

**INSTRUCTIONS FOR ABSTRACTING
ARIC COMMON HOSPITAL INFORMATION FORM
CHI, VERSION E, 09/20/2021
CHI QxQ 09/20/2021**

General Instructions

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

Q. 1 – 10 are common to both the Hospital Record Abstraction Form (HRA) and the Heart Failure Abstraction Form (HFA).

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

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.

Item 0.a. Hospital Code Number. Using the hospital selection drop down list, enter the two digit code assigned to this hospital. If outside the study community, use the appropriate code (96-99).

Item 0b. Medical Record Number: 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.

Item 0c, Date of Discharge enter from hospital index.

When available, these fields 0b and 0c will be auto-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.

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 CHI1b, e.g., ICD-10: I21.1

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 CHI1b.

Starting December 18, 2020, ICD-9 diagnosis and procedure codes are considered as invalid in CDART to reduce

data entry errors. (If a CHI needs to be entered for an old event year in which ICD-9 codes were used, the abstractor can override the invalid message so that the ICD-9 code can be entered.)

Here is a description of a valid ICD-10 diagnosis code: CNY.YYYC where C is A-Z, N is 0-9, Y is A-Z except U. The decimal portion of the code and the number of characters after the decimal are optional. Examples of valid codes: I21, I21.1, R99.6, U07.0, U07.1, I21., I21.01, I21.A, O9A, C50.919, S06.5X4A, T83.511A

2. Discharge codes and Procedure Codes for selection. At the time the case is determined to be eligible, the discharge and procedure codes are populated (pre-filled) into the DMS from the hospital discharge index. There are 104 fields for entering codes. If the codes are not pre-filled by the DMS and therefore must be manually entered, please follow the instructions below:

If this case was not identified using a discharge list (e.g., cohort follow-up), leave blank and set the first field status to "Not Applicable" in CHI2a. If an ICD code is in the listing twice, record it both times. For cases not identified through the discharge index and where codes are not available in the chart, the hospital index may be used for entering discharge codes. Record the primary discharge diagnosis listed in item CHI1b. **NOTE: DO NOT ENTER CODES IN THE NOTELOG FIELD.**

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Description of valid ICD-10 diagnosis codes: CNY.YYYC where C is A-Z, N is 0-9, Y is A-Z except U. Here the decimal portion of the code and the number of characters after the decimal are optional. Examples of valid codes: I21, I21.1, R99.6, U07.0, U07.1, I21., I21.01, I21.A, O9A, C50.919, S06.5X4A, T83.511A

Description of valid ICD-10 procedure codes: XXXXXXX (exactly 7 X's) where X is any numeral 0-9 or any letter A-Z except the letters I and O. Examples of valid codes: 06H93DZ, 5A2204Z, GZFZZZZ, HZ53ZZZ

3. Item deleted

4. Item deleted

- 4.a. Item deleted

- 5.a. Insurance. Determine whether the patient has any insurance coverage.

5.b3. Type of Insurance. Determine whether the patient has CMS Medicaid insurance. Medicaid insurance coverage can be provided in addition to other insurance (for example CMS Medicare). Please code "Yes" if the patient has Medicaid insurance even if he/she has additional insurance listed in the medical record.

- 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.

NOTE: When available, the "date of arrival" (6a) will be pre-filled from the Hlist. It will be the responsibility of the abstractor to verify, visually, that the pre-filled arrival date is consistent with the chart being abstracted. A reminder note is on the DMS screen as follows:

CHECK AND VERIFY THE PRE-FILLED ARRIVAL DATE

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. For Electronic Health Records (EHR) Study, answer question 8a 'No' and skip to question 11.

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. Item deleted

10. Item deleted

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".