

**Table 1. Consensus statements and percent endorsement**

	<b>Category</b>	<b>Statement</b>	<b>Endorsement (% agreement on final vote)</b>	<b>Number of vote rounds</b>
1	Case Definitions	Case definitions for rheumatic disease should be justified based on study purpose, validity assessment, and feasibility.	91%	1
2	Case Definitions	Validation studies of rheumatic disease case definitions using administrative data should adhere to published guidelines on their conduct and reporting.	94%	1
3	Case Definitions	Authors should acknowledge the limitations of their administrative data when ascertaining cases of rheumatic disease and the implications of these limitations on their findings	89%	1
4	Methods	Authors should address confounding by indication, use appropriate methods to avoid or reduce this bias, and estimate and discuss the impact of potential residual confounding.	94%	2
5	Methods	Authors should use appropriate methods to address other common sources of confounding and bias, such as channeling, immortal time, and depletion of susceptible subjects.	94%	1
6	Methods	Authors should clearly define and justify the risk window related to the exposure, based on biologic plausibility, and should perform analyses to evaluate the sensitivity of the results to the risk window choice.	90%	1
7	Methods	Authors must acknowledge limitations of their administrative data, such as potentially incomplete and/or inaccurate capture of health services. Implications for design, analysis, and results should be discussed.	90%	1
8	Comorbid Conditions: Osteoporosis	Osteoporosis diagnostic codes in administrative data should not be used alone for comorbidity adjustment or as an outcome.	83%	1
9	Comorbid Conditions: Fractures	Hospital discharge data, and physician and procedural data when available, can be used to identify hip fractures. Fractures that do not require hospitalization, in particular of the radius/ulna and of the humerus, can be identified in physician billing data by combining diagnostic and procedural codes.	90%	1

		Additional research is needed before recommending the use of administrative data to identify vertebral fractures.		
	Comorbid Conditions: Cancer	When using administrative data (exclusive of cancer registries) to define cancer outcomes, authors should choose an algorithm that has been demonstrated to have good sensitivity and excellent specificity for the cancer of interest in a comparable population. Additionally, implications of an imperfect case definition should be discussed.	80%	2
	Comorbid Conditions: Infections	When using administrative data to identify serious infections as outcomes or comorbidities, hospitalization data can be used to identify serious bacterial infections. If greater sensitivity is desired, using a more comprehensive definition to identify individual infections and/or using a diagnostic code for infection found in any position of the claims data, are recommended. Current data is not sufficient to recommend the use of administrative data to identify opportunistic infections. For infections that are reportable, such as tuberculosis and meningococcal diseases, multiple sources of data should be used, if available, to ensure greater completeness of case ascertainment.	96%	1
	Comorbid Conditions: Cardiovascular Disease	Hospitalization data can be used to identify acute myocardial infarction (AMI) or cerebrovascular accident as a covariate or outcome. Authors should take into consideration that hospitalization data to identify congestive heart failure has significant limitations due its relatively low sensitivity and specificity. When using vital statistics data, authors need to acknowledge that the accuracy of AMI as a cause of death is limited.	92%	1
	Comorbid Conditions: Renal Disease	Administrative data can be used to identify kidney disease requiring dialysis. Current data do not support the use of diagnostic codes from hospitalization data to adjust for acute or chronic kidney disease as a comorbidity or outcome.	95%	1

