General Instructions

The Common Hospital Information Form is completed for any eligible hospital record abstraction for coronary heart disease (CHD) or heart failure (HF), or both.

This form should be completed if an abstraction is needed for CHD or HF or both. Q. 1 – 10 are common to both the Hospital Record Abstraction Form (HRA) and the Heart Failure Abstraction Form (HFA).

A. The abstractor must be familiar with the ARIC Instructions for Completion of forms.

B. Several types of responses are used:

Record text answers.

Record number, such as a date, time, medical record number, or measurement.

To answer most questions you will have several choices, the simplest of all being Yes = Y, No = N, or Unknown = U. In that case, "Yes" or "No" will be marked only if there is no doubt due to information in the hospital record. If nothing is written down that definitely answers the question, "U" should be recorded. If the response categories are just Yes = Y or No = N, information not recorded is then marked as "No". In general, the following may be considered synonyms:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Rule out&quot;</td>
<td>&quot;Likely&quot;</td>
</tr>
<tr>
<td>&quot;Suggestive&quot;</td>
<td>&quot;Apparent&quot;</td>
</tr>
<tr>
<td>&quot;Equivocal&quot;</td>
<td>&quot;Consistent with&quot;</td>
</tr>
<tr>
<td>&quot;Suspicious&quot;</td>
<td>&quot;Probable&quot;</td>
</tr>
<tr>
<td>&quot;Questionable&quot;</td>
<td>&quot;Definite&quot;</td>
</tr>
<tr>
<td>&quot;Possible&quot;</td>
<td>&quot;Compatible with&quot;</td>
</tr>
<tr>
<td>&quot;Uncertain&quot;</td>
<td>&quot;Highly suspicious&quot;</td>
</tr>
<tr>
<td>&quot;Reportedly&quot;</td>
<td>&quot;Presumably&quot;</td>
</tr>
<tr>
<td>&quot;Could be&quot;</td>
<td>&quot;Borderline&quot;</td>
</tr>
<tr>
<td>&quot;Perhaps&quot;</td>
<td>&quot;Representing&quot;</td>
</tr>
<tr>
<td>&quot;Low probability&quot;</td>
<td>&quot;Minimal&quot;</td>
</tr>
<tr>
<td>&quot;Might be&quot;</td>
<td>&quot;Thought to be&quot;</td>
</tr>
<tr>
<td>&quot;May represent&quot;</td>
<td></td>
</tr>
<tr>
<td>&quot;May be&quot;</td>
<td></td>
</tr>
<tr>
<td>“Versus”</td>
<td></td>
</tr>
</tbody>
</table>

C. Complete only the appropriate questions.
D. Be sure to follow correct skip patterns, i.e., follow form logic.

E. To record dates, fill in 2 or 3 digit numbers for month/day/year. Zero is automatically filled in the data entry system for the left box for any single digit numbers (e.g., 03 for March and 06/08/45 for June 8, 1945). If part of the date is missing, record = for that part. For example, if the only information regarding date is June 1945, record 06/==/45.

F. For all times to be recorded on the HRAB form, use 24-hour clock notation. For example:
   12:00 pm = Noon = 12:00
   12:00 am - Midnight = 24:00

If an exact time cannot be recorded (i.e., is not given in the chart), the best estimate should be given. If a time cannot be clearly estimated, the following guidelines for estimating times may be used in conjunction with the admission time. Use these only as a last resort. For no mention of the time of day, please see xii.

   i) The middle of the night = 03:00
   ii) Early morning = 08:00
   iii) Morning = 09:00
   iv) Late morning = 10:00
   v) Midday = 12 Noon = 12:00
   vi) Early afternoon = 14:00
   vii) Afternoon or midafternoon = 15:00
   viii) Late afternoon = 16:00
   ix) Early evening = 19:00
   x) Evening = 21:00
   xi) Late evening = 22:00
   xii) No mention of time of day = 12:00 Noon = 12:00
   xiii) Earlier today = 12:00 Noon = 12:00

G. To record other time frames, use the following guidelines:

   Several days: ≥ 3 days
   Few days: ≥ 1 day and < 3 days
   Several hours: ≥ 4 hours and < 6 hours
   Few hours: ≥ 2 hours and < 4 hours
   "X days postoperative": the first postoperative day is the calendar day after the surgery

I. For timing purposes, when a patient was out of the hospital but not discharged (e.g., weekend pass), events will be considered in-hospital (an extension of the hospitalization).

J. Whenever you have questions about the medical information recorded in the hospital record, consult with your surveillance director.

K. "Aborted" MI is not an official medical term. The following probably occurred, there was clinical
and ECG evidence of evolving MI or reperfusion was attempted (thrombolysis, angioplasty) or serial ECGs suggested that infarction has not occurred (or was limited?). The HRA implications: history of "aborted MI" qualifies as history of MI (Q19f, Q32); "aborted MI" is equivalent to "acute MI" or "acute CHD" applies to the index event (Q20d, Q24b). The abstractor should abstract as all other events.

Detailed Instructions for Various Questions

The ID will be assigned either by computer or from the CEL form if this is a cohort hospitalization.

Items 0.a, 0.b and 0.c on this form are primarily for assisting the abstractor in confirming the medical record being abstracted matches the CHI form. Once these fields have been entered on the CELE (if a CELE is filled in before the CFDC), they can be duplicated (using the “dup key” feature) in the corresponding fields on the CFD, CHI, HRA, and/or HFA, if all 4 or 5 forms are entered in the same data session.

For 0a, enter code # of hospital assigned by Coordinating Center.

For 0b, enter the record number from the hospital chart. This number will be found stamped or typed on almost every page of the hospital record. The easiest place to find it is both on the medical record folder and in the upper right/left hand corner of the face sheet. List the number from left to right. Enter only digits and letters; omit dashes and spaces. Do not add zeroes to the right of the number. The medical record ought not change from admit to admit. The encounter (or account) # does change. Do not use it.

For 0c, enter from hospital index.

Once the planned hospitalization tracking management system is in place, these fields will be pre-filled for all forms, to ensure conformity. It will be the responsibility of the abstractor to verify, visually, that these extra key fields match the chart being abstracted.

Hospital, medical record number, and discharge date are stored encrypted because of their confidential nature

After completing questions 0a-c, the computer will double check to be sure these three items match the ID, if so, the abstractor may continue, if not, then the abstractor must check for errors.

1.a. Principal Admission Diagnosis. Fill in the ICD code for the first admission diagnosis listed on the admission/face sheet. If the admitting diagnosis is not listed on the admission/face sheet, take the admitting diagnosis or impression from the ER discharge summary if available. Note that the admitting diagnosis is that made by the physician. If both "rule out MI (R/O MI)" and chest pain are listed, record the former as the primary diagnosis. However, if both heart failure and chest pain are listed, record heart failure as the primary diagnosis. Record the primary discharge diagnosis code at item 2, e.g., 486

1.b. Primary Discharge Diagnosis. Fill in the ICD code for the primary/principal discharge diagnosis listed on the discharge index. If the discharge diagnosis is not listed on the discharge index, this needs to be coded by a nosologist, not a reviewer. Note that the discharge diagnosis is that made by the physician.
If both heart failure and MI are listed as discharge diagnosis and it is not clear which is the primary discharge diagnosis, select MI as the primary. If both HF and angina are listed and it is not clear which is primary, select angina. However, if both heart failure and chest pain are listed, record heart failure as the primary diagnosis. Record the primary discharge diagnosis code at item 2.

2. **Discharge codes for selection.** At the time this case is determined to be eligible, list the discharge and procedure codes from the hospital discharge index. If the fourth digit (the fourth digit, to the right of the decimal, is absent, leave space blank. Do not enter a zero there unless a zero actually appears in the index. If this case was not identified using a discharge list (e.g., cohort annual follow-up), enter = in the first set of boxes. If an ICD9 code is in the listing twice, record it both times; if you run out of room, then eliminate one of the repeat codes. For cases not identified through the discharge index and where codes are not available for CHI9, the hospital index may be used for entering discharge codes. Record the primary discharge diagnosis listed in item 1.b.

Note: If more than 26 diagnoses are listed the program run by the hospital selects the codes. If more than 26, do not as a reviewer, make this selection.

3. **Sex.** Indicate either male or female.

4. **Race or Ethnic Group.** This category may be found on the face sheet of the chart. If not, review the entire chart, i.e., Admission, M.D.’s History, Admitting Nurse's Notes or Nurse's General Notes. If conflicting information is found, circle the "O" (other) category and write a note in the space provided. If the patient's race is one that falls outside the categories listed, for example, if he is an Eastern Indian, indicate "Other" and specify in notelog. The following definitions should be used for determining race/ethnicity:

- **White.** A person having origins in the original peoples of Europe, North Africa, or the Middle East.
- **Black/African American.** A person having origins in any of the black racial groups of Africa.
- **Native Hawaiian or Other Pacific Islander.** A person having origins in any of the original peoples of Hawai or the Pacific Islands
- **Asian.** A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent,
- **American Indian or Alaskan Native.** A person having origins in the original peoples of North America, who maintains cultural identification through tribal affiliation.

4.a. **Hispanic or Latino origin?** This includes persons of Mexican, Puerto Rican, Cuban, Central and South American, and other or unknown Latin American or Spanish origins. Persons of Hispanic origin may be of any race. If not recorded, indicate “Unknown”, not “No”.

5.a. **Insurance.** Determine whether the patient has any of the types of insurance coverage listed in 5.b.below.

5.b. **Type of Insurance.** Note the type of health insurance coverage or payer status. "Other" payer category refers to government insurance (other than Medicare and Medicaid), Champus, Union insurance
(prepaid), VA Medical Insurance and workers' compensation. For senior citizens, when a private insurance i.e. HealthPartners Sr Care and Medicare is noted, indicate 5.b.1 & 5.b. 2 ‘Yes’. When only HealthPartners Sr Care noted, indicate 5.b.1 ‘Yes’; 5.b.2 ‘No’. Refer to Appendix HH for classifications of different types of insurance by center.

6.a. Date and Time of Arrival at Hospital. Note that the date and time of arrival at the hospital may be different from the time of admission. For example, a patient may first be taken to the emergency room (arrival at the hospital), but may not be admitted for several hours. In this case, record time of arrival at E.R. If the time of arrival at the hospital is not recorded explicitly in the chart, abstract the earliest time recorded in the chart (such as a time a procedure was ordered or time of the admitting history and physical examination). Arrival time may be taken from ambulance sheet.

6.b. If a patient has an Out Patient procedure at a hospital and then is admitted due to a complication the abstractor must define the time of arrival. If the Out Patient procedure or the complication is cardiac-related use the Out Patient admit time for the time of arrival. If neither the Out Patient procedure nor the complication is cardiac related use the admission time as the time of arrival.

7. Emergency Services. If an emergency medical service unit (ambulance, helicopter, etc., but not a private vehicle, taxi or on foot) transported the patient to the hospital, circle "Yes". This information can be found on the ambulance or ER sheet, in the admitting notes, on the face sheet, etc. "Ambulatory" should be considered "No". If not specified, answer "U". If patient arrives by wheelchair, this should not be considered emergency medical service.

8. Transfer. If the patient was transferred to or from another acute care hospital (hospital with emergency room), write the name of the hospital from which the patient was transferred, and the city and state in which it is located and the date of admission to that hospital. This information can be found on the face sheet of the chart and in admitting notes. (You may have to ask record room how this is coded if on the face sheet.) The purpose of this question is to identify recent hospitalization(s) of this patient, possibly to be reviewed at a later date. (For Surveillance cases, only hospitalization(s) in the catchment area will be reviewed. For Cohort cases, all hospitalizations are reviewed.) The hospitalizations should include multiple hospitalizations among different hospitals, or transfers from one hospital to another. If a patient went to one study hospital emergency room, and was not admitted, and then was sent to another study hospital and was admitted, this would not be a transfer from the first hospital (assuming that you are abstracting for the second hospital). The patient must have been admitted to the first hospital for a transfer to have taken place. A transfer to the rehabilitation unit of a hospital or the same hospital should generally be recorded as a "No", unless 1) it is a separate admission and 2) the chart appears to contain additional diagnostic information.

Indicate whether the transfer involved a catchment area hospital.

Note: In Washington County only, transfers to certain out-of-catchment area hospitals also need HRAs completed; these should be listed as "in-catchment." Transfers from Washington County Hospital ER have special consideration. See Manual 3.

Note: Clearly designated extended care facilities that are physically located within an acute care hospital are not considered as “another acute care hospital.”
9. **Discharge Diagnosis Codes.**
Fill in the discharge diagnoses and procedure codes as listed on the face sheet or discharge summary in the order listed. Use the most complete source. It is important that all diagnoses are coded. When a discrepancy exists between discharge codes and the code listed on the hospital index, the latter is used even if it represents a transcription error. If the fourth digit, to the right of the decimal, is absent, leave it blank. Do not enter a zero there unless it appears in the chart. Be sure to include all primary and secondary diagnoses as designated by the M.D. If ICD codes of the discharge diagnosis are not given on hospital charts and are only available from the diagnostic index, leave blank. Do not "mix and match" diagnoses and codes from different sources. If an ICD9 code is in the listing twice, record it both times; if you run out of room, then eliminate one of the repeat codes. Note: If more than 26 diagnoses are listed please contact the Coordinating Center.

10. **Discharge Diagnoses Transcribed.** If the response is “Yes” type the discharge summary. Write in the diagnoses in the order in which they are listed on the face sheet. If not listed on the face sheet, use the discharge summary. (Procedures do not have to be written out here.) Attach ID number label where specified. There is no need to re-type the discharge summary in item 22 of the HRA.

Note: In general, diagnoses codes should not be abbreviated but when necessary, medical abbreviations are acceptable.

11. **Abstractor Number.** This should be filled in, even when the chart proves to be ineligible. Double check that your code number has been written in on all the ineligibles since this is a common error. Include the date.

12. **Date abstract completed.** Record the date on which the form was completed.

13. **Source of information abstracted.** Record “P” if the medical record/s used for abstracting was/were a paper chart/s. If the medical record used for abstracting was/were an electronic chart/s, record “E”. If the medical record/s used for abstracting was/were an electronic chart(s) AND a paper chart, record “B”.