INSTRUCTIONS FOR ABSTRACTING
JHS COMMON HOSPITAL INFORMATION FORM
CHI, VERSION B, 05/27/2014
QxQ 05/27/2014

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 JHS 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:

NO	YES
"Rule out"	"Likely"
"Suggestive"	"Apparent"
"Equivocal"	"Consistent with"
"Suspicious"	"Probable"
"Questionable"	"Definite"
"Possible"	"Compatible with"
"Uncertain"	"Highly suspicious"
"Reportedly"	"Presumably"
"Could be"	"Borderline"
"Perhaps"	"Representing"
"Low probability"	"Minimal"
"Might be"	"Thought to be"
"May represent"	
"May be"	
“Versus”	

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 HRA and HF forms, 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. 03:00 | The middle of the night
II. 08:00 | Early morning/upon awakening
III. 09:00 | Morning
IV. 10:00 | Late morning
V. 12:00 | Midday OR Noon
VI. 14:00 | Early afternoon
VII. 15:00 | Afternoon or midafternoon
VIII. 16:00 | Late afternoon
IX. 19:00 | Early evening
X. 21:00 | Evening AND/OR last night
XI. 22:00 | Late evening
XII. 12:00 | No mention of time of day
XIII. 12:00 | Noon
XIV. 12:00 | Earlier today OR Noon
XV. 12:00 | Today
XVI. 12:00 | Yesterday
XVII. 22:00 | Symptom at bedtime
XVIII. 2 hours ago | short time
XIX. 18:00 | supper time

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

$\geq$ 3 days	Several days
$\geq$ 1 day and < 3 days	Few days
$\geq$ 4 hours and < 6 hours	Several hours
$\geq$ 2 hours and < 4 hours	Few 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 (eg., 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

Item 0a, Hospital Code Number: Enter code # of hospital assigned by Coordinating Center.

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.

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 CHI1b, e.g., 486

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.

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. If the codes are not pre-filled by the DMS and therefore must be manually entered, please follow the instructions below:

   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 follow-up), enter "=" signs in CHI2a. 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 in the chart (and therefore not in CHI9), the hospital index may be used for entering discharge codes. Record the primary discharge diagnosis listed in item CHI1b.

Note: If more than 26 codes are listed, follow the procedure below for determining the appropriate 26 ICD codes. DO NOT ENTER ANY CODES IN THE NOTELOG.

Sometimes the set of hospitalizations for the same Medical Record and Date of Discharge will have more than 26 discharge codes, which exceeds the spaces allotted for entering the discharge codes on the HRA or HFA. If any of the ICD codes appear more than once for the same Medical Record and Date of Discharge, then keep only the first occurrence of the ICD code and eliminate the duplicate codes. For example if the ICD codes for the same Medical Record and Date of Discharge are as follows:

Position on discharge list	ICD Code	Keep or Delete ICD code from list
1	250.00	keep
2	88.74	keep
3	88.75	keep
4	518.81	keep
5	88.72	keep
6	88.74	Duplicate (same as #2) - delete
7	88.72	Duplicate (same as #5) - delete
8	88.91	keep
9	88.75	Duplicate (same as #3) - delete
10	88.91	Duplicate (same as #8) - delete
11	88.71	keep
12	88.41	keep

For the hospitalizations (having the same Medical Record and Date of Discharge) that still have more than 26 discharge codes use the following rule to decide which ICD regarding the prefilling of the discharge codes:

- take the first 26 codes (excluding duplicates), but if we lose any of the following discharge diagnosis codes (390-459, 518.4) or any procedure code (2 or less digits to left of decimal) because they occur after the first 26 codes, then replace those in the first 26 positions starting from the end and going backwards. For example if we have the list:

Position on discharge list	ICD Code	Keep or Delete ICD code from list
1	250.00	keep
2	88.74	keep
3	88.75	keep
4	518.81	keep
5	88.72	keep
6	88.91	keep
7	88.71	keep
8	88.41	keep
9	390.1	keep
10	390.2	keep
11	391.1	keep
12	392.	keep
13	397.3	keep
14	325.2	keep
15	402.1	keep
16	403.2	keep
17	404.5	keep
18	404.7	keep
19	410.2	keep
20	411.2	keep
21	411.5	keep
22	412.6	keep
23	414.0	keep
24	428.1	keep
25	**550.2**	**delete – out of range**
26	438	keep
27	459	keep

For the above example we would delete the 25th code (ICD=550.2) and keep the 27th code (ICD=459). The value of ORIGCODE_N would have 26 codes from position 1 to 24, 26 to 27.

This keeps all circulatory discharge codes, all procedure codes, and acute edema of the lung.

NOTE: DO NOT ENTER CODES IN THE NOTELOG.

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 Hawaii 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 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.

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 and Procedure Codes.

The purpose of this section is to capture ICD codes both discharge diagnosis and procedure codes exactly as they appear in the medical chart (face sheet or discharge summary). This is important because there are situations where codes in the hospital index list (H-List) do not match the codes in the hospital chart.

Enter the discharge diagnoses and procedure codes as listed on the face sheet or discharge summary in the order listed in CHI9. Use the most complete source. It is important that all diagnoses are coded. When a discrepancy exists between discharge codes in the chart and the code listed on the hospital index (H-List) the latter is used to determine eligibility 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.

Note: If more than 26 codes are listed, follow the procedure below for determining the appropriate 26 ICD codes. DO NOT ENTER ANY CODES IN THE NOTELOG.

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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".