Clinical Outcomes Assessment Program

Inter-Rater Reliability (IRR) Program

Key to CABG Test Module
2004

Please note: not all fields (variables) on the data collection form will be scored. Only those scored are included below.
Fields in **bold** indicate questions answered <80% overall across all hospital (see supplemental materials for explanation).

Field number	Field Name/Description	Correct response	Comments
1.3	SSN	123-45-6789	Patient info sheet
1.4	Date of Birth	4-16-1929	Patient info sheet
1.5	Gender	Female	ER Record
1.6	Race/Ethnicity	Caucasian	Cath lab log
1.7	Date of Admission	7-26-2003	Patient info sheet
1.8	Admit Status	ER	ER Record
1.9	Type of procedure	CABG	
1.10	Date of Procedure	7-28-2003	Patient info sheet and Op Record
1.11	Time of procedure	13:00	Approx time patient entered room, see Op Record
1.15	Date of discharge	8-1-2003	Patient info sheet; Discharge Summary
2.0	Height	63 inches	ER Record
2.3	Weight	145 lbs	ER Record
3.0	Pre-procedure creatinine	0.7	Cr at 1140 on 7/28 was closest in time & prior to the CABG.
4.0	Hx of diabetes	No	
4.1	Type of control	Do not answer	
5.0	Hx of dialysis	No	
6.0	Hx of COPD	Yes	Emphysema, per D/C Summary
7.0	Hx of cerebrovasc dz	Yes	TIA, per D/C Summary
8.0	Hx of PVD	No	
9.0	Hx of HTN	Yes	D/C Summary refers to her home BP meds
10.0	Hx of smoking	Yes	ER Record
10.1	How long ago	Past	ER Record
11.0	Prior CABG	No	
12.0	Prior valve	No	

Field number	Field Name/Description	Correct response	Comments
13.0	Prior PCI	Yes	Following MI 4/9/03
14.0	Angina type	ACS	Angina at rest at home
14.1	Acute MI before procedure?	Yes, hospitalized with acute MI	Cath report: prolonged CP, ST depression, elevated enzymes; D/C summary: ruled in for MI.
14.11	Type of MI	NSTEMI	ER EKG: St depressions; elevated troponin 7/26,7/27
14.12	Time onset to procedure	24 hr-7 days.	Symptoms began on 7/26/03; CABG on 7/28/03.
15.0	Previous MI?	Yes	Per ER, MI 4/9/03
16.0	CCSC class	Class IV	Angina at rest
17.0	Hx CHF	No	
18.0	Thrombolytics before procedure?	No	
19.0	Agents to treat ischemia	IV heparin	Cath lab log
20.0	LVEF	64	Cath lab log
20.1	Method	Estimated visually	
21.0	LM stenosis	0% or best category 1	No change post-attempted PCI
21.1	Prox LAD stenosis	Not measured	
21.2	Other LAD stenosis	60%	No change post-attempted PCI
21.3	CFX stenosis	90%	No change post-attempted PCI
21.4	RCA stenosis	65%	No change post-attempted PCI
22.0	Aortic stenosis	No	
22.1	Aortic insufficiency	No	
22.2	Mitral stenosis	No	
22.3	Mitral insufficiency	No	
23.0	Cardiogenic shock	No	
24.0	Pre-op IABP	No	
25.0	Priority	Urgent	CABG performed to minimize further deterioration; patient experienced CP at rest after attempted PCI, per Op Record
26.0	Bypass	No	
27.0	Distal venous anastamoses	3	OM1, OM3,and right graft per Op Record
28.0	LIMA	0	
28.1	RIMA	0	
28.2	GEPA	0	

Field number	Field Name/Description	Correct response	Comments
28.3	Radial artery	0	
28.4	Other	0	
33.0	EKG	No	Telemetry but no documentation of 12-lead EKG
34.0	Enzymes	Neither	None in this time frame
35.0	MI	No	
36.0	Arrhythmia	No	
37.0	Creatinine	0.8	Per lab record, 8/1 at 0558
38.0	Dialysis	No	
39.0	CVA	No	
40.0	New tamponade	No	
42.0	Vent hours	4.0	Procedure end 15:00, extubated 19:00 (D/C Summary)
43.0	Return to OR	No	
44.0	Return to cath lab	No	
45.0	RBC	0	
45.1	WB	0	
45.2	FFP	0	
45.3	Cryoprecipitate	0	
45.4	Platelets	0	
46.0	Death	No	
47.0	Discharge disposition	Home with services	Home with PT
48.0	Discharge meds	ASA, BB, ACE/ARB, LL drug	D/C Summary