Instructions for Completing the HIV Care Sampling Medical Record Abstraction Form

GENERAL COMMENTS

- A medical record abstraction form should be completed for each patient aged 13 years and older who is selected from the provider list as outlined in the project protocol.

- The abstraction form is completed only if the patient was in care at the provider during the study period (for the pilot project, calendar year 1998). Being “in care” is defined as any visit to the practice, correspondence with the office, prescription of medications, including refill authorizations.

- "**No**" should only be given as a response to a question if the medical record documents that the patient did not have a particular condition or did not receive a particular therapy. If there is no documentation in the medical record, the response should be recorded as "**Unknown/Not documented**."

- "**Medically contraindicated**" should only be given as a response to a question if the medical record documents that the patient did not receive a particular treatment or procedure because they have a medical condition (such as an allergy) that makes receipt of that treatment or procedure inadvisable.

- If you are uncertain how to answer a question or have found contradictory medical record information, skip that question and note your concerns in the "Comments" section *(Page 9)* for later review with your project coordinator.

- Patient identifier information is not collected. Patient stateno will not be transmitted to the Centers for Disease Control and Prevention (CDC).

INSTRUCTIONS

Box 1:Abstraction and Identification Information

Patient Number

This field may be used locally to identify patients with a number in addition to the patient stateno. Local sites are not required to use a patient number in addition to the stateno.

Patient Stateno

The patient stateno is the HARS patient number assigned by the state or local health department.

First Date of Care in Interval

The names of months should be converted to numeric representations and years should be recorded in full.

For example, February 15, 1998, would be recorded as "**2** / **15** / **1998**."

This field is completed **only if, based on the information in the medical records, the patient was not in care in the practice as of January 1, 1998**. Examples of situations where this field would be completed:

- A patient completed a new patient information form on March 15, 1998
- A note in the chart indicates that the patient moved into town from another state in April 1998
- Transfer of medical records from another provider indicates that the patient changed to the provider in the sample in December 1998.

However, if the patient did not come to the doctor's office until November 1998, although she was seen in the practice several times in 1997, this field would NOT be filled in .

Last Date of Care in Interval:

The names of months should be converted to numeric representations and years should be recorded in full.

For example, February 15, 1998, would be recorded as "**2** / **15** / **1998**."

This field is completed only if, based on the information in t
was not in care in the practice as of December 31, 1998. Examples of situations where this field would be completed:

- A patient requests a transfer of all records to a new primary care provider in the city in April 1998.
- A note in the record indicates that the patient is moving out of state in October 1998.
- A patient is referred to a specialty clinic for management of HIV disease, and no further care is provided at the sampled provider.

However, if the patient is seen in the practice in January 1998 and no further information in the record indicates that the patient has transferred to another care provider, this field would not be completed as the patient would be assumed to be in care at the sampled provider.

Box 2: Demographic Information:

Date of Birth

Record the patient's month, day, and year of birth in the appropriate spaces. The names of months should be converted to numeric representations and years should be recorded in full.

> ***For example,*** if the patient was born on February 15, 1960, the date of birth would be recorded as "**2** / **15** / **1960**."

Please Note: If any part of the date of birth is unknown, the space(s) corresponding to the missing information should be left blank and the patient's age should be recorded in the adjacent field.

Sex

Indicate the patient's sex **at birth** by checking the appropriate box *(only **one** box should be checked)*.

Race/Ethnicity

Indicate the patient's race or ethnicity by checking the appropriate box *(only **one** box should be checked)*.

Please Note: To be considered "White" or "Black," a patient **cannot** be of Hispanic origin. Patients of Hispanic origin, regardless of race, are **all** considered to be "Hispanic."

Country of Birth

Indicate the patient's country of birth by checking the appropriate box *(only **one** box should be checked)*. If the patient was born in a country not listed on the questionnaire, check "Other" and record the name of the country in the adjacent field.

Please Note: U.S. dependencies and possessions are:

American Samoa
Federated States of Micronesia
Guam
Marshall Islands
Northern Mariana Islands
Palau
Puerto Rico
U.S. Virgin Islands

Vital Status

Indicate the patient's current vital status by checking the appropriate box *(only **one** box should be checked)*. If a patient is deceased, check "Dead" and record the date of death in the adjacent field.

Also Note: See ***Date of Birth*** above for the proper method of recording dates.

Box III: Risk Factors

Risk Factors

Indicate **all** of the patient's risk factors for HIV infection by checking the appropriate boxes *(**multiple** boxes may be checked)*. If any risk factor is not listed on the abstraction form, check "Other" and list the risk factor(s) in the adjacent field *(**multiple** risk factors may be listed in this field)*.

Please Note: "Heterosexual contact" should **only** be checked if the patient's sexual partner was known to be infected with HIV or was at risk for HIV infection (*i.e.*, was a bisexual male, injecting drug user, or person with hemophilia).

Box IV: Diseases Indicative of AIDS

In this section, mark an X through the appropriate box to indicate a definitive or presumptive AIDS-defining opportunistic illness. Definitions for definitive and presumptive diagnoses are available in MMWR1992; 41[no RR-17]: 1-19 and MMWR 1987; 36[suppl. No.1S]:1S-15S.

In this section, record all AIDS-defining opportunistic illnesses that occurred **at any time in the past.** Indiciate the month and year of the first known diagnosis in the corresponding boxes. Multiple illnesses may indicated in this section.

Box V: Treatment and Prophylaxis

Prescription of therapies

For this question, check the corresponding box if the medication was prescribed at any time during the interval, either during a visit or by refill authorization. Record the prescription even if there is subsequent information in the medical record indicating that the patient did not adhere to the prescribed therapy.

Pneumococcal Vaccine

Indicate whether the patient received a pneumococcal vaccine (Pneumovax) **before** or **during** the review period by checking the appropriate box *(only **one** box should be checked)*.

Please Note: While "Yes" should be checked if the patient received their pneumococcal vaccine **before** or **during** the review period, "No" should be checked if the patient received it **after** the review period.

Tuberculin Skin Test

Indicate whether the patient received a tuberculin skin test (TST) **before** or **during** the review period by checking the appropriate box *(only **one** box should be checked)*.

Please Note: While "Yes" should be checked if the patient received their tuberculin skin test **before** or **during** the review period, "No" should be checked if the patient received it **after** the review period.

Also Note: Alternative names for a tuberculin skin test are:

Mantoux
Purified protein derivative (PPD)
Tuberculosis (TB) skin test

Flu Vaccine

Indicate whether the patient received an influenza (flu) vaccine during the review period by checking the appropriate box *(only **one** box should be checked)*.

Please Note: Brand names of flu vaccines include:

Fluogen
Flu-imune
Fluvax

Toxoplasma Antibody Titer

Indicate whether the patient received a toxoplasma antibody titer **before** or **during** the review period by checking the appropriate box *(only **one** box should be checked)*.

Please Note: While "Yes" should be checked if the patient received their toxoplasma antibody titer **before** or **during** the review period, "No" should be checked if the patient received it **after** the review period.

Also Note: Alternative names for a toxoplasma antibody titer are:

Toxoplasma antibody IgG

Pap Smear

This question should only be completed for female patients.

Indicate whether the patient received a pelvic examination and pap smear during the review period by checking the appropriate box *(only **one** box should be checked)*.

Box V: Antriretroviral Medications

For each regimen, indicate **all** antiretroviral medications that the patient was prescribed by checking the appropriate boxes *(**multiple** boxes may be checked for each regimen)*. If the patient was prescribed an antiretroviral medication not listed on the questionnaire, record its name in one of the fields under "Other" and indicate the quarters that it was prescribed by checking the appropriate boxes.

Please Note: A regimen is defined as a set of medications, prescribed at one time by the physician. Any change in a drug, addition or deletion of a drug should be treated as a new regimen. However, changes in dosage of a drug do not constitute a change in regimen.

Also Note: At least one box should be checked for regimen number 1. If the patient was **not** prescribed any antiretroviral medications during the abstraction period, check "None Documented" for Regimen #1.

Box VII: Insurance Status

Primary Insurance Type

Indicate the type of health insurance that the patient had at the **beginning** of the abstraction interval by checking the appropriate boxes. If the patient had more than one form of insurance, indicate only the primary insurance. If the patient had a type of health insurance not listed on the questionnaire, check "Other" and record the type of insurance in the adjacent field.

Please Note: Only one box should be checked.

ADAP Enrollment

If the patient was enrolled in the state AIDS Drug Assistance Program (ADAP) during the study interval, indicate so by checking the appropriate box. It is not necessary to see documentation of specific drugs received through the program if enrollment is documented in the medical record.

Box VIII: Laboratory Data

Date of Earliest HIV-Positive Test

Record the month and year of the patient's earliest HIV-positive test in the appropriate spaces. If the date of the earliest HIV-positive test is **not** known, check "Date Unknown/Not documented" and leave the month and year fields blank.

Please Note: The patient's earliest HIV-positive test should not be obtained from the HARS database, but left blank if this information is not in the patient's medical records See ***Documentation of Earliest HIV-Positive Test*** below.

Also Note: See ***Date of Birth*** above for the proper method of recording dates.

Documentation of Earliest HIV-Positive Test

Indicate how the patient's earliest HIV-positive test is documented by checking the appropriate box *(only **one** box should be checked)*. If the earliest positive test is documented by several means, check the first that is listed on the form (the choices are in order of importance, starting with a laboratory report).

> ***For example,*** if the patient's earliest positive test is documented by a physician's report and a laboratory report, **only** check "Laboratory report" since this appears first in the hierarchy of importance.

"Physician report" should only be checked if the patient's medical record contains a letter or report from another physician that documents the earliest positive test. If the earliest positive test is mentioned in a physician's note without any formal confirmation or was

provided by the patient, "Patient self-report" should be checked. If the earliest positive test is documented by a means not listed on the questionnaire, check "Other" and record how the test is documented in the adjacent field.

Please Note: Since a laboratory report is the preferred means of documenting the patient's earliest HIV-positive test, always search the available medical records for a laboratory report even if a physician report or patient self-report is already available.

Date of First Confirmatory HIV Test

Indicate the type of earliest confirmatory test for HIV infection. If no mention of confirmatory test appears in the medical records, or if a confirmatory test is mentioned but not specified as to type, mark the box for "Unknown/Not Documented".

Genotypic of Phenotypic Resistance Testing

Genotypic and phenotypic resistance testing are non-FDA licensed procedures to determine whether HIV is resistant to one or more antiretroviral agents. These tests may appear under the following names:

Antivirogram
Vircogen
HIV-GenotypR Plus
HIV sequencing
Recombinant phenotyping

CD4+ Results

Record **all** of the patient's CD4+ results during the review period and the dates of these tests in the appropriate fields. CD4+ results may be obtained from both inpatient and outpatient reports. It is not necessary to record the CD4+ percent if the count is available. However, if the CD4+ count is **not** available, the percent should be recorded.

Please Note: See ***Date of Birth*** above for the proper method of recording dates.

Viral Load Results

Record **all** of the patient's viral load results during the review period and the dates of these tests in the appropriate fields. Also, indicate the type of viral load test by checking the appropriate box *(**one** box should be checked for each viral load result)*. Viral load results may be obtained from both inpatient and outpatient reports.

Please Note: The viral load results should be recorded exactly as they are documented in the patient's medical record.

For example, if a result was reported as <500 copies/ml, then the viral load result would be recorded as "**<500**," **not** "500" or "499."

As another example, if a result was reported as undetected, then the viral load result would be recorded as "**Undetected**," **not** "0" or "<###."

Exponential numbers and logarithmic (log) values should **not** be converted to whole numbers.

For example, if a result was reported as 8.65 X 10E3 copies/ml, then the viral load result would be recorded as "**8.65 X 10E3**," **not** "8.65" or "8,650."

As another example, if a result was reported as log 4.7 copies/ml, then the viral load result would be recorded as "**log 4.7**," **not** "4.7" or "50,000."

Also Note: Examples of viral load tests are:

Type	**Name**	**Manufacturer**
PCR	Amplicor HIV Monitor	Roche Diagnostic Systems
bDNA	Quantiplex HIV RNA	Chiron
NASBA	NASBA HIV-1 RNA QT	Organon Teknika

Also Note: See ***Date of Birth*** above for the proper method of recording dates.

Box IX: Health Care Data

Inpatient Visits

Inpatient visits may be documented by physician notes in the primary medical record, or by copies of inpatient records which are included in the primary medical record. If there is no record of inpatient visits/hospitalizations, leave the field blank. If the total number of hospital admissions or hospital days is not available, indicate this with “99" or “999".

When tabulating the number of inpatient days, include the day of admission, but exclude the day of discharge. This yields the same result as subtracting the date of admission from the date of discharge if both dates are in the same month.

For example, if the patient was admitted on February 15, 1998 and discharged on February 16, 1998, the number of inpatient days would be "1" (just the day of admission or February 16, 1998 minus February 15, 1998).

If the hospitalization spans the abstraction interval, count only the days of hospitalization which are in the abstraction interval.

Outpatient visits may be at the facility where medical records are being reviewed, or at other outpatient facilities if visits are documented in the primary medical record.

Box X. Substance Abuse/Mental Health Comorbid Conditions

History of Substance Abuse

Indicate whether the patient was diagnosed with any of the types of substance abuse listed during the interval by checking the appropriate boxes *(**multiple** boxes may be checked)*. If the patient's medical record documents that they have **not** abused any substances, or if there is no information on substance abuse in the medical record, leave the box empty. Either patient self-report **or** provider diagnosis may be used to document a history of substance abuse.

Injection Drug Abuse: To meet the definition of injection drug abuse, the patient's medical record must document that they **(1)** injected illicit drugs, **(2)** injected drugs obtained without a prescription or used contrary to medical indication, **or (3)** were treated for injection drug abuse.

Please Note: Examples of some drugs commonly injected include:
Amphetamines (speed) and other stimulants
Cocaine
Heroin and other opiates
Speedball (heroin and cocaine)
Steroids

Also Note: If the patient used a drug that is commonly injected, such as heroin, but there is **no** documentation that the patient injected the drug, check "Non-injection drug abuse." The patient's medical record must document that they injected the drug to check "Injection drug abuse."

Non-injection Drug Abuse: To meet the definition of non-injection drug abuse, the patient's medical record must document that they **(1)** used illicit non-injection drugs, **(2)** used non-injection drugs obtained without a prescription or used contrary to medical indication, **or (3)** were treated for non-injection drug abuse.

Also Note: Examples of some common non-injection drugs include:
Amphetamines (speed) and other stimulants
Barbiturates
Cocaine (including crack)
Heroin and other opiates
Marijuana and hashish
Nitrites, poppers, and other inhalants
PCP, LSD, and other hallucinogens
Steroids
Valium and other benzodiazepines

Also Note: Marijuana used for medical purposes does **not** constitute non-injection drug abuse.

Alcohol Abuse: To meet the definition of alcohol abuse, the patient's medical record must document that they **abused** alcohol or were treated for alcohol **abuse**; heavy alcohol use alone does **not** constitute abuse.

Other conditions:

Severe Mental Illness:

Severe mental illnesses to be recorded with this check box are:

Affective disorder (bipolar disorder, depression, mania, manic-depression, mood disorder)
Anxiety
Post-traumatic stress disorder (PTSD)
Schizophrenia (psychotic disorder)

Homelessness:

If the patient was homeless at any time during the review period, indicate this by checking the box.

Please Note: A patient is considered to have been homeless if **(1)** there is documentation in their medical record that they were homeless, **or (2)** their primary residence during the night is a facility that provides temporary living accommodations, such as a "homeless shelter."

Also Note: If a patient does not have a permanent address listed, but there is no documentation that they were homeless, this box should be left blank.

Incarceration:

Indicate incarceration if evidence of incarceration in a city, county, state, or federal correctional institution is documented in the medical records, regardless of the length of incarceration. Patient self-report is adequate evidence of confinement.

Referral for psychiatric services, other than severe mental illness:

This box does NOT include referral for the conditions listed under “severe mental illnesses” above, but might include referral for individual or group counseling or therapy.