HEALTH ABC
ADJUDICATION PROTOCOL FOR OVERNIGHT HOSPITALIZATIONS
(REVISED NOVEMBER 2005)

I. Definitions

1) Overnight hospitalization

An overnight hospitalization occurs when the attending physician admits a Health ABC participant to an acute-care, in-patient hospital and the participant stays overnight at the hospital for at least one night. An overnight hospitalization does NOT include an ER or outpatient stay or an overnight stay solely for outpatient procedures.

II. Ascertainment of Overnight Hospitalizations during Surveillance

1) Semi annual telephone interview
2) Annual clinic visit
3) Scheduling of annual clinic visit
4) Proxy, spouse, relative, or friend contacts field center to report hospitalization
5) Hospital medical records from later event indicate an overnight hospitalized event occurred.
6) HCFA tape review
7) Obituary

III. Health ABC Data Collection Forms to be Completed by Examiners and Events Coordinators (or their designates) at the Field Centers

Data collection forms required for <u>all</u> overnight hospitalizations include:

1) Health ABC Event Form
2) Discharge Abstract Form
3) Local Adjudication Report
4) As appropriate:
    - Cancer Adjudication Report
    - Cardiovascular Disease Adjudication Report
    - Fracture Adjudication Report
    - Report of Death
    - Decedent Proxy Interview

IV. Documentation to be Requested for Overnight Hospitalizations by Events Coordinator (or their designates)

1) Face sheet or physician attestation with ICD codes
2) Discharge summary
3) Event-specific documentation may include:
    - History and physical exam

- ECG
- Cardiac enzymes
- Cardiac catheterization
- Stress test
- Echocardiography
- Carotid dopplers
- Carotid angiogram
- Lower extremity doppler
- Lower extremity angiography
- Exercise test
- CT head
- MRI brain
- Neurology consult
- Chest x-ray report
- Arterial blood gases report
- Pulmonary function test results
- Microbiology report of blood culture, sputum culture, transtracheal aspirate, bronchial brushing, or biopsy
- Endoscopy report
- Upper GI report
- Angiography report
- Barium enema/lower GI report
- Radiology report
- Pathology report
- Death Certificate

V) Procedures

Once the Health ABC field center learns about the overnight hospitalization of a participant, the following protocol should be followed:

1) An Event Form is completed by an examiner or Event Coordinator at the local field center once notified of the overnight hospitalization. Check the appropriate box in Section #3 “Overnight hospitalization (exception for cancer, fracture(s), and pneumonia).” If the overnight hospitalization is for a cancer, fracture(s) or pneumonia, check either “Cancer”, “Fracture(s)”, or “Pneumonia.”
2) The completed Event Form is scanned into data system.
3) A copy of the Event Form is forwarded to the Event Coordinator at the local field center.
4) The Event Coordinator enters tracking information into the web-based D and D tracking system.
5) The Event Coordinator requests:
   a) Face sheet or physician attestation with ICD codes
   b) Discharge summary
   c) Event-specific documentation (refer to Section IV above)

d) Records of medical history and physical exams (preferred)

6) The Event Coordinator notes first request for documentation in the D and D tracking system.
7) If necessary, the Event Coordinator makes second request for documentation.
8) The Event Coordinator notes second (and all additional) requests for documentation in the D and D tracking system.
9) All documentation received is noted in the D and D tracking system.
10) Once all documentation is received, the appropriate data collection forms, including the Discharge Abstract Form and the Local Adjudication Report is completed.
11) Event Coordinator notes the date the event packet is complete (documentation received and all appropriate data collection forms filled out) in the D and D tracking system.
12) Once the overnight hospitalization is adjudicated locally according to the protocol, all data collection forms related to the event are entered into the data system.
13) The final status of the adjudicated overnight hospitalization is entered into the D and D tracking system. The event is officially closed out.

VI) Completing the Local Adjudication Report

Question #1: Record the Health ABC Event Form reference number from the lower left-hand corner of the Event Form.

Question #2: Record the date that the participant was admitted to the hospital as stated on the face sheet or discharge summary.

Question #3: Record the date that the participant was discharged from the hospital as stated on the face sheet or discharge summary.

Question #4: Check all of the conditions and/or diagnoses that were present during the entire interval of the hospitalization.

b) Indicate whether the conditions/diagnoses that were present during the hospitalization were current events, definitely not current events, or whether it was possible that they were current events.

c) Indicate whether the conditions/diagnoses present during the hospitalization were the primary reason for the hospitalization. Only one reason should be marked.

Question #5: Indicate all of the supporting documents that are attached to the Local Adjudication Report. If documents other than those listed in Question #5 are attached, please mark “Other” and specify what the documents are. Please do NOT staple supporting documents to the back of the Local Adjudication

Report, since this may interfere with the scanning of the form; use binder clips to attach documents to the Local Adjudication Report.

Question #6: Mark the appropriate criteria for symptomatic or surgery for carotid artery disease, corresponding to question 4 d.

Question #7: Mark the appropriate diagnosis and criteria for peripheral arterial disease, corresponding to question 4e.

Question #8: Mark the appropriate stroke subtype and criteria for stroke, and if the stroke was procedure-related, corresponding to question 4f.

Question #9: Mark the appropriate criteria for TIA, corresponding to question 4g.

Question #10: Mark the appropriate diagnosis and criteria for chronic pulmonary disease, corresponding to question 4h.

Question #11: Mark the appropriate criteria and organism, if known, for pneumonia corresponding with question 4i.

Question #12: Mark the appropriate diagnosis and criteria for upper GI disease, corresponding with question 4j.

Question #13: Mark the appropriate diagnosis and criteria for lower GI bleed, corresponding with question 4k.

Question #14: Mark the appropriate diagnosis and criteria for abdominal hernia, corresponding with question 4l.

Question #15: Mark the appropriate criteria for BPH, corresponding to question 4m.

Question #16: Mark the appropriate criteria for an acute diabetes event, corresponding with question 4n.

Question #17: Mark the appropriate diagnosis and criteria for gallbladder disease, corresponding with question 4o.

Question #18: Mark the appropriate diagnosis and criteria for dementia, corresponding with question 4r.

Question #19: Mark the appropriate location and diagnosis for osteoarthritis joint surgery, corresponding to question 4s.

VII) Decision rules

1. Do not code/list chronic conditions on the local adjudicator form unless there was an acute exacerbation or new treatment for that condition during the hospitalization.
2. If a diagnosis was made of a condition not listed in question 4 a-t, then enter a brief text field in question 4 u and enter the associated diagnosis code based on the following categories:
    1. Infectious diseases
    2. Neoplasms (only benign because malignant will be in 'cancer')
    3. Endocrine, nutritional and metabolic diseases, and immune disorders
    (not including DM because there's a separate category for us)
    4. Diseases of the blood and flood forming organs
    5. Mental disorders (not including dementia or depression)
    6. Diseases of the nervous system and sense organs
    7. Diseases of the circulatory system (not including MI, angina, CHF,
    stroke, TIA, carotid disease, aortic aneurysms, LEAD)
    8. Diseases of the respiratory system (not including COPD, emphysema,
    chronic bronchitis, asthma, or pneumonia)
    9. Diseases of the digestive system (not including our upper GI disease
    groups or lower GI bleeding, or abdominal hernia, or gallbladder disease)
    10. Diseases of the genitourinary system (not including BPH)
    11. Diseases of the skin
    12. Diseases of the musculoskeletal system and connective tissue (not
    including osteoarthritis)
    13. Symptoms, signs and ill-defined conditions (we would discourage
    using this unless an etiology for a symptom could not be identified such
    as chest pain unknown etiology, vertigo etc)
    14. Injury and poisoning (not including fractures)
    15. Coronary revascularization (CABG, PTCA, stent)

3. Regarding the specific questions below:

Q7. Renal artery disease, subclavian steal syndrome, and other arterial disease not noted in these choices should be noted under Q4.u. Other diagnoses on p. 2.

Q8. The adjudicator may choose to classify an event as a stroke even though not all four criteria have been met. In some cases, the CT/MRI evidence is not conclusive, but in all other aspects the event appears to be a clinical stroke.

Q10. For the diagnosis classifications, mark the diagnoses that were mentioned in the medical record. Frequently, more than one type of lung condition is mentioned.

Q12. This question refers to non-malignant upper GI conditions. Gastroesophageal reflux disease (GERD) should be noted under "Other esophageal".
If no diagnostic criteria are met, but participant is symptomatic and treated, then mark as "possible" on p.2.

Q 13. This question refers to lower GI bleeding. Other lower GI conditions not accompanied by bleeding (diverticulosis, polyps), should be noted in Q4.u. on p.2.

Q14. Incisional hernia of the flank should also be noted here under "incisional."

Q15. Mark BPH as current event only if symptomatic and under treatment. Do not mark BPH if asymptomatic and on treatment.

Q16. If participant is admitted for other diabetes related conditions, such as hyperglycemia, nephropathy, retinopathy, or neuropathy, note these events under Q 4.u. on p.2.

Q17. The criteria for the diagnosis of gallbladder disease can include notes in the records of prior diagnostic procedures.

Q18. The dementia diagnosis should be noted only when the hospitalization is directly related to dementia or is complicated by dementia. Mention in the medical record of dementia or current treatment of dementia in the absence of a direct effect of dementia on the hospitalization or hospital course does not warrant listing dementia as a current event.

Q19. Frequently, the pre-operative radiology report will not be found or noted in the medical record. The adjudicator may use the orthopedic surgeon's statement of the presence of OA or DJD as the criterion and fill in the bubble for "Pre-operative X-ray evidence of OA or DJD: no radiology report ".