

## Procedures for Completing Subject Abstract

Line #	Instructions
<b>Subject ID Page</b>	<p><b>Subject's clinic ID number</b> Fill in the ID/medical record number assigned to this subject by the clinic.</p> <p><b>Subject's study ID number</b> A four-digit ID has been filled in.</p>
<b>1</b>	<p><b>Subject's Study ID#</b> A four-digit ID has been filled in.</p>
<b><i>Then tear off the subject ID page and put it in your "Subject ID" folder.</i></b>	
<b>2</b>	<p><b>Clinic site code</b> Your clinic site code has been filled in.</p>
<b>3</b>	<p><b>Primary physician code</b> Fill in the three-digit code that corresponds to the subject's primary MD. List the physician that the patient sees most frequently. If the patient is technically assigned to a faculty MD but typically sees a resident, list the resident. The list of physician codes has been sent to you.</p>
<b>4</b>	<p><b>Gender</b> Circle either M or F to denote the subject's gender.</p>
<b>5</b>	<p><b>Subject age</b> Fill in the subject's age in years as of his/her last birthday.</p>
<b>6</b>	<p><b>Column a: Race</b> Circle the one number (i-vi) that best denotes the subject's race. If (vi) "other" is circled, write in a description of the race in the space provided; you may include Hispanic here if a Hispanic's race is not known. Circle (vii) if the record indicates the subject declares &gt;1 racial identity. Circle (viii) if the subject's race is not documented or unknown.</p> <p><b>Column b: Ethnicity</b> Circle (i) if the subject's ethnicity is Hispanic or Latino. Circle (ii) if the subject's ethnicity is not Hispanic or Latino. Circle (iii) if the subject's ethnicity is not documented or unknown.</p>
<b>7</b>	<p><b>Height</b> Fill in the subject's height in <i>either</i> centimeters or inches. You may use the height documented at any visit within 3 years of the index visit, or you may take a height at the time of consent. Write ND if not documented.</p>

<b>8</b>	<p><b>Type of health insurance:</b></p> <p>Circle the one letter (a-d) that best describes the type of health insurance the subject has.</p> <p>Circle (e) if the subject has no insurance and self-pays his/her medical bills.</p>
<b>9</b>	<p><b>Insurance coverage for prescriptions</b></p> <p>Circle (a) if the subject's insurance includes prescription drug coverage.</p> <p>Circle (b) if the subject's insurance does not include prescription drug coverage.</p> <p>Circle (c) if the medical record does not include any documentation regarding prescription drug coverage.</p>
<b>Substance Use</b>	
<b>10</b>	<p><b>Smoking history</b></p> <p>Circle (a) if the subject currently smokes, then go to line 11.</p> <p>Circle (b) if the subject is a former smoker, then skip to line 12.</p> <p>Circle (c) if the subject has never smoked, then skip to line 13.</p> <p>Circle (d) if smoking history is not documented, then skip to line 13.</p>
<b>11</b>	<p><b>Packs per day currently smoking</b></p> <p>Circle the one letter (a-e) that best describes the number of packs per day the subject currently smokes.</p> <p>Circle (f) if the number of packs the patient smokes is not documented.</p>
<b>12</b>	<p><b>Elapsed time since quitting</b> (if the subject is a former smoker)</p> <p>Circle the letter (a)-(c) that best describes the amount of time that has elapsed since the subject stopped smoking.</p> <p>Circle (d) if the time since quitting is not documented.</p>
<b>13</b>	<p><b>Alcoholic beverages per day</b></p> <p>Circle the letter (a-d) that best describes the number of alcoholic beverages the subject drinks per day.</p> <p>Circle (e) if the # of alcoholic beverages drunk per day is not documented.</p>

<p><b>14-18</b></p>	<p><b>Cardiovascular risk factors</b> - Review the subject’s history and physical, progress notes, referrals, procedure reports, and laboratory reports.</p> <p><b>Column a - Subject has risk factor:</b></p> <p>Circle Y if documentation specifically indicates that the subject currently has the listed condition or has a history of the listed condition.</p> <p>Circle N if documentation specifically indicates that the subject does not have the listed condition or a history of the condition.</p> <p>Circle N/D (not documented) if there is no indication in the medical record regarding the presence or absence of the condition or a history of the condition.</p> <p>Line 17: If the chart notes that the subject’s father died of an MI at age 60 but does not document the onset of the father’s cardiovascular disease, mark line (17a) “Not documented.”</p> <p><b>Column b - Documented by MD:</b></p> <p>Circle Y if the medical record includes documentation <i>by the physician</i> (in a history and physical or progress note) that the patient has the listed condition or a history of that condition.</p> <p>Circle N if the medical record does not include documentation <i>by the physician</i> (in a history and physical or progress note) that the patient has the listed condition or a history of that condition.</p> <p>Circle N/A (not applicable) if the subject does not have the risk factor OR there is no indication in the medical record that the patient has the condition.</p>
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<p><b>19-25</b></p>	<p><b>Subject has compelling indications that affect treatment:</b> Review the subject's history and physical, progress notes, referrals, procedure reports, and laboratory reports.</p> <p>Circle Y if documentation specifically indicates that the subject currently has the listed condition or has a history of the listed condition.</p> <p>Circle N if documentation specifically indicates that the subject does not have the listed condition or a history of the condition.</p> <p>Circle Not Doc. (not documented) if there is no indication in the medical record regarding the presence or absence of the condition or a history of the condition.</p>
<p><b>26-28</b></p>	<p><b>Subject has indicators of target organ damage:</b> Review the subject's history and physical, progress notes, referrals, procedure reports, and laboratory reports.</p> <p>Circle Y if documentation specifically indicates that the subject currently has the listed condition or has a history of the listed condition.</p> <p>Circle N if documentation specifically indicates that the subject does not have the listed condition or a history of the condition.</p> <p>Circle Not Doc. (not documented) if there is no indication in the medical record regarding the presence or absence of the condition or a history of the condition.</p> <p>Specific indicators of target organ damage:</p> <ul style="list-style-type: none"> <li>▪ Retinopathy: arteriolar narrowing, AV nicking, exudates/hemorrhages, and/or papilledema</li> <li>▪ Left ventricular hypertrophy: Indicated on ECHO or EKG</li> <li>▪ Peripheral arterial disease: BP in lower extremities &lt; BP in arm (as measured by ankle brachial index)</li> </ul>
<p><b>29-31</b></p>	<p><b>List any antihypertensive medications to which the subject has an allergy or intolerance:</b></p> <p>Review the subject's list of allergies, history and physical, and progress notes.</p> <p>Fill in the drug code* for each antihypertensive medication <i>or class of antihypertensive medications</i> to which the subject has exhibited an allergy or intolerance (recorded in the medical record).</p> <p>Leave lines blank that are not needed to report allergies or intolerance.</p> <p>*See the list of Drug Codes for Antihypertensive Agents</p>
<p><b>32-35</b></p>	<p><b>List dates of last four EKGs</b></p> <p>Fill in the dates of the subject's last four EKGs, beginning with the most recent and going backward. Include the dates of cardiostress tests.</p> <p>Leave lines blank that are not needed.</p>

<b>36</b>	<p><b>A goal blood pressure is documented</b></p> <p>Circle Yes if any goal blood pressure is documented in the medical record; proceed to line 37.</p> <p>Documentation of a goal blood pressure could be the following:</p> <ul style="list-style-type: none"> <li>▪ “Goal blood pressure is &lt;140/90.”</li> <li>▪ “Target blood pressure 130/80.”</li> </ul> <p>Circle No if a goal blood pressure is never documented in the medical record and skip to line 39.</p>
<b>37</b>	<p><b>Goal blood pressure:</b></p> <p>Fill in the most recent date that the physician documented a goal BP.</p> <p>Then fill in the blood pressure that the physician specified as the goal BP.</p>
<b>38</b>	<p><b>Subject was informed of goal BP:</b></p> <p>Record this information at the time a patient signs a consent form. The script asks a question about whether or not the physician told the patient his/her goal BP.</p> <p>Circle Yes if the patient states that the physician told him/her the goal BP.</p> <p>Circle No if the patient states that the physician did not tell him/her the goal BP.</p>
<b>Assessment Data:</b>	
<b>39</b>	<p>On line 39, fill in the following pieces of information for the patient visit that occurred when the blood pressure script used to recruit this patient was written. (This visit is the Index Visit.)</p> <p><b>Column (a) Visit date</b></p> <p>List the date of the visit.</p> <p><b>Column (b) Main reason for visit</b></p> <p>Circle Hypertension if hypertension was the major reason for the visit or a major problem addressed in the progress note for the visit.</p> <p>If hypertension was NOT the major reason for the visit or a major problem addressed in the progress note, write in the main reason for the visit on the line provided (and do not circle Hypertension).</p> <p><b>Column (c) Blood pressure</b></p> <p>Fill in the lowest blood pressure* that was recorded at the visit.</p> <p>Circle N/D if no blood pressure is documented for the visit.</p> <p>* E.g., if the nursing note records a BP of 158/88, but the physician note documents a BP of 148/82, use 148/82.</p>

	<p><b>Column (d) Uncontrolled BP noted</b></p> <p>Circle Y if the blood pressure in column (c) is uncontrolled* AND the physician noted so in the progress note (“Pt not at goal” or “BP not controlled”).</p> <p>Circle N if the blood pressure in column (c) is uncontrolled* and the physician did NOT note lack of control in the progress note.</p> <p>Circle N/A if the blood pressure in column (c) is controlled.</p> <p><i>* Uncontrolled BP = <math>\geq 140/90</math> for subjects without diabetes  <math>\geq 130/80</math> for subjects with diabetes.</i></p> <p><b>Columns (e)–(g)</b></p> <p>Write in patient weight in kilograms in column (e) <b>OR</b></p> <p>Write in patient weight in pounds in column (f) <b>OR</b></p> <p>Circle N/D if patient’s weight at the visit was not documented.</p> <p><b>Column (h) HTN mentioned</b></p> <p>Circle Y if either</p> <ul style="list-style-type: none"> <li>▪ Hypertension was the major reason for the visit (see column b) <b>OR</b></li> <li>▪ The physician mentions hypertension in the progress note under either assessment or treatment/plan</li> </ul> <p>Circle N if</p> <ul style="list-style-type: none"> <li>▪ Hypertension was not circled in column (b) <b>AND</b></li> <li>▪ No mention of hypertension is found in the progress note under either assessment or treatment/plan</li> </ul>
<b>40-58</b>	Complete the same steps outlined for line 39, counting visits backward from the Index Visit for 18 months, up to 19 additional visits. Leave lines blank if not needed.

**Compiling Materials for Abstract Folder** - Photocopy the pieces of the subject's medical record, as described below.

<b>I. Eliminating identifiers:</b>	
<b><i>On each photocopy, either black out or cut out the following identifiers:</i></b>	
<ul style="list-style-type: none"> <li>▪ <b><i>Subject name</i></b></li> <li>▪ <b><i>Subject address</i></b></li> <li>▪ <b><i>Subject phone number</i></b></li> <li>▪ <b><i>Subject clinic ID/medical record number</i></b></li> <li>▪ <b><i>Subject social security number</i></b></li> <li>▪ <b><i>Subject health plan number</i></b></li> <li>▪ <b><i>Worksite or school</i></b> (<i>E.g.: "Works at John Deere" or "Attends NIACC"</i>)</li> <li>▪ <b><i>Physician name</i></b></li> <li>▪ <b><i>Clinic identifiers</i></b></li> <li>▪ <b><i>Hospital</i></b> (<i>E.g.: "Admitted to Broadlawns"</i>)</li> </ul>	
<b>II. Photocopy the item listed in A ONLY for those visits listed in #39-58 where Y/Yes was circled in column (k). Insert the copies into the subject's abstract folder.</b>	
<b>A</b>	Physician progress notes
<b>III. Search the medical record for the items listed in B-F, make photocopies of each and insert the copies into the subject's abstract folder.</b>	
<b>B</b>	The subject's complete medication list.
<b>C</b>	The subject's complete problem list/list of diagnoses.
<b>D</b>	All documents related to any episode of care that occurred OUTSIDE of the clinic and before a clinic visit listed in lines (39)-(58). Include visits to the emergency room, in-patient admissions to acute care, and referral visits to other providers. Photocopy all acute care reports, discharge summaries, and referral reports for these visits.
<b>E</b>	Reports for all procedures (e.g., ECHO cardiogram, cardiac catheterization) completed within the previous 18 months.
<b>F</b>	Any nursing notes, including phone calls, during the previous 18 months that address hypertension.
<b>IV. Search your list or pile of carbon copy prescriptions and photocopy the prescriptions listed in G.</b>	
<b>G</b>	All carbon copy prescriptions written on the day of the index visit.

**Interventions:**

59

**Index Visit:**

***\*\*Use line 59 and succeeding lines as needed to document every antihypertensive drug the subject is taking at the time of the Index Visit, even if no changes occurred at that visit.\*\****  
***If the subject is on multiple antihypertensives at the time of the Index Visit, use multiple lines, duplicate the date and duplicate the drug treatment code as needed.***

**Column (a) Date of visit**

Fill in the date of the Index Visit, the visit listed on line 39

**Column (b) Prior Hospital Visit/Referral**

Circle Y/Yes if any episode of care occurred OUTSIDE of the clinic (hospital, emergency room, referral visit to another provider not in the clinic) before the Index Visit and after the previous visit to the clinic.

***If Y/Yes is circled in column (b), fill in line 147 on page 12 to record information from the hospital or referral visit.***

Circle N/No if no episodes of care occurred OUTSIDE of the clinic (hospital, emergency room, referral visit to another provider not in the clinic) before the Index Visit and after the previous visit to the clinic.

**Column (c) Drug Rx**

Fill in the appropriate code:

- a if an antihypertensive drug was started at this visit
- b if the dose of an antihypertensive was increased
- c if the dose of an antihypertensive was decreased
- d if an antihypertensive was discontinued
- e if no change in drug treatment was made during the visit

**Column (d) Drug Code**

Fill in the three-digit numerical code for the medication that corresponds to the change in drug treatment noted in column (c).

Codes are found on the List of Drug Codes for Antihypertensive Agents. If no change in drug treatment occurred, leave columns (d), (e), (f), and (g) blank.

**Columns (e) Dose 1 and (f) Dose 2**

List the total daily dose for each dose that is filled in.

If the medication indicated in column (d) contains only one agent, list the dose of that agent in column (e) Dose 1 and leave blank column (f) Dose 2.

If the medication indicated in column (d) contains two agents, then:

- For a combination drug that includes a diuretic –
  - Fill in the total daily dose of the diuretic in column (f) Dose 2.
  - Fill in the total daily dose of the other agent in (e) Dose 1.

	<ul style="list-style-type: none"> <li>▪ For a combination drug that includes an ACE inhibitor and a calcium channel blocker, <ul style="list-style-type: none"> <li>– Fill in the total daily dose of the ACE inhibitor in column (e) Dose 1.</li> <li>– Fill in the total daily dose of the calcium channel blocker in column (f) Dose 2.</li> </ul> </li> </ul> <p>If the medication dose cannot be found anywhere in the chart (med list, physician note, or hospital report), write ND (not documented) in column (e).</p> <p><b>Column (g) Date discontinued</b></p> <p>If column (c) = <u>d</u> (drug discontinued), fill in the date the drug was discontinued.</p> <p>Leave blank if column (c) ≠ <u>d</u>.</p> <p><b>Column (h) Lifestyle changes discussed</b></p> <p>Fill in the codes <u>a-f</u> that best describe the lifestyle changes that the physician discussed with the patient at the visit.</p> <p>Multiple codes <u>a-f</u> may be filled in.</p> <p>Fill in <u>g</u> if no lifestyle changes were discussed at the visit.</p> <p><b>Column (i) Other lifestyle changes</b></p> <p>If the code <u>f</u> was listed in column (g), then write out a description of the “other” lifestyle changes that were discussed at the visit.</p> <p>More than one “other” lifestyle change may be written in.</p> <p>List only those lifestyle changes that could affect blood pressure.</p> <p><b>If more than one drug intervention occurred during the visit:</b></p> <p>Use successive lines.</p> <p>For instance, if one antihypertensive was discontinued and another was added, list the drug treatment codes, drug codes and doses for those two interventions on different lines, but give each of those lines the same date.</p> <p>Columns (h) and (i) should only be completed once for a given intervention date.</p>
<p><b>60-96</b></p>	<p><b>Prior visits:</b> Repeat the instructions given for 59 for prior clinic visits listed in (40-58) where Y/Yes is circled in column (h).</p>
<p><b>97-146</b></p>	<p><b>Laboratory tests:</b> Begin with the most recent lab test and go backwards for up to 50 instances of the tests listed in the key on the right side of the page.</p> <p>Column (a): Fill in the date of the test</p> <p>Column (b): Fill in the code number for the test (see key on right)</p> <p>Column (c): Fill in the test result</p> <p><b><i>Include ONLY the tests listed in the key.</i></b></p>

## Acute Care Visits and Referrals

**147-156**

Use these lines to record information from acute care visits and referral visits (designated by a Y/Yes in column (b) on lines 59-96).

### Column (a) Date of visit

Fill in the date of the acute visit or referral visit.

### Column (b) Drug Rx

Fill in the appropriate code:

- a if an antihypertensive drug was started at this visit
- b if the dose of an antihypertensive was increased
- c if the dose of an antihypertensive was decreased
- d if an antihypertensive was discontinued
- e if no change in drug treatment was made during the visit

### Column (c) Drug Code

Fill in the three-digit numerical code for the medication that corresponds to the change in drug treatment noted in column (b).

Drug codes are found on the List of Drug Codes for Antihypertensive Agents.

If no change in drug treatment occurred, leave columns (c), (d), (e) blank.

### Columns (d) Dose 1 and (e) Dose 2

List the total daily dose for each dose that is filled in. Write ND if not documented.

If the medication indicated in column (c) contains only one agent, list the dose of that agent in column (d) Dose 1 & leave blank column (e) Dose 2.

If the medication indicated in column (c) contains two agents, then:

- For a combination drug that includes a diuretic –
  - Fill in the total daily dose of the diuretic in column (e) Dose 2.
  - Fill in the total daily dose of the other agent in (d) Dose 1.
- For a combination drug that includes an ACE inhibitor and a calcium channel blocker,
  - Fill in the total daily dose of the ACE inhibitor in column (d) Dose 1.
  - Fill in the total daily dose of the calcium channel blocker in column (e) Dose 2.

If the medication dose prescribed at the hospital or referral visit cannot be found anywhere in the chart (medication list, physician note, hospital report, referral report), write ND (not documented) in column (d).

**FINAL STEPS:**

- 1. Remove subject ID page from abstract.**
- 2. Verify that the subject study ID number is located on page 1 of the abstract.**
- 3. Staple together all photocopies and write in the subject study ID number on the top page of photocopies.**
- 4. Confirm that the subject's study ID number on the abstract matches the number on the abstract folder.**
- 5. Place the photocopies and the abstract in the folder.**
- 6. File the folders in numerical order in a locked file cabinet.**