

More than $3,000 per month....(GO TO B)....01
Less than $3,000 per month....(GO TO C)....02

DON'T KNOW.....-1
REFUSED.....-3
} (GO TO Q8.9)

B. Would you say it was....

between $3,001 to $3,500 (per month).....01
between $3,501 to $4,000 (per month).....02
between $4,001 to $5,000 (per month).....03
between $5,001 to $7,000 (per month).....04
More than $7,001 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

*** * * GO TO Q8.9 * * ***

C. Would you say it was...

between $ 500 to $1,000 (per month).....01
between $1,001 to $1,500 (per month).....02
between $1,501 to $2,000 (per month).....03
between $2,001 to $2,500 (per month).....04
between $2,501 to $3,000 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

8.9 Please tell me about how many weeks (you/he/she) spent working (including paid vacations) in 1987, and how many weeks (you/he/she) missed because of illness, layoff or strikes, and for other reasons. USE CATEGORIES AS PROBES. ANSWERS SHOULD TOTAL 52 UNLESS THE PATIENT DIED.

		WEEKS	DON'T KNOW
A.	WORKING INCLUDING PAID VACATION	|__|__|	-1
B.	MISSED BECAUSE OF ILLNESS OR INJURY . . .	|__|__|	-1
C.	LAYOFF OR STRIKE.	|__|__|	-1
D.	OTHER REASONS (SPECIFY)	|__|__|	-1
	_____	52 TOTAL	

8.10 INTERVIEWER: ARE ANY WEEKS CODED IN Q8.9B (ILLNESS OR INJURY)?

YES.....(ASK Q8.11).....01
NO.....(GO TO Q8.14).....00

8.11 What was the nature of the illness (or other medical problem) that prevented (you/PATIENT) from working during those weeks? (RECORD VERBATIM.) RECORD PREGNANCY AS CODE 99 AND SKIP TO Q8.14.

_____

_____ (ASK Q8.12)

PREGNANCY.....99 → (GO TO Q8.14)
DON'T KNOW.....-1 → (ASK Q8.12)

8.12 Was this caused by an accident or injury?

YES.....(ASK A).....01
NO.....(GO TO Q8.13)....00
DON'T KNOW.....(GO TO Q8.13)....-1

A. Where did the accident or injury take place? Was it... (READ CATEGORIES 01-03 ONLY.) (CODE ONE ONLY.)

On the job?.....01
During service in the Armed Forces, or...02
In (your/PATIENT's) home?.....03 (GO TO Q8.13)
SOMEWHERE ELSE (SPECIFY).....09

IN THE HOSPITAL.....04 (ASK B)

REFUSED.....-3
DON'T KNOW.....-1 (GO TO Q8.14)

B. What is the name of the hospital where the accident or injury took place?

_____|__|__|__|

REFUSED.....-3
DON'T KNOW.....-1

8.13 Was (your/PATIENT's) illness (or other medical problem) related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

8.14 DID PATIENT DIE OR RETIRE IN 1987?

YES.....(GO TO SECTION 10)....01
NO.....00

SECTION 9. WAGES AND WORK HISTORY, FIRST HALF OF 1988 (THROUGH JUNE 30, 1988)

9.1 INTERVIEWER: DID RESPONDENT DIE IN 1988?

YES.....01 — ASK TIME REFERENCE ONLY THROUGH DEATH DATE

NO.....00

9.2 During the period from January 1988 through June 30, 1988, did (you/PATIENT) work at all, either full- or part-time?

YES..... ..(ASK Q9.4).....01
NO.....(GO TO Q9.3).....00
DON'T KNOW.....(SKIP TO Q9.3).....-1

9.3 What was the main reason (you/PATIENT) did not work during those months? (CODE ONE ONLY.)

Ill/Disabled/Unable to work.....01	→ (ASK A)
Retired due to ill health.....02	→ (ASK A)
Retired.....03	(GO TO Q10.1)
Care of home/Family/Pregnant.....04	
School.....05	
Could not find work.....06	
Doing something else (SPECIFY).....07	
_____	
Other (SPECIFY).....09	
_____	

A. What was the nature of the illness that prevented (you/PATIENT) from working (through June 30/until RESPONDENT's death)? (RECORD VERBATIM.)

_____

_____

B. Was this illness related to (your/PATIENT's) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

*** * * GO TO Q10.1 * * ***

9.4 What is the name of (your/PATIENT's) current employer?

PROBE: Where (you/he/she) works the most hours?

_____

_____

SELF-EMPLOYED..(GO TO Q9.4B)....98
DON'T KNOW.....(GO TO Q9.6).....-1

A. In what city is (EMPLOYER) located?

CITY NAME: _____

B. What kind of business or industry is (EMPLOYER)?

(FOR EXAMPLE: TV AND RADIO MFG., RETAIL SHOE STORE, DOCTOR's OFFICE.)

_____

_____

9.5 What kind of work (do you/does PATIENT) do for (EMPLOYER)?

IF MORE THAN ONE KIND OF WORK, PROBE: What kind of work (were you/was he/she) doing for most of the hours?

|__|__|
OFFICE CODE

_____

_____

9.6 INTERVIEWER: DID PATIENT WORK IN 1987 (Q9.2 = YES (01))?

YES.....01
NO.....(GO TO Q9.9).....00

9.7 Is the type of work (you have/PATIENT has) been doing so far this year been the same as what (you/he/she) did in 1987?

YES.....(GO TO Q9.8).....01
NO.....(ASK A).....00
DON'T KNOW.....(GO TO Q9.8).....-1

A. What was the main reason (you/PATIENT) changed the type of work (you/he/she) did? (CODE ONE ONLY.)

HEALTH PREVENTED FROM DOING THE SAME WORK...01
PROMOTION.....02
WORK NOT AVAILABLE.....03
OTHER (SPECIFY).....09

_____

DON'T KNOW.....-1

GO TO Q9.8

9.8 You mentioned that (you/PATIENT) worked an average of (NUMBER OF HOURS IN Q8.7) hours per week in 1987. Did (you/PATIENT) work the same number of hours per week during the first half of 1988 as (you/he/she) did in 1987?

YES.....(GO TO Q9.10).....01
NO.....(ASK A).....00
DON'T KNOW...(GO TO Q9.9).....-1

A. What was the main reason (you/PATIENT) changed the number of hours (you/he/she) worked? (CODE ONE ONLY.)

FELT BETTER, WORKED MORE.....01
HEALTH PROBLEM, WORKED LESS.....02
OTHER (SPECIFY).....09

_____

DON'T KNOW.....-1

9.9 Altogether, how many hours per week did (you/PATIENT) usually work at all (your/his/her) jobs through June of 1988?

RECORD NUMBER OF HOURS: |__|__|

DON'T KNOW.....-1

9.10 What (were your/was PATIENT's) monthly earnings from wages and salaries, before taxes and deductions, from all jobs during the first half of 1988? CODE TIME PERIOD.

IF NECESSARY, PROBE: Is that per hour, day, week or what?

$ |__|__|,|__|__|__|.|__|__|
DOLLARS CENTS

Per hour.....01
day.....02
week.....03
month.....04
year.....05
} GO TO Q9.11

REFUSED.....(ASK A).....-3
DON'T KNOW.....(ASK A).....-1

A. We just need to know which category (your/PATIENT's) income was in. Would you say (your/PATIENT's) average monthly income at that time was over $3,000 per month, or less than $3,000 per month?

More than $3,000 per month....(GO TO B)....01
Less than $3,000 per month....(GO TO C)....02

DON'T KNOW.....-1
REFUSED.....-3
} (GO TO Q9.11)

B. Would you say it was....

between $3,001 to $3,500 (per month).....01
between $3,501 to $4,000 (per month).....02
between $4,001 to $5,000 (per month).....03
between $5,001 to $7,000 (per month).....04
More than $7,001 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

* * * GO TO Q9.11 * * *

C. Would you say it was...

between $ 500 to $1,000 (per month).....01
between $1,001 to $1,500 (per month).....02
between $1,501 to $2,000 (per month).....03
between $2,001 to $2,500 (per month).....04
between $2,501 to $3,000 a month.....05

DON'T KNOW.....-1
REFUSED.....-3

9.11 Please tell me about how many weeks (you/he/she) spent working during the first 26 weeks of 1988, and how many weeks (you/he/she) missed because of illness, layoff or strikes, and for other reasons. USE CATEGORIES AS PROBES. ANSWERS SHOULD TOTAL 26 UNLESS THE PATIENT DIED.

	WEEKS	DON'T KNOW
A. WORKING INCLUDING PAID VACATION	|__|__|	-1
B. MISSED BECAUSE OF ILLNESS OR INJURY . . .	|__|__|	-1
C. LAYOFF OR STRIKE.	|__|__|	-1
D. OTHER REASONS (SPECIFY)	|__|__|	-1
_____	26 TOTAL	

9.12 INTERVIEWER: ARE ANY WEEKS CODED IN Q9.11B (ILLNESS OR INJURY)?

YES.....(ASK Q9.13).....01
NO.....(GO TO Q10.1).....00

9.13 What was the nature of the illness (or other medical problem) that prevented (you/PATIENT) from working during those weeks? (RECORD VERBATIM.) RECORD PREGNANCY AS CODE 99 AND SKIP TO Q10.1.

_____

_____ (ASK Q9.14)

PREGNANCY.....99 → (GO TO Q10.1)
DON'T KNOW.....-1 → (ASK Q9.14)

9.14 Was this caused by an accident or injury?

YES.....(ASK A).....01
NO.....(GO TO Q9.15)....00
DON'T KNOW.....(GO TO Q9.15)....-1

A. Where did the accident or injury take place? Was it... (READ CATEGORIES 01-03 ONLY.) (CODE ONE ONLY.)

On the job?.....01
During service in the Armed Forces, or...02
In (your/PATIENT's) home?.....03
SOMEWHERE ELSE (SPECIFY).....09
(GO TO Q9.15)

IN THE HOSPITAL.....04 (ASK B)

REFUSED.....-3
DON'T KNOW.....-1
(GO TO Q10.1)

B. What is the name of the hospital where the accident or injury took place?

_____|__|__|__|

REFUSED.....-3
DON'T KNOW.....-1

9.15 Was (your/PATIENT's) illness (or other medical problem) related to (your/his/her) hospitalization in (ADMISSION DATE)?

YES.....01
NO.....00
DON'T KNOW.....-1

SECTION 10

The final questions refer to sources of income (you/PATIENT) or (your/his/her) spouse may have received. The information will help us understand the effects serious illness or injury may have on a family's economic well being.

10.1 Next, at any time since (START DATE), did (you/PATIENT), (your/his/her) spouse, or both of (you/them) receive (SOURCE)?

READ EACH SOURCE AND CODE YES OR NO IN COLUMN A. IF THE PATIENT AND/OR HIS/HER SPOUSE WAS ELIGIBLE FOR THE SOURCE, ASK QUESTIONS B-F FOR EACH ELIGIBLE PERSON, THEN GO TO THE NEXT SOURCE.

COLLECT FOR PATIENT UNTIL DEATH AND FOR SPOUSE THROUGH JUNE, 1988.

FOR YEARS PRIOR TO PATIENT'S DEATH, ONLY COLLECT FOR SPOUSE IF SPOUSE WAS MARRIED TO OR LIVING WITH THE PATIENT DURING THAT YEAR.

COUNT SIGNIFICANT OTHER AS A SPOUSE.

		A ELIGIBLE	B Who was eligible (you/PATIENT), (your/his/her) spouse, or both?	C When did (you/[PERSON]) first receive (SOURCE)?	D Did (you/PERSON) receive (SOURCE) continuously fro (DATE IN (C)) until (June of 1988/DEATH DATE)?		
10.1	Any kind of Social Security? What type was that? IF NECESSARY, READ Q10.2-10.5 AS PROBES.	YES...01 (Q10.2) NO....00 (Q10.6) DK....-1 (Q10.6)					
10.2	(Social Security) for old age?	YES...01 (B) → NO....00 (Q10.3) DK....-1 (Q10.3)	PATIENT...01 (C)→ SPOUSE....01 (C)→	__|__/__|__ MO YR → __|__/__|__ MO YR →	YES 01 (F) 01 (F)	NO 00 (E) 00 (E)	DK -1 (F -1 (F
10.3	(Social Security) for disability?	YES...01 (B) → NO....00 (Q10.4) DK....-1 (Q10.4)	PATIENT...01 (C)→ SPOUSE....01 (C)→	__|__/__|__ MO YR → __|__/__|__ MO YR →	YES 01 (F) 01 (F)	NO 00 (E) 00 (E)	DK -1 (F) -1 (F)
10.4	(Social Security) for survivor's benefits?	YES...01 (B) → NO....00 (Q10.5) DK....-1 (Q10.5)	PATIENT...01 (C)→ SPOUSE....01 (C)→	__|__/__|__ MO YR → __|__/__|__ MO YR →	YES 01 (F) 01 (F)	NO 00 (E) 00 (E)	DK -1 (F) -1 (F)
10.5	Any (other) type of Social Security?	YES...01 (B) → NO....00 (Q10.6) DK....-1 (Q10.6)	PATIENT...01 (C)→ SPOUSE....01 (C)→	__|__/__|__ MO YR → __|__/__|__ MO YR →	YES 01 (F) 01 (F)	NO 00 (E) 00 (E)	DK -1 (F) -1 (F)
10.6	Any veteran's benefits for retirement?	YES...01 (B) → NO....00 (Q10.7) DK....-1 (Q10.7)	PATIENT...01 (C)→ SPOUSE....01 (C)→	__|__/__|__ MO YR → __|__/__|__ MO YR →	YES 01 (F) 01 (F)	NO 00 (E) 00 (E)	DK -1 (F) -1 (F)
10.7	Veteran's benefits for injury or illness?	YES...01 (B) → NO....00 (Q10.8) DK....-1 (Q10.8)	PATIENT...01 (C)→ SPOUSE....01 (C)→	__|__/__|__ MO YR → __|__/__|__ MO YR →	YES 01 (F) 01 (F)	NO 00 (E) 00 (E)	DK -1 (F) -1 (F)

E	F	G
When did (you/PERSON) last receive (SOURCE)?	How much did (you/PERSON) receive per month the last time (you/he/she) received a payment from (SOURCE)?	ASK ONLY IF PATIENT IS DEAD Did (SPOUSE) receive (SOURCE) because of (PATIENT's) death?
__/__ → MO YR	$ ____ per month → GO TO SPOUSE OR Q10.3	X
__/__ → MO YR	$ ____ per month → GO TO G IF PATIENT DEAD ----> → GO TO Q10.3 IF PATIENT ALIVE	YES.....01 NO.....00
__/__ → MO YR	$ ____ per month → GO TO SPOUSE OR Q10.4	X
__/__ → MO YR	$ ____ per month → GO TO G IF PATIENT DEAD ----> → GO TO Q10.4 IF PATIENT ALIVE	YES.....01 NO.....00
__/__ → MO YR	$ ____ per month → GO TO SPOUSE OR Q10.5	X
__/__ → MO YR	$ ____ per month → GO TO G IF PATIENT DEAD ----> → GO TO Q10.5 IF PATIENT ALIVE	YES.....01 NO.....00
__/__ → MO YR	$ ____ per month → GO TO SPOUSE OR Q10.6	X
__/__ → MO YR	$ ____ per month → GO TO G IF PATIENT DEAD ----> → GO TO Q10.6 IF PATIENT ALIVE	YES.....01 NO.....00
__/__ → MO YR	$ ____ per month → GO TO SPOUSE OR Q10.7	X
__/__ → MO YR	$ ____ per month → GO TO G IF PATIENT DEAD ----> → GO TO Q10.7 IF PATIENT ALIVE	YES.....01 NO.....00
__/__ → MO YR	$ ____ per month → GO TO SPOUSE OR Q10.8	X
__/__ → MO YR	$ ____ per month → GO TO G IF PATIENT DEAD ----> → GO TO Q10.8 IF PATIENT ALIVE	YES.....01 NO.....00

		A ELIGIBLE	B Who was eligible (you/PATIENT), (your/his/her) spouse, or both?	C When did (you/[PERSON]) first receive (SOURCE)?	D Did (you/PERSON) receive (SOURCE) continuously frc (DATE IN (C)) until (June of 1988/DEATH DATE)?
					YES NO DK
10.8	Any type of SSI? (Supplemental Security Income)	YES..01 (B) → NO...00 (Q10.9) DK...-1 (Q10.9)	PATIENT...01 (C)→	__|__|/__|__| → MO YR	01 (F) 00 (E) -1 (F
			SPOUSE....01 (C)→	__|__|/__|__| → MO YR	01 (F) 00 (E) -1 (
					YES NO DK
10.9	AFDC? (Aid to Families with Dependent Children)	YES..01 (B) → NO...00 (Q10.10) DK...-1 (Q10.10)	PATIENT...01 (C)→	__|__|/__|__| → MO YR	01 (F) 00 (E) -1 (
			SPOUSE....01 (C)→	__|__|/__|__| → MO YR	01 (F) 00 (E) -1 (
10.10	Any pensions?	YES..01 (Q10.11)→ NO...00 (Q10.15) DK...-1 (Q10.15)			
					YES NO DK
10.11	What type of pension? (SPECIFY) _____	YES..01 (B) → NO...00 (Q10.14) DK...-1 (Q10.14)	PATIENT...01 (C)→	__|__|/__|__| → MO YR	01 (F) 00 (E) -1
			SPOUSE....01 (C)→	__|__|/__|__| → MO YR	01 (F) 00 (E) -1
					YES NO DK
10.12	Any other pension? What type? (SPECIFY) _____	YES..01 (B) → NO...00 (Q10.14) DK...-1 (Q10.14)	PATIENT...01 (C)→	__|__|/__|__| → MO YR	01 (F) 00 (E) -1
			SPOUSE....01 (C)→	__|__|/__|__| → MO YR	01 (F) 00 (E) -1
					YES NO DK
10.13	Any other pension? What type? (SPECIFY) _____	YES..01 (B) → NO...00 (Q10.14) DK...-1 (Q10.14)	PATIENT...01 (C)→	__|__|/__|__| → MO YR	01 (F) 00 (E) -1
			SPOUSE....01 (C)→	__|__|/__|__| → MO YR	01 (F) 00 (E) -

E	F	G
When did (you/PERSON) last receive (SOURCE)?	How much did (you/PERSON) receive per month the last time (you/he/she) received a payment from (SOURCE)?	ASK ONLY IF PATIENT IS DEAD Did (SPOUSE) receive (SOURCE) because of (PATIENT's) death?
|_|_|/|_|_| → MO YR	$ |_|_|_|_| per month → GO TO SPOUSE OR Q10.9	X
|_|_|/|_|_| → MO YR	$ |_|_|_|_| per month → GO TO G ---------->	YES.....01 NO.....00
|_|_|/|_|_| → MO YR	$ |_|_|_|_| per month → GO TO SPOUSE OR Q10.10	X
|_|_|/|_|_| → MO YR	$ |_|_|_|_| per month → GO TO G ---------->	X
|_|_|/|_|_| → MO YR	$ |_|_|_|_| per month → GO TO SPOUSE OR Q10.12	X
|_|_|/|_|_| → MO YR	$ |_|_|_|_| per month → GO TO G ---------->	YES.....01 NO.....00
|_|_|/|_|_| → MO YR	$ |_|_|_|_| per month → GO TO SPOUSE OR Q10.13	X
|_|_|/|_|_| → MO YR	$ |_|_|_|_| per month → GO TO G ---------->	YES.....01 NO.....00
|_|_|/|_|_| → MO YR	$ |_|_|_|_| per month → GO TO SPOUSE OR Q10.14	X
|_|_|/|_|_| → MO YR	$ |_|_|_|_| per month → GO TO G ---------->	YES.....01 NO.....00

10.14 (Were any of these pensions/Was this pension) (that is, NAME[S] OF PENSION IN Q10.11-10.13) received because of a disability?

YES.....01
NO.....00

A. INTERVIEWER: IF ONLY ONE PENSION RECEIVED, CODE WITHOUT ASKING.

Which one(s)?

PENSION IN Q10.11 FOR PATIENT.....01
FOR SPOUSE.....02

PENSION IN Q10.12 FOR PATIENT.....03
FOR SPOUSE.....04

PENSION IN Q10.13 FOR PATIENT.....05
FOR SPOUSE.....06

The next income questions are about sources of income people may have when they are unable to work for short periods of time. These questions refer only to (you/PATIENT).

- o ASK IF PATIENT RECEIVED INCOME FROM (SOURCE).
- o IF YES: ASK HOW MANY TIMES INCOME WAS RECEIVED FROM (SOURCE).
- o ASK C AND D FOR FIRST FIVE TIMES INCOME WAS RECEIVED. IF YOU RECEIVE TWO DK's IN C FOR THAT SOURCE, GO TO E.
- o THEN ASK THE AMOUNT OF THE LAST PAYMENT PATIENT RECEIVED FROM (SOURCE).
- o GO TO THE NEXT (SOURCE).

Since (START DATE), (have you/has [he/she]) received (SOURCE).

	A	B	C	D	E
	RECEIVED?	How many times from (START DATE) until (June of 1988/ DEATH DATE) did (you/he/ she) receive (SOURCE)?	When did (you/he/she) (first/ next) receive (SOURCE)?	For how long did (you/he/she) receive (SOURCE) that time?	How much did (you/PERSON receive the last time (y he/she) received a payme from (SOURCE)?
10.15 New York State Temporary Disability Insurance?	YES...01 (B) ---> NO....00 (Q10.16) DK....-1 (Q10.16)	|__|__| TIMES DON'T KNOW.....-1 (E)	C1 |__|__|/|__|__| --> MO YR C2 |__|__|/|__|__| --> MO YR C3 |__|__|/|__|__| --> MO YR C4 |__|__|/|__|__| --> MO YR C5 |__|__|/|__|__| --> MO YR	D1 |__|__| WEEKS.....01 MONTHS....02 D2 |__|__| WEEKS.....01 MONTHS....02 D3 |__|__| WEEKS.....01 MONTHS....02 D4 |__|__| WEEKS.....01 MONTHS....02 D5 |__|__| WEEKS.....01 MONTHS....02	$ |__|__|__| per week.. per month. DON'T KNOW
10.16 Worker's Compensation?	YES...01 (B) ---> NO....00 (Q10.17) DK....-1 (Q10.17)	|__|__| TIMES DON'T KNOW.....-1 (E)	C1 |__|__|/|__|__| --> MO YR C2 |__|__|/|__|__| --> MO YR C3 |__|__|/|__|__| --> MO YR C4 |__|__|/|__|__| --> MO YR C5 |__|__|/|__|__| --> MO YR	D1 |__|__| WEEKS.....01 MONTHS....02 D2 |__|__| WEEKS.....01 MONTHS....02 D3 |__|__| WEEKS.....01 MONTHS....02 D4 |__|__| WEEKS.....01 MONTHS....02 D5 |__|__| WEEKS.....01 MONTHS....02	$ |__|__|__| per week.. per month. DON'T KNOW

		A RECEIVED?	B How many times from (START DATE) until (June of 1988/ DEATH DATE) did (you/he/ she) receive (SOURCE)?	C When did (you/he/she) (first/ next) receive (SOURCE)?	D For how long did (you/he/she) receive (SOURCE) that time?	E How much did (you/PERSON) receive the last time (you/ he/she) received a payment from (SOURCE)?
.0.17	Any other income related to illness? (SPECIFY) _____	YES...01 (B) --> NO....00 (Q10.18) DK....-1 (Q10.18)	|__|__| TIMES DON'T KNOW.....-1 (E)	C1 |__|__|/|__|__| --> MO YR C2 |__|__|/|__|__| --> MO YR C3 |__|__|/|__|__| --> MO YR C4 |__|__|/|__|__| --> MO YR C5 |__|__|/|__|__| --> MO YR	D1 |__|__| WEEKS.....01 MONTHS....02 D2 |__|__| WEEKS.....01 MONTHS....02 D3 |__|__| WEEKS.....01 MONTHS....02 D4 |__|__| WEEKS.....01 MONTHS....02 D5 |__|__| WEEKS.....01 MONTHS....02	$ |__|__|__| per week....01 per month...02 DON'T KNOW..-1

10.20 Did (you/PATIENT) have any other income or lump sum payments since (ADMISSION DATE) that we haven't already discussed?

YES.....01
NO.....(GO TO Q10.21).....00

A. What was that (income/money) from?

B. Did (you/PATIENT) receive this as a single payment?

YES.....(GO TO Q10.20F).....01
NO.....00

C. When (were you/was PATIENT) first eligible to receive (SOURCE)?

|__|__|/|__|__|
MO YR

D. Did (you/PATIENT) receive (SOURCE) continuously from (DATE IN (C)) until (June of 1988/DEATH DATE)?

YES.....(GO TO F).....01
NO.....00
DON'T KNOW.....(GO TO F).....-1

E. When did (you/PATIENT) last receive (SOURCE)?

|__|__|/|__|__|
MO YR

F. How much did (you/PATIENT) receive per month the last time (you/he/she) received a payment from (SOURCE)?

$ |__|__|__|__| PER MONTH

G. WAS (PATIENT) MARRIED OR LIVING AS MARRIED AT ANY TIME FROM (START DATE) UNTIL (JUNE 1988/DEATH DATE)?

YES.....01
NO.....(GO TO Q10.22).....00

10.21 Has (your/PATIENT's) spouse had any other income or lump sum payments since (ADMISSION DATE) that we haven't already discussed?

YES.....01
NO.....(GO TO Q10.22).....00

A. What was that (income/money) from?

_____

B. Did (your/PATIENT's) spouse receive this as a single payment?

YES.....(GO TO Q10.21F).....01
NO.....00

C. When was (your/PATIENT's) spouse first eligible to receive (SOURCE)?

|__|__|/|__|__|
MO YR

D. Did (your/PATIENT's) spouse receive (SOURCE) continuously from (DATE IN (C)) until (June of 1988/DEATH DATE)?

YES.....(GO TO F).....01
NO.....00
DON'T KNOW.....(GO TO F).....-1

E. When did (your/PATIENT's) spouse last receive (SOURCE)?

|__|__|/|__|__|
MO YR

F. How much did (your/PATIENT's) spouse receive per month the last time (you/he/she) received a payment from (SOURCE)?

$ |__|__|__|__| PER MONTH

TIME INTERVIEW ENDED: |__|__|:|__|__| AM....01 PM....02

10.22 Thank you for your time and help.

FIELD ONLY READ: May I please have your name and telephone number just in case my office wants to verify this interview?

PROXY NAME: _____

TELEPHONE NUMBER: |__|__|__|-|__|__|__|-|__|__|__|__|
AREA CODE

REFUSED.....-3 (END)
NO PHONE.....00 (END)

A. Is this phone located in your own home?

YES.....01 (END)
NO.....00 (B)

B. Where is this phone located?

_____