This table contains both core data elements and optional data elements that are identified under the column labeled "Status". Core elements are data elements that must be collected by States funded to conduct the Paul Coverdell National Acute Stroke Registry. Optional elements can be added to State registries. If States choose to collect data on an optional element, the definition and response categories in the table should be used. This table may be subject to minor revisions after consultation with funded States.

| Item | Status <Variable name> | Text Prompt | Field Type | Legal Values | Suggestions, Notes, Definitions, Formats |
|---|---|---|---|---|---|
| 1 | | **Demographic Data** | | | |
| **1.1** | Core<br><Age> | Age \|__\|__\|__\| years | Numeric<br>### = 3-digit | | **This is the age on the day of admission, calculated from date of birth in medical record.**<br>It is recommended that the data collection system ask the abstractor to input the Birth date, as determined by chart review, then enter the date of admission, and then have the data system automatically calculate the age. Input for dates should be MM-DD-YYYY.<br><br>The following would be acceptable:<br>Private Sub age_Click()<br>Dim DOB as Date<br>Dim HAD as Date<br>Dim age as Integer<br>DOB = InputBox("Input patient's date of birth")<br>HAD = InputBox("Input patient's date of hospital admission")<br>Form.age = (HAD-DOB)/365<br>End Sub<br><br>PCNASR cannot collect birth date because it is considered private health information.<br>Be advised that TJC stroke certification requires birthdates, while CDC can only collect age rather than birthday. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume the UB-92 claim information for the birth date is correct. If the abstractor determines through chart review that the UB-92 day is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct |

| Item | Status <Variable name> | Text Prompt | Field Type | Legal Values | Suggestions, Notes, Definitions, Formats |
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| | | | | | birth date through chart review, she/he should default to the UB-92 date of birth.<br>Suggested Data Sources:<br>- Emergency department record<br>- Face sheet<br>- Registration form<br>- UB-92, Field Location: 14. |
| **1.2** | Core<br><Gender> | Gender (Check only one) | Numeric<br># = 1-digit | 1 - Male<br>2 – Female | Gender will be captured as it is written in medical record – if there is conflict, document with the self identified gender<br><br>Determined by the ER admissions document or the intake/face sheet/hospital admissions database consultation notes, history and physical, nursing admission notes, progress notes, or UB-92 Field Location 15. Use the gender written in the medical record. If there is a conflict as to gender in the medical record, use self-identified gender. |
| **1.3** | Core<br><RaceW><br><RaceAA><br><RaceAs><br><RaceHPI><br><br><RaceAIAN><br><RaceOth><br><RaceOthS><br><RaceUnk> | *Race (Check all that apply)*<br>White<br>Black or African American<br>Asian<br>Native Hawaiian or Other Pacific Islander<br>American Indian or Alaskan Native<br>Other<br>Specify<br>Unknown | <br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit<br><br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Text (25)<br>Numeric # = 1-digit | <br>1 -Yes<br>0 - No | Determined by the ER admissions document or the intake/face sheet/hospital admissions database. If not specified, check "Unknown."<br>'**White'** implies White or origins in Europe, Middle East or North Africa (e.g., Caucasian, Iranian, White').<br>'**Black'** would also include Haitian.<br>'**Asian'** includes those from the Far East, southeast Asia, or the Indian subcontinent, including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippines, Hmong, Thailand, and Vietnam.<br>**Native Hawaiian or Pacific Islander** |

| Item | Status <Variable name> | Text Prompt | Field Type | Legal Values | Suggestions, Notes, Definitions, Formats |
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| | | | | | includes persons having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.<br><br>**American Indian or Alaska Native**<br>A person having origins in any of the original peoples of North and South American (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American).<br><br>Use '**RaceUnk'** if unable to determine race, or race is not stated, or patient is unwilling to provide.<br>'Hispanic' denotes ethnicity, not race. Hispanic should be denoted as 'White', unless patient is Black/Latino, in which select 'RaceAA'.<br>A 25 character text field to specify variable <RaceOth> verbatim <RaceOthS> should only be filled in if item <RaceOth> is checked.<br><br>Example 1: Based on physical characteristics, the patient appears to be of Asian descent. When asked, the patient clarifies that she is both African American and Fijian. Check both the Black or African American AND the Pacific Islander boxes<br><br>Determined by the ER admissions document or the intake/face sheet/hospital |

| Item | Status <Variable name> | Text Prompt | Field Type | Legal Values | Suggestions, Notes, Definitions, Formats |
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| | | | | | admissions database. If not specified, check "Unknown." |
| 1.4 | Core<br><Hisp> | Hispanic Ethnicity | Numeric<br># = 1-digit | 1 – Hispanic or Latino<br>0 – Not Hispanic or Latino<br>9 – Unknown | Determined by the ER admissions document or the intake/face sheet/hospital admissions database. Ethnicity is not an alternative to race. Both fields should be completed. Other terms for Hispanic ethnicity include Black-Hispanic, Chicano, H, Hispanic, Latin American, Latino/Latina, Mexican-American, Spanish, White-Hispanic. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.<br>Example: A patient is Caucasian and reports that she is from Puerto Rico. Check Hispanic/Latino for Ethnicity (after having checked White/Caucasian for Race).<br>This information is usually listed in the Admission sheet, Discharge summary, EMS transport sheets, ED Nurses notes, ED Physician notes, ED triage sheet, History and physical notes, Nurses progress notes, Physician progress notes. |

| Item | Status <Variable name> | Text Prompt | Field Type | Legal Values | Suggestions, Notes, Definitions, Formats |
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| **1.5** | Core<br><br><br><HlthInsM><br><HlthInsC><br><HlthInsP><br><HlthInsN><br><HlthInND | *Health insurance status (Check all that apply)*<br><br>Medicare/Medicare Advantage<br>Medicaid<br>Private/VA/Champus/Other<br>Self Pay/No Insurance<br>Not Documented | <br><br><br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit | <br><br><br>1 – Yes<br>0 – No | Determined by the ER admissions document or the intake/face sheet/hospital admissions database.<br>If checking "Self Pay/No Insurance" or "Not Documented", then no other selections should be checked. Patients may have a combination of "Medicare", "Medicaid", and "Private/VA/Champus/Other Insurance" Be mindful of your states name for Medicaid (e.g., MassHealth).<br><br>Determined by the ER admissions document or the intake/face sheet/hospital admissions database. |
| **1.6** | Core<br><CMO><br><br><br><CMODay2> | Is there evidence that the patient's care was restricted to "comfort measures only" at the time of discharge?<br><br>Is there any evidence that the patient's care was restricted to CMO anytime prior to the end of Hospital Day 2? | Numeric # = 1-digit<br><br><br>Numeric # = 1-digit | 1 – Yes<br>0 – No | If the only mention of comfort measures or hospice is at discharge, select "No" for the answer.<br><br>Physician/nurse practitioner/physician assistant documentation the patient was receiving "comfort measures only". Commonly referred to as "palliative care" in the medical community and "comfort care" by the general public. Palliative care includes attention to the psychological and spiritual needs of the patient and support for the dying patient and the patient's family. Usual interventions are not received because a medical decision was made to limit care to comfort measures only. "Comfort Measures Only" are not equivalent to the following: Do Not Resuscitate (DNR), living will, no code, and no heroic measure.<br><br>If DNR-CC is documented, select "No" unless |

| Item | Status <Variable name> | Text Prompt | Field Type | Legal Values | Suggestions, Notes, Definitions, Formats |
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| | | | | | there is documented clarification that CC stands for "comfort care"<br><br>If any of the inclusions are documented, select "Yes" regardless of other documentation.<br><br>If "continue supportive care" is documented in the context of a patient's age, chronic illness or terminal/grave prognosis, select "Yes".<br><br>Comfort measures include:<br>• Comfort measures only<br>• Comfort measures provided<br>• Hospice care<br>• Maintain treatment for comfort, terminal care<br>• Palliative care<br>• Physician documentation that care is limited at family's request due to patient's age or chronic illness or patient's conditions is grave or that death is imminent<br>• Supportive care only<br><br>Comfort measures does not include:<br>• Chemical code only<br>• DNR<br>• Do not cardiovert<br>• Do not defibrillate<br>• Do not intubate (DNI)<br>• Living will<br>• NCR<br>• No antiarrhythmic therapy<br>• No artificial respirations<br>• No cardiac monitoring<br>• No chest compressions<br>• No code<br>• No code 99<br>• No heroic or aggressive measures |

| Item | Status <Variable name> | Text Prompt | Field Type | Legal Values | Suggestions, Notes, Definitions, Formats |
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| | | | | | • No intubation and/or ventilation<br>• No invasive procedures<br>• No other protocols associated with advanced cardiac life support<br>• No resuscitative medication<br>• No resuscitative measures (NRM)<br>• No vasopressors |

| 2 | | **Pre-Hospital/Emergency Medical System (EMS) Data** | | | |
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| **2.1** | Core<br><PlcOccur> | Where was the patient when stroke was detected or when symptoms were discovered? In the case of a patient transferred to your hospital where they were an inpatient, ED patient, or NH/long-term care resident, from where was the patient transferred? | Numeric # = 1-digit | 1 – Not in a healthcare setting,<br>2 – Another acute care facility<br>3 –Chronic health care facility<br>4 – Stroke occurred while patient was an inpatient in your hospital<br>9 – Cannot be determined | In the case of a patient transferred to your hospital where they were an inpatient, ED patient, or resident, from where was the patient transferred?<br>If the patient was admitted to an ED of another hospital or was an inpatient of another hospital and was transferred to your hospital – choose 2.<br>If the patient was a resident of a nursing home, but was out with family for the day and suffered a stroke and the family/EMS brought the patient to your hospital, choose 1.<br>If the patient was a resident of a nursing home and the stroke occurred at the NH, and the patient came from the NH to your hospital, choose 3.<br>If the patient was an inpatient in your hospital choose 4, and skip to 4.1. If the patient was at home, at work, or even a visitor in your hospital and had stroke symptoms, then choose 1.<br>A chronic care facility would include nursing home, long-term care facility, inpatient rehab facility. |
| **2.2** | Core<br><ArrMode> | How did the patient get to your hospital for treatment of their stroke? | | 1 – EMS<br>2 – Private transportation/taxi/other<br>9 – ND or unknown | Choose EMS whenever the patient was brought to your hospital by EMS, whether by ground EMS or Air EMS.<br>"Other" includes private transportation (e.g. cab, bus, car, walk-in, etc.). |

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| **2.3** | Core<br><PlaceRcd> | In what area of your hospital was the patient first evaluated? | Numeric # = 1-digit | 1 – Emergency Department/Urgent Care<br>2 – Direct Admit or direct to floor, not through ED<br>3 – Imaging suite prior to ED arrival or DA<br>9 – Cannot be determined | This question refers to route of patient arrival. Direct admit refers to type of admissions that circumvent ED and might (but not always) include admissions from clinics/urgent care centers and transfers. Some hospitals may have a policy where EMS coordinates with the ED while enroute to go directly to imaging prior to ED triage. |
| **2.4** | Core<br><EMSRecD><br><EMSRecT><br><EMSrcDND><br><EMSrcTND> | *Date & time call received by EMS*<br>_ _/ _ _/_ _ _ _<br>_ _:_ _<br>Date Not documented<br>Time Not documented | <br>Date MMDDYYYY<br>Time HHMM<br>Numeric # = 1-digit<br>Numeric # = 1-digit | <br><br><br>1 -Yes<br>0 - No | As recorded on the EMS trip sheet or other similar documentation. This should be on a 24-hour time or military time. |
| **2.5** | Core<br><EMSNote> | Was there EMS pre-notification to your hospital? | Numeric # = 1-digit | 1 – Yes<br>0 – No<br>9 – Cannot determine/Unknown | Whether EMS notified the receiving hospital prior to arrival of possible stroke patient. Options include:<br>Yes: EMS notified the receiving hospital prior to arrival<br>No / Not Documented: EMS either did not pre-notify the receiving hospital or this was not documented<br>If the patient did not arrive via EMS, this question should be omitted.<br><br>Example: The stroke patient was picked up by the EMTs at 0810. On their departure to the hospital at 0820, they call the ED to inform them they are bringing in a potential stroke patient. They arrive at the ED at 0830. The hospital was therefore pre-notified that a potential stroke patient was arriving.<br><br>This information can usually be found in the ED record, ED nursing notes, ED triage notes, ED physician notes, or EMS trip record |

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| **2.6** | Core<br><EMSGCS><br><EMSGCSND> | Glasgow Coma Scale (GCS)?<br>_ _<br>Not documented | Numeric<br>## = 2-digit<br>Numeric # = 1-digit | Range: 3 to 15 | Only assess for hemorrhagic stroke patients |
| 3 | | **Hospital Arrival Data** | | | |
| **3.1** | Core<br><br><br><br><EDTriagD><br><br><EDTriagT><br><br><EDTrgDND><br><EDTrgTND> | Date & time of arrival at your hospital<br>What is the earliest documented time (military time) the patient arrived at the hospital?<br><br>_ _ / _ _ / _ _ _ _<br><br>_ _: _ _<br><br>Date Not documented<br>Time Not documented | <br><br><br><br>Date MMDDYYYY<br><br>Time HHMM<br><br>Numeric # = 1-digit<br>Numeric # = 1-digit | <br><br><br><br><br><br><br><br>1 -Yes<br>0 - No | Documents the **earliest time** when ED or hospital was aware that there was a patient at their facility who needed to be evaluated.<br><br>This may differ from the admission time. When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician office records, laboratory reports) obtained prior to arrival. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.<br>If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to the hospital, use the time the patient presents to the ED or arrives on the floor for inpatient care as arrival time.<br>For "Direct Admits" to the hospital, use the earliest time the patient arrives at the hospital.<br><br>mm/dd/yyyy; 24-hour clock (military time). Check "Not documented" box to indicate that either date or time is not documented.<br><br>For The Joint Commission purposes, this is known as the arrival date and arrival time. |

| 4 | | **Hospital admission data** | | | |
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| **4.1** | Core<br><br><HospadD> | What is the hospital admission date?<br><br>_ _ / _ _ / _ _ _ _ | <br><br>Date<br>MMDDYYYY | | Date of official admission to a hospital's **inpatient** service.<br><br>The date that the patient was actually admitted to acute care or in-patient unit of your institution. The dates of ED triage or an observation admission are not included. Hospital arrival date and admission date are usually the same for direct admissions but frequently differ for ED admissions. If the patient arrives through the ED and is held in observation for a day or two, use the actual date of admission to the hospital for the admission date, not the arrival date to the ED. Record as: ____/____/____ (mm/dd/yyyy) = the date of hospital admission.<br><br>Example: Patient 019 is seen in the ED of your institution on November 30, 2004 at 22:35. After the ED evaluation, the patient is a candidate for intra-arterial thrombolytic administration and is taken to the Neurovascular Catheterization Lab at 23:45 and treatment is completed. The patient is admitted to the Stroke Unit of your institution on December 1, 2004 at 04:10. Data entry will be 12/01/2004 (mm/dd/yyyy).<br><br>This information is usually listed in the Admission sheet, Discharge summary, ED Nurses notes, History and physical notes, Nurses progress notes, or UB-92 claim information as a last resort. |

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| **4.2** | Core | *Was the presumptive hospital admission diagnosis at the time of admission either ischemic stroke, TIA, or no stroke related diagnosis? (**check only one**)* | | | This is sometimes different from final clinical hospital admission diagnosis. The presumptive diagnosis tries to identify presumptive diagnosis at the time of hospital admission. It applies to transfer diagnosis, direct admission diagnosis or ED discharge/hospital admission diagnosis. In prospective case identification, if someone has a presumed diagnosis of migraine on admission, and 24 hours later is determined to have had an ischemic stroke, the presumed admission diagnosis is 'No stroke related diagnosis', while the final hospital diagnosis would be 'Ischemic stroke'.<br><br>Example: a patient with official diagnosis of "right-sided weakness" might have presumptive diagnosis of stroke in the admission notes. Presumptive diagnosis reflects what diagnosis a patient is evaluated for from the perspective of medical personnel.<br><br>Presumptive diagnosis can often be derived from physicians' hospital admission, transfer, or ED discharge notes and is often accompanied with keywords such as "suspected", "presumed", "probable", "rule out", etc. |
| | <PreDxIH> | Intracerebral Hemorrhage | Numeric # = 1-digit | 1 -Yes<br>0 - No | |
| | <PreDxSH> | Subarachnoid Hemorrhage | Numeric # = 1-digit | | |
| | <PreDxIS> | Ischemic stroke | Numeric # = 1-digit | | |
| | <PreDxTIA> | Transient ischemic attack | Numeric # = 1-digit | | |
| | <PreDxSNS> | Stroke not otherwise specified | Numeric # = 1-digit | | |
| | <PreDxNoS> | No stroke related diagnosis | Numeric # = 1-digit | | |

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| **4.3** | Core<br><AmbStatA> | Was patient ambulatory prior to the current stroke/TIA? | Numeric # = 1-digit | 1 – Able to ambulate independently w/or w/o device<br>2 – With assistance (from person)<br>3 – Unable to ambulate<br>9 –not documented | Ambulatory:<br>• Patient ambulating without assistance (no help from another person)<br>• Patient ambulating throughout the day with assistance of another person or assistive device<br>• Patients ambulating to and from the bathroom<br>Non-ambulatory:<br>• Patient is on bed rest<br>• Patient is only getting out of bed to the bedside commode (or up in chair) and is primarily in the bed (or immobile)<br><br>This information is usually listed in the history and physical notes, physician progress notes. |

| 5 | | **Imaging** | | | |
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| **5.1** | Core | | | | This question applies to the initial brain image for this event. If patient did not receive any brain imaging at this hospital/facility, then ImageYN should be "No"<br>If a patient had outside brain imaging prior to transfer from another hospital, and results for that imaging are recorded in the record please record Image Results in 5.2 |
| | <ImageYN> | Was Brain Imaging Performed at your hospital after arrival as part of the initial evaluation for this episode of care or this event? | Numeric # = 1-digit | 1 - Yes<br>0 - No/ND<br>2 - NC - if outside imaging prior to transfer or patient is DNR/CMO | |
| | <ImageD> | Date & time of initial brain imaging (not time dictated)<br>_ _/ _ _/ _ _ _ _; | Date<br>MMDDYYYY | | mm/dd/yyyy; 24-hour clock, Check "Not documented" box to indicate that either date or time is not documented. Time is only documented for imaging at the registry hospitals. You do not need to record time and date of outside brain imaging time.<br><br>Enter date and time stamped on the initial CT/MRI of the head performed at your institution. Record only CT/MRI date/time if the first study was performed at your hospital. Please note. If the first brain image is done at an outside hospital, "Outside brain imaging prior to transfer" is selected, and "Date/Time Initial Brain Imaging Completed" should not be filled in. Use the time stamp on the radiology report only if it clearly indicates the time of study completion and NOT time of scheduling, dictation or reporting. If an exact time is not available, see appropriate response categories for estimates and information not available below.<br>Example: If the ED nurses notes document that the head imaging study was done at 10:30 in the morning of November 23, 2004, the data entry would be: 11/23/04 |
| | <ImageT> | _ _: _ _ | Time HHMM | | |
| | <ImageDND> | Date Not documented | Numeric # = 1-digit | 1 -Yes<br>0 - No | |
| | <ImageTND> | Time Not documented | Numeric # = 1-digit | | |

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| | | | | | 10:30.<br>This information is usually listed in the Diagnostic reports, ED Nurses notes, ED pathway documentation, ED Physician notes, History and physical notes, Nurses progress notes, Physician order sheets, Physician progress notes, Radiology notes, rt-PA Protocol Sheets. Validate with nurses or physician. Also may be found printed on the original film or on the electronic radiology system.<br><br>These questions apply only to the initial imaging done for the primary stroke event. Do not record later imaging. Answers "No" and "NC" are mutally exclusive – select the appropriate answer. |
| **5.2** | Core<br><ImageRes> | Initial brain imaging findings? | Numeric<br># = 1-digit | 1 – Hemorrhage<br>0 - No hemorrhage<br>9 - Not available | Hemorrhage is taken to mean **any** intracranial hemorrhage.<br><br>It is important that only new hemorrhages thought to be responsible for the current event should be used if checking hemorrhage. Do not mark hemorrhage for old hemorrhages found on imaging, which are not responsible for the current event. |

| 6 | | **Time of Signs and Symptoms** | | | |
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| **6.1** | Core | | | | Military (24 hour) time should be used. |
| | | When was the patient last known to be well (i.e., in their usual state of health or at their baseline), prior to the beginning of the current stroke or stroke-like symptoms? (To within 15 minutes of exact time is acceptable.) | | | If a stroke "onset time" is listed in the medical record, without reference to the circumstances preceding its detection, then it should be assumed to be the time "last known well". Enter this time in the specified format. If there is a specific reference to the patient having been discovered with symptoms already present, then this time should be treated as a "time of symptom discovery" rather than a time of "last known well". |
| | <LKWD><br><LKWT> | _ _/ _ _/ _ _ _ _<br>___: ____ | Date MMDDYYYY<br>Time HHMM | | |
| | <LKWDNK> | Date last known well is unknown/not documented | Numeric # = 1-digit | 1 –Yes (Statement is True)<br>0 – No (Statement is False) | When a time of discovery is documented, but the symptom onset is not witnessed and no time "last known well" is documented, then "ND" should be selected for time "last known well". |
| | <LKWTNK> | Time last known well is unknown/not documented | Numeric # = 1-digit | 1 –Yes (Statement is True)<br>0 – No (Statement is False) | **When the onset of symptoms is clearly witnessed, then the time "last known well" is identical to the time of symptom discovery.** |
| | | When was the patient first discovered to have the current stroke or stroke-like symptoms? (To within 15 minutes of exact time of discovery is acceptable.) | | | If the time of "last known well" is documented as being a specific number of hours prior to arrival (e.g., 2 hours ago) rather than a calendar time, subtract that number from the time of hospital or ED arrival and enter that time as the time "last known well." |
| | <DiscD><br><DiscT> | _ _/ _ _/ _ _ _ _<br>___: ____ | Date MMDDYYYY<br>Time HHMM | | |
| | <DiscDNK> | Date patient discovered with symptoms unknown/not documented | Numeric # = 1-digit | 1 –Yes (Statement is True)<br>0 – No (Statement is False) | If the time of "last known well" is noted to be a range of time prior to hospital or ED arrival (e.g., "2 – 3 hours ago"), assume the maximum time from the range (e.g., 3 hours), and subtract that number of hours from the time of arrival to compute the time "last known well". |
| | <DiscTNK> | Discovery time unknown/not documented | Numeric # = 1-digit | 1 –Yes (Statement is True)<br>0 – No (Statement is False) | If there are multiple times of "last known well" documented, either because subsequent more accurate information became available or because of different levels of expertise in sorting out the actual time of "last known well", use the time recorded according to the |

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| | | | | | following hierarchy:<br>1. stroke team/neurology<br>2. admitting physician<br>3. emergency department physician<br>4. ED nursing notes<br>EMS<br><br>The purpose of 'last known well' is to conservatively identify/estimate time of symptom onset. Use "last known well" to identify when the patient was either last seen or last known to be well (well means at the patient's baseline or usual state of health). This may change with various observers. If the last known well time cannot be identified, then indicate that last known well time and/or date is not known.<br><br>Indicate the date and time of discovery of patient's symptoms (i.e., when the patient was found with symptoms). This should be the earliest time that patient was known to have symptoms. This date and time should not vary. If the event was witnessed, then the last known well date and time and the discovery date and time will be identical. Record both, even if identical.<br><br>EXAMPLES<br>1) Patient arrived in ED via EMS at 2:43 pm accompanied by her daughter. Family states that patient was found 2:00 pm 'in her chair slumped over, I couldn't understand what she was saying and she was drooling from her mouth – and her face didn't look right.' On further questioning by the neurologist, the daughter says her mother ate lunch at 12:30 pm and then went to sit in her chair where she was later found as noted above.<br><br>Time and date of last known well are known as 12:30 on date of arrival in ED, and time and |

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| | | | | | date of discovery are known as 14:00 on date of arrival in ED.<br><br>2) Patient arrived in the ED with his son at 8:09 am. His son states that he last saw his father last night at 8:30 pm. His father lives alone. His father woke up this morning about 6:30 am and noticed that his right arm was weak. It did not get better, so patient called his son at 7:00 am, who came over right away and was concerned that his father was having a stroke, but his father could walk and talk OK. Daughter arrives and states that she had talked to her father on the phone last night around 9:30 pm and that he didn't mention anything about a problem with his arm.<br><br>Time and date of last known well are known as 21:30 on day prior to day of arrival in ED, and time and date of discovery are known as 06:30 on day of arrival in ED.<br><br>3) Patient was eating dinner with his wife tonight after they finished watching the nightly news on TV 'when his arm began shaking and he couldn't hold onto his fork or his water glass or anything. He has never done this before.' Their nightly news show is on from 6:00 to 6:30 pm. She called the ambulance right away. ED arrival time is 7:53 pm.<br><br>Time and date of last known well are known as 18:30 on day of arrival in ED, and time and date of discovery are known as unknown time on day of arrival in ED. There is no reference to time of discovery in this scenario, so it remains unknown to the abstractor.<br><br>4) Patient states she has been having numbness come and go in her left arm for the past week, but it always went away. Today the numbness started about 4 hours |

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| | | | | | before she came to the ED and didn't go away so she decided to get it checked. She thinks her arm isn't completely numb, but it feels heavy, and she can't hold a pen tightly. ED arrival time is 5:15 pm.<br><br>Time and date of last known well are known as 13:15 on day of arrival in ED, and time and date of discovery are known as 13:15 on day of arrival in ED.<br><br>5) Patient was found on the floor beside the commode by the charge nurse at Starlight Nursing Home on her night rounds at 12:45 am. He wasn't able to talk or move, but his left leg was shaking. He is normally quite alert and normally walks with his walker. She called 911 right away after conferring with another nurse on duty. According to the evening charge nurse, there were no problems reported with Patient at change of shift. They think that the evening nurse would have seen him between 9 and 10 pm on her rounds. Information was provided by sheet sent from the nursing home. A phone call to the charge nurse does not reveal any further information from the patient's medical chart. ED arrival time 1:37 am.<br><br>Time and date of last known well are known as 21:00 on day prior to day of arrival in ED, and time and date of discovery are known as 00:45 on day of arrival in ED.<br><br>6) A 58 y/o woman was last known normal at 7:00 pm and was found at 7:30 pm with right hemiparesis and aphasia. She is transferred to your hospital from another hospital having IV t-PA initiated at 9:30 pm and arrived at your hospital at 10:15 pm.<br><br>Time and date of last known well are known as 19:00 on day of arrival in ED, and time and |

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| | | | | | date of discovery are known as 19:30 on day of arrival in ED. |
| **6.2** | Core<br><NIHSSYN> | Was NIH Stroke Scale score performed as part of the initial evaluation of the patient? | Numeric # = 1-digit | 1 – Yes<br>0 – No/Not documented | Yes if only complete NIH stroke scale has been performed<br>No if other stroke scale was performed which includes Modified NIH stroke scale |
| | <NIHStrkS> | If performed, what is the first NIH Stroke Scale total score recorded by hospital personnel (enter score)<br>— — | Numeric<br>## = 2-digit | Range: 00 to 42 | Total score maximum is 2-digit<br>First NIHSS can be recorded by either the MD or a member of the "stroke team" (including a PA or RN).<br>ED physician or nurses notes, ED Pathway, Acute physician or nursing notes, NIHSS documentation form, Acute Stroke Pathway Documentation Forms |

| 7 | | **Thrombolytic Treatment** | | | |
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| **7.1** | Core | | | | Do not include thrombolytic therapy for indications other than ischemic stroke. That is, do not include intra-cerebral venous infusion for cerebral venous thrombosis, intraventricular infusion for intraventricular hemorrhage, intraparenchymal infusion for percutaneous aspiration of intracerebral hematoma, myocardial infarction, PE, or peripheral clot. |
| | <TrmIVM> | Was IV tPA initiated for this patient at this hospital?<br><br>If IV tPA was initiated at this hospital or ED, please complete this section: | Numeric # = 1-digit | 1 – Yes<br>0 – No<br>2 – NC – Documented reason exists for not giving IV thrombolytic. | |
| | <TrmIVMD><br><TrmIVMT><br><TrmIVMDN><br><TrmIVMTN> | _ _/ _ _/ _ _ _ _<br>___: ____<br>Date Not documented<br>Time Not documented | Date MMDDYYYY<br>Time HHMM<br>Numeric # = 1-digit<br>Numeric # = 1-digit | <br><br>1 – Yes<br>0 – No | If patient received IV tPA in the ED in your hospital and was then transferred from your ED (without hospital admission) to another acute care hospital, this instance of providing IV tPA by your hospital must be recorded by your hospital even though the patient may not have been formally admitted to your hospital. If this situation existed, this record is complete after completing items 1.1-7.3 and 12.5. That is, only if this patient was an instance of 'drip and ship' IV tPA in this hospital, you may skip the remaining items after section 7 and item 12.5 for this patient.<br><br>**If Documented reason exists for not giving IV thrombolytic therapy at this hospital, then complete Question 8.1 after finishing the remaining questions in section 7.1, 7.2 and 7.3. That is, if '2' is selected for IV tPA in this hospital, then Question 8.1 must be answered after finishing the remaining questions in section 7.2 and 7.3.**<br><br>Principal investigators/clinical consultants from state registries should develop and maintain a list of thrombolytic solutions that data abstractors can use for reference.<br><br>Source: ED Order Sets, ED physician or nurses' notes, medication documentation. If there is not documentation of thrombolytic therapy in the physician or nurses notes, check the ED order sets, medication ordering system |

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| | | | | | in the computer (if available at your institution) Acute Stroke Pathway documentation or admission order sets. |
| **7.2** | Core | Was other thrombolytic therapy administered? | | | IA catheter-based reperfusion therapy includes all uses of IA thrombolytic therapy, even if used in conjunction with mechanical devices such as "Clot retrieval devices". Mechanical devices may be used alone or in conjunction IA thrombolytic therapy. The start time for IA catheter-based reperfusion therapy should be either the date and time on the angio showing evidence of treatment, or the start time of the infusion if the angio time is not available. Mark <TrmExp> 'yes' if medical records suggest that some kind of investigational thrombolytic protocol was used during provision of care. If TrmExp is checked 'Yes', then record <ExpType>. Do not specify text without checking TrmExp = 'Yes'. Text field is to describe the nature of the experimental protocol described in <TrmExp>. If investigational or experimental protocol was used, there should be a signed IRB consent in the medical record.<br><br>Source: ED Order Sets, ED physician or nurses' notes, medication documentation. If there is not documentation of thrombolytic therapy in the physician or nurses notes, check the ED order sets, medication ordering system in the computer (if available at your institution) Acute Stroke Pathway documentation or admission order sets. |
| | <TrmIVT> | IV tPA at an outside hospital | Numeric # = 1-digit | 1 – Yes<br>0 – No | |
| | <TrmIAM> | IA catheter-based reperfusion at this hospital?<br>If yes, please record date and time | Numeric # = 1-digit | | |
| | <TrmIAMD> | _ _/ _ _/ _ _ _ _ | Date MMDDYYYY | | |
| | <TrmIAMT> | ___: ____ | Time HHMM | | |
| | <TrmIAMDN> | Date Not documented | Numeric # = 1-digit | | |
| | <TrmIAMTN> | Time Not documented | Numeric # = 1-digit | | |
| | <TrmIAT> | IA catheter-based reperfusion at outside hospital? | Numeric # = 1-digit | 1 – Yes<br>0 – No | |
| | <TrmExp> | Investigational or experimental protocol for thrombolysis | Numeric # = 1-digit | | |
| | <ExpType> | If yes, Specify | Text 50 | | |

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| **7.3** | Core | Complications of thrombolytic therapy (Check all that apply among responses) | | | Definition for symptomatic intracranial hemorrhage: CT hemorrhage shows intracranial bleed AND physician's notes indicate clinical deterioration due to hemorrhage. |
| | <ThrmCmpS> | Symptomatic intracranial hemorrhage | Numeric # = 1-digit | 0 – No<br>1 –Yes – within 36 hours (≤ 36 hours) of t-PA<br>9 – Unknown/Unable to Determine | Indicate if hemorrhagic complications of tPA occurred as a result of IV tPA administration within 36 hours from the time of tPA bolus.<br><br>Symptomatic brain hemorrhage is defined by a CT within 36 hours that shows intracranial hemorrhage AND physician's notes indicate clinical deterioration due to hemorrhage<br><br>Serious systemic hemorrhage is defined by bleeding within 36 hours of IV tPA and > 3 transfused units of blood within 7 days or discharge (whichever is earlier) AND physician note attributing bleeding problem as reason for transfusion<br><br>Indicate if no serious complications occurred<br>If no tPA given, then this element is not applicable, select Unknown/Unable to Determine<br><br>Check "No" box to indicate that patient did not experience either symptomatic intracranial hemorrhage or life threatening, serious systemic hemorrhage as complications of thrombolytic therapy.<br><br>Example: The patient received intravenous tPA in the ED on 07/01/04. The following day the patient developed a sudden headache and decreased level of consciousness. A head CT was performed which showed a large intracerebral hemorrhage.<br><br>Source: Acute stroke pathway documentation, Admission sheet, Diagnostic reports, Discharge summary, ED Nurses notes, ED order sets, ED pathway documentation, ED Physician notes, triage sheet, Medication order sheets or |
| | <ThrmCmpL> | Life threatening, serious systemic hemorrhage | Numeric # = 1-digit | 1 – Yes – within 36 hours (≤ 36 hours) of t-PA<br>0 – No<br>9 – Unknown/Unable to Determine | |

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| | | | | | medication ordering system in the computer (if available), Nurses progress notes, Physician order sheets, Physician progress notes, Radiology progress notes, rt-PA Protocol Sheets.<br><br>If you administered or prescribed tPA at your hospital or emergency room, and then shipped the patient to another hospital, you are to follow up on the patient with the hospital that you referred the patient to, and you are required to answer these questions regarding hemorrhagic complications of thrombolytic therapy. |

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| 8 | | **Non-Treatment with Thrombolytics**<br>Section 8 completed only if thrombolytic therapy not given or started.<br><br>Disclaimer: The reasons provided herein are not intended to supersede physician judgment, but serve as a guideline to abstractors. As always, the physician must exercise due caution in providing treatment, given the risks and benefits to the individual patient and the available information at the time of treatment decision. Reasons have been taken from the package insert for Activase, as well as those used in previous clinical trials. | | | |

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| **8.1** | Core | Were one or more of the following reasons for not administering IV thrombolytic therapy at this hospital explicitly documented or clearly implied by a physician, nurse practitioner, or physician assistant's notes in the chart?<br>(Check all that apply.) | | | Intent of this question is to capture documented contraindications. Check item if documented by physician or nurse in admission or discharge notes. Do not document evidence from outside the physician or nurse notes that it played a factor in the decision-making process for not giving thrombolytic therapy.<br><br>It is the intent that the abstractor will not make inference as to the reason for non-treatment, but will abstract from documented reasons existing in the medical record.<br><br>"Unable to determine eligibility" means that the diagnosis of stroke was made but that eligibility for thrombolytic therapy could not be established or the clinician could not verify the patient's eligibility for treatment. The most common reason for this is that the time of onset could not be clearly established at the time of patient assessment in the ED. It can also arise when the timing of a recent procedure or surgery could not be definitively established, or time of LKW is unknown.<br><br>Advanced age is a warning condition – it must be clearly stated in the chart that this was the reason the patient did not receive tPA, and not checked only because the patient is above a certain age.<br><br>Conditions that increase the risk of bleeding or decrease the benefit of treatment to the individual patient should be explicitly listed in the medical record and documented as being the reason that thrombolytics were not used.<br><br>If there is a time delay due to the patient's condition that required other treatment (e.g., intubation, resuscitation), select stroke severity. If there are delays in patient arrival or inhospital processes, select "Time Delay". |
| | <NonTrtC> | **Contraindications**, which include any of the following:<br>SBP > 185 or DBP > 110 mmHg<br>Seizure at onset<br>Recent surgery/trauma (<15 days)<br>Recent intracranial or spinal surgery, head trauma, or stroke (<3 mo.)<br>History of intracranial hemorrhage or brain aneurysm or vascular malformation or brain tumor<br>Active internal bleeding (<22 days)<br>Platelets <100,000, PTT> 40 sec after heparin use, or PT > 15 or INR > 1.7, or known bleeding diathesis<br>Suspicion of subarachnoid hemorrhage | Numeric # = 1-digit | 1 -Yes<br>0 - No | |
| | <NonTrtCT> | CT findings (ICH, SAH, or major infarct signs) | Numeric # = 1-digit | | |
| | <NonTrtWN> | **Warnings:** conditions that might lead to unfavorable outcomes:<br>Stroke severity – Too severe (e.g., NIHSS >22)<br>Glucose < 50 or > 400 mg/dl<br>left heart thrombus<br>Increased risk of bleeding due to:<br>Acute pericarditis<br>Subacute bacterial endocarditis (SBE)<br>Hemostatic defects including those secondary to severe hepatic or renal disease<br>Pregnancy<br>Diabetic hemorrhagic retinopathy, or other hemorrhagic ophthalmic conditions<br>Septic thrombophlebitis or occluded AV cannula at seriously infected site<br>Patients currently receiving oral anticoagulants, e.g., Warfarin sodium | Numeric # = 1-digit | | |
| | <NonTrtAG> | Advanced age | Numeric # = 1-digit | | |
| | <NonTrtSM> | Rapid improvement or Stroke severity too mild | Numeric # = 1-digit | | |

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| | <NonTrtIL> | Life expectancy < 1 year or severe co-morbid illness or CMO on admission | Numeric # = 1-digit | 1 -Yes<br>0 - No | Data element <NonTrtOt> is a text field to record Other responses.<br>Do not enter text in <NonTrtOt> unless NonTrtOC = 1<br><br>**Be very certain that a reason does not logically fit into any of the listed categories before resorting to entering text in the <NonTrtOt> field. Review of the past data reveals that most of the reasons for not giving t-PA will fall into one of the above delineated categories.**<br><br>The following should help abstractors in classifying reasons:<br><br>If patient is on anticoagulants (Warfarin, Coumadin) and this is documented as the reason for no thrombolytics, and the PT, PTT, or INR is elevated, select <NonTrtC>. If the patient is on anticoagulants and this is documented as the reason, but there is no INR or PTT recorded to document its elevation, then select <NonTrtWN><br><br>If patient declines IV tPA in favor of catheter-based reperfusion or other investigational therapy, then select option "patient/family refused"<br><br>If record documents that the reason is "NIHSS low" or something like "NIHSS = 3", then this would appropriately be categorized as stroke severity too mild.<br><br>If the documented reason is something like severe dementia, then select severe co-morbid condition.<br><br>If the diagnosis was unclear during the ED evaluation or at the time of admission, select "failure to diagnose in the 3 hour time frame", <NonTrtDX>. This might be an admitting diagnosis such as "rule out migraine" for the |
| | <NonTrtFR> | Pt./Family refused | Numeric # = 1-digit | | |
| | <NonTrtNC> | Care-team unable to determine eligibility | Numeric # = 1-digit | | |
| | <NonTrtOH> | IV or IA tPA given at outside hospital | Numeric # = 1-digit | | |
| | | **Hospital-Related or Other Factors:** | | | |
| | <NonTrtDX> | Failure to diagnose in 3 hour time frame | Numeric # = 1-digit | | |
| | <NonTrtTD> | Inhospital Time Delay | Numeric # = 1-digit | | |
| | <NonTrtA> | Delay in patient arrival | Numeric # = 1-digit | | |
| | <NonTrtIV> | No IV access | Numeric # = 1-digit | | |
| | <NonTrtOC> | Other: | Numeric # = 1-digit | | |
| | <NonTrtOt> | _____ | Text 25 characters | | |

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| | | | | | admission diagnosis.<br><br>If the diagnosis was known to be ischemic stroke, but the workup of the patient could not be completed within the timeframe to treat, and the record indicates something like "delay in obtaining CT scan" or "Delay in reading CT scan", then select <NonTrtTD>.<br><br>Only use the "Other Reason" field if there is no reason specified that could be accurately captured by the listed choices. Do not select and enter "Other Reason" if you have already selected a specified reason. The "other reason" field will not exclude patients from the denominator of the tPA measures.<br><br>Remember to only abstract reasons that are specifically stated as the reason for not giving thrombolytic therapy.<br><br>If the treatment team cannot determine when the stroke occurred and they document something like "cannot determine time of onset", this would be classified as <NonTrtNC>, "cannot determine eligibility.<br><br>Acute stroke pathway documentation, Admission sheet, Diagnostic reports, Discharge summary, ED Nurses notes, ED order sets, ED pathway documentation, ED Physician notes, triage sheet, Medication order sheets or medication ordering system in the computer (if available), Nurses progress notes, Physician order sheets, Physician progress notes, Radiology progress notes, rt-PA Protocol Sheets. |

| 9 | | **Medical History** | | | |
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| **9.1** | Core | Documented past medical history of any of the following:<br>(Check all that apply.) | | | Check item if documented by physician or nurse in admission or discharge notes. |
| | <MedHisDM> | Is there a history of Diabetes Mellitus (DM)? | Numeric # = 1-digit | 1 -Yes<br>0 - No | These should be checked only for conditions that were known to be present prior to the current even. Do not record yes for conditions that were only newly diagnosed on this admission.<br><br>CAD/prior MI: CAD/Prior MI if there is a history of coronary artery disease, or a physician diagnosed MI or EKG evidence of an old MI prior to this event.<br>Carotid Stenosis: stenosis may be documented either (1) in words in the record as "moderate" or greater than or equal to 50%, (2) previous duplex ultrasound or MR/CT/conventional angiography methods recorded as "moderate" or greater than or equal to 50%, (3) history of carotid endarterectomy or stenting.<br>Diabetes Mellitus (DM): Diabetes mellitus (DM) is a history of physician diagnosed diabetes (Types I or II) regardless of duration of disease, including the use of diet, need for antidiabetic agents, oral hypoglycemic agents or insulin, or a fasting blood sugar greater than 7 mmol/l or 126 mg/dl. Do not include diabetes based on a patient's statements about elevated glucose or based on a single value of elevated blood sugar in the chart. In order to select this element, there must be a confirmed diagnosis of diabetes mellitus.<br>PVD: PVD, Peripheral Vascular Disease, refers to a history of peripheral vascular disease of the arteries of the extremities, especially conditions that interfere with adequate blood flow to the extremities and occurring prior to this acute event. Example: peripheral arterial occlusion, abdominal aortic aneurysm.<br>Hypertension: Hypertension (HTN) is present if the patient has a history of high blood |
| | <MedHisST> | Is there a history of prior Stroke/Transient ischemic attack/VBI? | Numeric # = 1-digit | | |
| | <MedHisCS> | Is there a history of carotid stenosis? | Numeric # = 1-digit | | |
| | <MedHisMI> | Is there a history of myocardial infarction (MI) or coronary artery disease (CAD)? | Numeric # = 1-digit | | |
| | <MedHisPA> | Is there a history of peripheral arterial disease (PAD)? | Numeric # = 1-digit | | |
| | <MedHisVP> | Does the patient have a valve prosthesis (heart valve)? | Numeric # = 1-digit | | |
| | <MedHisHF> | Is there a history of Heart Failure (CHF)? | Numeric # = 1-digit | | |
| | <MedHisSS> | Does the patient have a history of sickle cell disease (sickle cell anemia)? | Numeric # = 1-digit | | |
| | <MedHisPG> | Did this event occur during pregnancy or within 6 weeks after a delivery or termination of pregnancy? | Numeric # = 1-digit | | |

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| | | | | | pressure whether or not the patient is on prescribed medications. Defined as systolic blood pressure greater than 140 and diastolic blood pressure greater than 90 in the non-acute setting on at least 2 occasions, current use of antihypertensive pharmacological therapy, history of HTN diagnosed and treated with medication, diet, and/or exercise. Do not base this decision solely on blood pressure recordings taken in the ED or in the first few days of admission after stroke, since many normotensive patients will have elevated BP after stroke.<br>VBI = vertebral-basilar insufficiency<br>Heart Failure includes CHF<br>Include both Sickle cell disease or sickle cell trait, or sickle cell anemia<br>Pregnancy includes women who are currently pregnant, or with in six weeks post partum<br><br>This information is usually listed in the stroke pathway documentation, Admission sheet, Diagnostic reports, Discharge summary, ED Nurses notes, ED Physician notes, Medication order sheets, Nurses progress notes, Physician order sheets, Physician progress notes. |
| **9.2** | Optional<br><Height ><br><br><HgtUnit><br><br><br><HgtND> | <u>Record patients height</u><br>\|__\|__\|__\|<br><u>Is height in inches or cm?</u><br><br>Height not documented | Numeric ### = 3 digit<br>Numeric # = 1-digit<br><br>Numeric # = 1-digit | <br><br>1 = in<br>2 = cm<br><br>1 -Yes<br>0 - No | Enter the patient's height and weight. Indicate if these are measured in inches, cm or lbs, kg respectively. BMI will be calculated by the computer. If height/weight information is not documented, select ND.<br><br>This information is usually listed in the Admission sheet, ED Nurses notes, ED Physician notes, Medication order sheets, Nurses progress notes, Physician order sheets, Physician progress notes, Dietary or nutrition services, Physical therapy or Occupation |
| **9.3** | Optional<br><Weight><br><br><WgtUnit><br><br><br><WgtND> | <u>Record patient's weight</u><br>\|__\|__\|__\|<br>Is weight in lbs or kg?<br><br>Weight not documented | Numeric ### = 3 – digit<br>Numeric # = 1-digit<br><br>Numeric # = 1-digit | <br><br>1 = lbs<br>2 = kg<br><br>1 -Yes<br>0 – No | |

| 10 | | **In-Hospital Procedures and Treatment** | | | |
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| **10.1** | Core<br><br>Where was patient care for and by whom (Check all that apply)?<br><SUnitA> Neuro Admit<br><SUnitB> Other Service Admit<br><SUnitC> Stroke Consult<br><SUnitD> No Stroke Consult<br><SUnitE> In Stroke Unit<br><SUnitF> Not in Stroke Unit<br><SUnitND> Unable to Determine | | Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit | 1 -Yes<br>0 - No | In order to track the service on which care was rendered, choose from the options available. The patient is admitted once, either as a neuro admit, or as an other service admit – that is, the choices are mutually exclusive. Stroke consult or no stroke consult should be mutually exclusive, and in stroke unit or not in stroke unit should be mutually exclusive.<br><br>Patient 019 was admitted directly to the floor from private internal medicine physician practice. The physician at this practice has admitting privileges at your institution. The internal medicine physician (Primary Attending) requests a consultation from Neurology via a written consultation request, which the neurology resident performs and documents. The patient is transferred from regular unit to stroke unit, to the neurologist's care. The Data Entry will be "Yes" for <SUnitB>, "Yes" for <SUnitC>, and "Yes for <SUnit F>.<br>*Admission sheet. If you have the capacity to view the attending or resident physician's patient list (usually obtained from the institutions computer system daily) you will find the admissions and consultations from other services listed there.* |
| **10.2** | Core<br><br><AThr2Day> | Was antithrombotic therapy received by the end of hospital day 2? | Numeric # 1-digit | 1 – Yes<br>0 – No/Not documented<br>2 – NC – Documented reason for | The intent of this question is to document anti-thrombotic therapy by the end of the second hospital day. While the abstractors may make reasonable inferences from available doctors' notes, |

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| | | | | not giving antithrombotic therapy exists in the medical record | they should not actively search in the patient's record for contraindications.<br><br>**Only the following are considered acceptable antithrombotic therapy:**<br>▪ Aspirin (ASA)<br>▪ ASA/dypiridamole (Aggrenox) BID<br>▪ Warfarin (Coumadin)<br>▪ Clopidogrel (Plavix)<br>▪ Ticlopidine (Ticlid)<br>▪ Full dose unfractionated heparin IV<br>▪ Full dose LMW heparin<br><br>To compute end of hospital day two, count the day of as arrival at this hospital day one. If antithrombotic therapy was administered by 11:59 PM of hospital day two, answer "Yes" for this data element. E.g., patient arrives in ED on Monday 05:00; antithrombotic therapy must be initiated before 23:59 on Tuesday; if patient arrives at 23:30 on Monday antithrombotic therapy must be initiated by 23:59 on Tuesday.<br><br>If patient/family refuses treatment, record this as 'NC'.<br><br>Example: Patient arrives at ED on Monday at 05:00 with an ischemic stroke. Because beds are full, patient waits in ED holding bed, and patient is not delivered to the stroke unit until 15:00 on Tuesday. Hospital day 1 is Monday (day of arrival at hospital), and hospital day 2 is Tuesday. Patient should receive antithrombotic therapy by 23:59 on Tuesday in order to answer "Yes"<br><br>Reasons for patients not receiving antithrombotic medication must be documented by a physician, nurse practitioner or physician assistant. If reasons are not mentioned in the context |

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| | | | | | of antithrombotics, do not make inferences (e.g., do not assume that antithrombotic medication is not being prescribed because of a bleeding disorder unless documentation explicitly states so.)<br><br>Acceptable reasons for not giving antithrombotic medication by the end of the 2nd hospital day include:<br>Acceptable reasons for not giving include:<br>• Risk of bleeding<br>• Allergy to or complication r/t aspirin, Ticlopidine, Clopidogrel, dipyridamole and Warfarin (hx or current)<br>• Patient receiving terminal or comfort care only<br><br>This information is usually listed in the Admission notes, Consultation progress notes, Discharge summary, Medication list or orders, Discharge orders, Nurses progress notes, Physician progress notes, Physical or Occupational therapy progress notes |
| **10.3** | Core<br><DVTAmbul> | Was patient ambulatory at the end of hospital day two? | Numeric # 1-digit | 1 - Yes – Skip to question 10.5<br>0 – No/ Not documented | Ambulatory:<br>o Patient ambulating without assistance (no help from another person)<br>o Patient ambulating with assistance of another person or assistive device throughout the day<br>o Patient ambulating to and from the bathroom<br>Non-ambulatory:<br>o Patient is on bed rest<br>o Patient is only getting out of bed to the bedside commode (or up in |

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| | | | | | chair) and is primarily in the bed (or immobile) on the 2nd hospital day<br>If unable to determine from documentation consider this patient non-ambulatory<br><br>Hospital Day 2:<br>Day 1 is day of ARRIVAL. If there is documentation that the patient was ambulatory at or before 23:59 on the day after arrival, answer "Yes" to this question.<br>Example: Patient 019 is only getting out of bed to the bedside commode and is primarily in the bed on the 2nd hospital day. This patient is considered non-ambulatory. Data entry would be "No".<br><br>Nurses progress notes, Occupational Therapy progress notes, Physical Therapy progress notes, Physician order sheets, Physician progress notes. |
| **10.4** | Core<br><br><DVTProYN> | Was DVT prophylaxis initiated by the end of the 2nd hospital day? | Numeric # 1-digit | 1 - Yes<br>0 – No – Not Documented<br>2 - NC – Documented reason for not administering DVT prophylaxis was present in the medical record. | Determination if medication and/or devices were ordered and initiated within 48 hours of hospital admission for prophylaxis against the formation of deep venous thrombosis. Inclusion:<br><br>1) Low-dose, sub-Q, subcutaneous, unfractionated ("regular") heparin, Low Molecular Weight (LMW) heparin (enoxaparin, dalteparin, nadroparin, danaparoid, hirudin, bivalirudin, heparinoids) or trial based antithrombin agent or other agent not listed above<br><br>2) Intravenous heparin, IV heparin.<br><br>3) Pneumatic Compression Stockings, |

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| | | | | | compression socks, Intermittent compression devices, ICDs, (TED Hose do NOT apply)<br><br>4) Warfarin, Aldocumar, Anisindione, Anisinidine, Athrombin, Athrombin-K, Barr Warfarin Sodium, Barr's Warfarin Sodium, Carfin, Coufarin, Coumadan, SodicoCoumadin, Coumadina, Coumadine, Dicumarol, Dicoumarol, Indandione, Liquamar, Marevam, Marevan, Miradon, Orfarin, Panwarfin, Panwarfarin, Phenprocoumon, Sefarin, Sofarin, Uniwarfin, Waran, Warfarin, Warfarin Sod, Warfarin Sodium, Warfilone Sodium, Warifilone<br><br>**Select:**<br><br>Yes = if any of these medications or treatments are ordered for the patient and initiated even if "DVT Prophylaxis" as the indication is not specifically documented in the order or progress notes. Therapeutic anticoagulation also meets the criteria for prophylaxis. Also, select "Yes" if a patient continues receiving one of the DVT prophylaxis listed above that was started prior to admission.<br><br>No = if none of the above methods are ordered and initiated for the patient.<br><br>If patient/family refuses treatment, record this as 'NC'.<br><br>To compute end of hospital day two, count the day of as arrival at this hospital day one. If DVT prophylaxis was administered by 11:59 |

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| | | | | | PM of hospital day two, answer "Yes" for this data element. E.g., patient arrives in ED on Monday 05:00; DVT prophylaxis must be initiated before 23:59 on Tuesday; if patient arrives at 23:30 on Monday antithrombotic therapy must be initiated by 23:59 on Tuesday.<br><br>Example: Patient arrives at ED on Monday at 05:00 with an ischemic stroke. Because beds are full, patient waits in ED holding bed, and patient is not delivered to the stroke unit until 15:00 on Tuesday. Hospital day 1 is Monday (day of arrival at hospital), and hospital day 2 is Tuesday. Patient should receive DVT prophylaxis by 23:59 on Tuesday in order to answer "Yes"<br><br>Reasons for not prescribing DVT prophylaxis must be documented by a physician, nurse practitioner or physician assistant. If reasons are not mentioned in the context of DVT prophylaxis, do not make inferences<br><br>Example: Patient 025 is admitted to the in-patient unit following treatment with thrombolytic therapy. Thirty-six hours after administration of rt-PA, the patient is not able to ambulate and requires two people to assist him. His medications do not include any anticoagulants and he is on Plavix. Data Entry will be to select No. If patient had TED hose, data entry would also be to select "No".<br>This information may be found in the Medication Order Sheets, Printed or Electronic Order Sheets, Physician or Nurses notes, Physical or Occupational therapy notes. |

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| **10.5** | Core<br><NPO> | Was the patient NPO throughout the entire hospital stay? (That is, this patient never received food, fluids, or medication by mouth at any time.) | Numeric # 1-digit | 1 – Yes Skip to Question 11.1<br>0 – No or Not documented | Answer "Yes" for this data element only if the patient was kept NPO during the entire hospitalization and was discharged or transferred or deceased NPO. This response should not be used in any other circumstances. Data abstractors should wait until either patient is taken off NPO or discharged prior to answering this question.<br><br>Delivery via NG or OG or gastrostomy tube should be independent of NPO. |
| | Core<br><DysphaYN> | Was patient screened for dysphagia prior to any oral intake, including food, fluids or medications? | Numeric # 1-digit | 1 – Yes<br>0 – No/Not documented<br>2 – NC – documented reason for screening not required exists in the medical record. | Documentation in the record should indicate that an assessment of the patient's **ability to swallow** was completed by a health care professional prior to oral intake of food, fluid, or medications.<br><br>Reasons for not performing a dysphagia screen must be explicitly documented or clearly implied by a physician, nurse practitioner, or physician assistant. If reasons are not mentioned in the context of dysphagia screening, do not make inferences unless documentation explicitly states so.) Acceptable reasons for not performing dysphagia screening include the presence of a previously place gastrostomy tube, and complete recovery of all symptoms and neurological deficits.<br><br>A variety of methods may be employed to assess swallowing status. These methods may include but are not limited to:<br>• bedside swallow assessment<br>• Simple water swallow test<br>• Burke water swallow test<br>• Bedside swallowing assessment<br>• Simple standardized bedside swallowing assessment (SSA)<br>• Barium swallow |

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| | | | | | • Video fluoroscopy<br>• Double contrast esophagoscopy<br>• Radio nucleotide studies<br>• Manometry<br>• Endoscopy<br>• Formal evaluation by speech language pathologist<br><br>The following are not acceptable as swallow screening:<br>• Patient evaluation using the NIH/NIHSS (National Institute of Health/National Institute of Health Stroke Scale) is NOT considered dysphagia screening<br>• Documentation of "Cranial nerves intact" is NOT considered dysphagia screening<br>• Positive gag reflex noted<br><br>If patient/family refuses treatment, record this as 'NC'.<br><br>Example 1: Patient 019 is admitted to the in-patient unit from the ED as NPO. The ED physician notes document evidence of dysphagia and a formal swallowing evaluation is ordered. Data entry will be to check "Yes".<br>Example 2: Patient 020 is admitted with dysarthria and drooling. The ED physician notes evidence of dysphagia and the diet order reads NPO except meds. No formal swallowing evaluation is performed. Data entry is "ND".<br><br>This information is usually listed in the Acute pathway documentation, Consultation progress notes, Diagnostic reports, Discharge summary, ED Physician notes, Nurses progress notes, Nutritionist progress notes, Physician progress notes, Speech therapy progress notes |

| 11 | | **Other In-Hospital Complications** | | | |
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| **11.1** | Core<br><DVTDocYN> | Did patient experience a DVT or pulmonary embolus (PE) during this admission? | Numeric # 1-digit | 1 – Yes<br>0 – No<br>9 – Not Documented | Confirmed by ultrasound or venous imaging. [TJC defines this as objectively confirmed DVT based on duplex ultrasound, contrast venography, CT with contrast or CT venogram, MR imaging or MR venography]<br>Items 11.1 through 11.4 refer to in-hospital acquired events requiring treatment. Pre-existing conditions and therapy present prior to admission should not be counted in responding to these data element.<br><br>Example: Patient 019 was prescribed DVT prophylaxis on admission to hospital for ischemic stroke. On day 4 of admission the patient had a tender calf, ultrasound revealed a DVT of the left calf. Answer would be "Yes".<br>Example: Patient 019 was prescribed DVT prophylaxis on admission to hospital for ischemic stroke. On day 4 of admission the patient had a tender calf, ultrasound was negative for DVT. Answer would be "No". |
| **11.2** | Core<br><PneumYN> | Was there documentation that the patient was treated for pneumonia during this admission? | Numeric # 1-digit | 1 – Yes<br>0 – No<br>9 – Not Documented<br>. | Indicate if patient was treated for nosocomial aspiration pneumonia that occurs after 48 hours of admission. Yes: There was clinical mention of hospital-acquired pneumonia by the physician, and treatment with an antibiotic for pneumonia<br>No: There was clinical mention of hospital-acquired pneumonia by the physician, but treatment with an antibiotic was not prescribed<br>Not Documented: There was no clinical mention of hospital-acquired pneumonia, |

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| | | | | | select "ND."<br><br>Example: Patient 019 is admitted with stroke symptoms and started on an oral diet after passing a dysphagia screen. A chest Xray from day 2 describes "pneumonia vs. atlectasis." This is mentioned in the physician notes but the decision is made to treat for congestive heart failure and wait for a fever before starting antibiotics. No antibiotics are subsequently given. Select "No".<br><br>This information is usually listed in the Consultation progress notes, Diagnostic reports, Discharge summary, Nurses progress notes, Nutritionist progress notes, Physician progress notes, Speech therapy progress notes. |
| **11.3** | Core<br><UTI><br><br><br><UTIFoley> | Was patient treated for a urinary tract infection (UTI) during this admission?<br><br>If patient was treated for a UTI, did the patient have a Foley catheter during this admission? | Numeric # 1-digit<br><br><br>Numeric # 1-digit | 1 – Yes<br>0 – No<br>9 – Not documented<br><br>1 – Yes, and patient had catheter in place on arrival<br>2 – Yes, but only after admission<br>0 – No<br>9 – Unable to determine | Indicate if patient was treated for urinary tract infection that developed following admission.<br>Yes: There was clinical mention of UTI by the physician, and treatment with an antibiotic for UTI<br>No: There was clinical mention of UTI by the physician, but treatment with an antibiotic was not prescribed<br>Not Documented: There was no clinical mention UTI "ND."<br><br>For the Foley catheter, if the patient had a catheter in place prior to the event/admission select choice 1. If patient did not arrive with a catheter in place, but required a Foley after admission, select 2. If patient had a condom catheter only, select No. |

| 12 | | **Discharge Data** | | | |
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| **12.1** | Core<br><DschrgD> | Date of discharge from hospital<br>_ _/ _ _/_ _ _ _ | Date MMDDYYYY | | mm/dd/yyyy,<br>Indicate the date the patient was discharged from acute care, left against medical advice, or expired during this stay.<br><br>The discharge date is the day that the patient is discharged from your institution's acute care unit OR the date of the patient's expiration OR the date of the patient's discharge OR date of transfer to, a rehabilitating, skilled nursing, or hospice unit in your institution OR transfer to an acute in-patient unit outside of your own institution, even if that hospital is affiliated with your own. Record as: ____/____/____ (mm/dd/yyyy) = the date of the actual discharge/transfer/expiration of the patient as defined above.<br><br>Example: Patient 019 is admitted to your in-patient neurology floor from your ED, with a diagnosis of acute ischemic stroke, on January 10, 2004 (01/10/2004). Due to extension of the infarct, need for jejunosotmy and placement, the patient is still on the in-patient unit on January 30, 2004 (01/30/2004). The patient has been on the in-patient unit for 16 days. The patient expires from complications of aspiration pneumonia on February 12, 2004 (02/12/2004). Data entry is 02/12/2004 (mm/dd/yyyy).<br><br>Because this data element is critical in determining the population for all measures, the abstractor should NOT assume the UB-04 claim information for |

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| | | | | | the discharge date is correct. If the abstractor determines through chart review that the UB-04 day is incorrect, she/he should correct and override the value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the UB-04 date.<br><br>This information is usually listed in the Discharge summary, Physician order sheets, Physician progress notes. Use the UB-04 date only as a last resort. |
| **12.2** | Core<br><br><ICD9StDx><br><br><ICD9StND> | ICD-9-CM discharge diagnosis related to stroke<br>__ __ __ . __ __<br><br>Not present | ###.## 5 – digit, 2 decimal places<br><br>Numeric # = 1-digit | | Allow only one ICD-9 code.<br><br>Determined by ICD-9-CM code recorded in chart. The following are typical stroke ICD-9-CM codes:<br>430 (SUBARACHNOID HEMORRHAGE)<br>431 (INTRACEREBRAL HEMORRHAGE)<br>432 ( OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE)<br>432.9 (UNSPECIFIED INTRACRANIAL HEMORRHAGE)<br>433 (OCL PRECEREBRAL ART)<br>433.00 (OCL BSLR ART WO INFRCT)<br>433.01 (OCL BSLR ART W INFRCT)<br>433.10 (OCL CRTD ART WO INFRCT)<br>433.11 (OCL CRTD ART W INFRCT)<br>433.20 (OCL VRTB ART WO INFRCT)<br>433.21 (OCL VRTB ART W INFRCT)<br>433.30 (OCL MLT BI ART WO INFRCT)<br>433.31 (OCL MLT BI ART W INFRCT)<br>433.80 (OCL SPCF ART WO INFRCT)<br>433.81 (OCL SPCF ART W INFRCT)<br>433.90 (OCL ART NOS WO INFRCT)<br>433.91 (OCL ART NOS W INFRCT)<br>434.00 (CEREBRAL THROMBOSIS W/O INFARCTION)<br>434.01 (THROMBOSIS WITH CEREBRAL INFARCTION)<br>434.10 (CEREBRAL EMBOLISM W/O INFARCTION)<br>434.11 (CEREBRAL EMBOLISM WITH INFARCTION) |

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| | | | | | 434.90 (CRBL ART OC NOS WO INFRC)<br>434.91 (CRBL ART OCL NOS W INFRC)<br>435 (TRANSIENT CEREBRAL ISCHEMIA)<br>435.0 (BASILAR ARTERY SYNDROME)<br>435.1 (VERTEBRAL ARTERY SYNDROME)<br>435.2 (SUBCLAVIAN STEAL SYNDROM)<br>435.3 (VERTEBROBASILAR ARTERY SYNDROME)<br>435.8 (TRANS CEREB ISCHEMIA NEC)<br>435.9 (TRANS CEREB ISCHEMIA NOS)<br>436 (ACUTE, BUT ILL-DEFINED, CEREBROVASCULAR DISEASE)<br>The following can have 5th digit of (0,1,2,3,4)<br>671.5 x CEREBRAL VENOUS SINUS THROMBOSIS DURING PREGNANCY OR IN THE PUERPERIUM<br>674.0x CEREBROVASCULAR COMPLICATIONS OF THE PUERPERIUM |
| **12.3** | Core<br><ICD9PrDx> | Principle discharge ICD-9-CM diagnosis<br>__ __ __ . __ __ | ###.## 5 – digit, 2 decimal places | | This is the principle diagnosis at the time of discharge. |
| **12.4** | Core<br><br><br><AdmDxSH><br><AdmDxIH><br><AdmDxIS><br><AdmDxTIA><br><AdmDxSNS><br><AdmDxNoS> | Clinical hospital diagnosis related to stroke that was ultimately responsible for this admission (check only one item)<br><br>Subarachnoid hemorrhage<br>Intracerebral hemorrhage<br>Ischemic stroke<br>Transient ischemic attack<br>Stroke not otherwise specified<br>No stroke related diagnosis | <br><br><br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit<br>Numeric # = 1-digit | <br><br><br>1 -Yes<br>0 - No | This is the clinical admission diagnosis after completion of all diagnostic procedures, examinations and consultations.<br><br>Note that this may be different from the presumptive hospital admission diagnosis and the final ICD-9-CM code. |

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| **12.5** | Core<br><DschDest> | Discharge destination (Check only one.) | Numeric<br>## 2-digit | 01 Discharged to home or self care (routine discharge)<br>02 Discharged/transferred to a short-term general hospital for inpatient care.<br>03 Discharged/transferred to SNF with Medicare certification in anticipation of covered skilled care (effective 2/23/05). See Code 61 below.<br>04 Discharged/transferred to an Intermediate Care Facility (ICF)<br>05 Discharged/transferred to another type of institution not defined elsewhere in this code list (effective 2/23/05).<br>**Code Structure**<br>Usage Note: Cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such other types of institutions.<br>06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skills care (effective 2/23/05).<br>07 Left against medical advice or discontinued care<br>08 Reserved for National Assignment<br>20 Expired (or did not recover - Religious Non Medical Health Care Patient)<br>30 Still patient or expected to return for outpatient services<br>40 Expired at home (Hospice claims only)<br>41 Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice (Hospice claims only)<br>42 Expired - place unknown (Hospice claims only)<br>43 Discharged/transferred to a federal health care facility. (effective 10/1/03)<br>Usage note: Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration (VA) hospital or VA hospital or a VA nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.<br>50 Discharged/transferred to Hospice - home<br>51 Discharged/transferred to Hospice - | [Reference source: UB-04 Codes]<br><br>Code numbers correspond to UB-04 codes for discharge. If there is a discrepancy between what the abstractor believes is correct from the record and what is on the UB-04, the abstractor should override the UB-04 code.<br><br>This information is usually listed in the medical record discharge summary, discharge instruction sheet, nurses progress notes, physician order sheets, physician progress notes, face sheet, nursing discharge notes, social service note, transfer record, or in the administrative Data: UB-04 Field Location 17.<br><br>"Did not recover" is specific to the Christian Science religion. They use this term rather than referring to death. "41" refers to hospice patients that die in a hospital. Non-hospice patients who die should be coded as "20".<br><br>Example1: Patient 019 was admitted to your institution for new onset stroke symptoms from a local shelter. The patient had partial resolution of symptoms leaving only minor neurologic deficits. The patient was scheduled to be discharged to a shelter on Friday, December 21, 2004 (12/21/2004) with a written care plan for home care services; however, patient left the unit prior to discharge and did not return. Check the box for left AMA (07). If the patient had been d/c to shelter with home health, data entry would be to select |

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| | | | | medical facility<br>61 Discharged/transferred within this institution to a hospital based Medicare approved swing bed.<br>62 Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital<br>63 Discharged/transferred to long term care hospitals<br>64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare<br>65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.<br>66 Discharged/transferred to a Critical Access Hospital (CAH). (effective 1/1/06)<br>70 Discharged to another healthcare unit not defined elsewhere in this code list | "06 - Discharged/transferred to home under organized home care".<br><br>[Reference source: UB-04 Codes]. CDC does not create these codes, nor does CDC have control over their language. |
| **12.6** | Core<br><AmbStatD> | Ambulation status at Discharge | Numeric # 1-digit | 1 – Able to ambulate independently w/or w/o device<br>2 – With assistance (from person)<br>3 – Unable to ambulate<br>9 –not documented | Ambulatory:<br>• Patient ambulating without assistance (no help from another person)<br>• Patient ambulating throughout the day with assistance of another person or assistive device<br>• Patients ambulating to and from the bathroom<br>Non-ambulatory:<br>• Patient is on bed rest<br>• Patient is only getting out of bed to the bedside commode (or up in chair) and is primarily in the bed (or immobile)<br>If Item 12.5 = Code 20 or 41 and the patient expired during hospitalization, item 12.6 can be skipped. |

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| **12.7** | Core<br><MedHisSM> | Is there documented past medical history of Smoking – did the adult patient smoke at least one cigarette during the year prior to hospital arrival? | Numeric # 1-digit | 1 - Yes (If "No", then skip to 12.8)<br>0 - No/Not documented | Smoking history – patient has smoked at least one cigarette within the past year.<br>- In some cases, smoking history documentation in one medical record source may further clarify the patient's smoking history documented in another medical record source. Examples:<br>• Progress note states "history of smoking" and the nursing admission assessment notes "quit 2 years ago" – select "No."<br>• Discharge summary states smoker without specifying the type of tobacco and the ED record specifies the type of tobacco as cigar – select "No."<br>- In cases where conflicting information about the patient's smoking history is documented and there is no specific documentation that the patient has not smoked during the year prior to hospital arrival, select "Yes." Examples:<br>o "Current smoker" per H&P, but ED note states "Non-smoker" – select "Yes"<br>"Cigarette Smoking: Yes, 1-2 cigarettes a day" on nursing admission<br>"Cigarette Smoking: Yes, 1-2 cigarettes a day" on nursing admission note, but "Smoking – Quit" on H&P – select "Yes."<br>o "Recent smoker" in H&P, but progress note states "Smokes – No" – select "Yes."<br>- In cases where at least one source has specific documentation that the patient has not smoked anytime during the year prior to hospital arrival, select "No." Examples:<br>o "Current smoker" per H&P, but |
| | <SmkCesYN> | If past medical history of smoking is checked as yes, was the adult patient or their care giver given smoking cessation advice or counseling during the hospital stay? | Numeric # 1-digit | 1 – Yes<br>0 – No or not documented in the medical record<br>2 –NC A documented reason exists for not performing counseling. | |

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| | | | | | consultation note states patient "quit 2 years ago" – select "No."<br>o " + tobacco use" per ED note, "Smoker – Yes" per nursing admission note, but H&P states, "Quit smoking in 2002" – select "No."<br>o Progress note states "Still smokes occasionally" but nursing admission assessment has "No" circled next to "Tobacco use within past year" – select "No."<br>- If there is documentation of current smoking or tobacco use, or a history of smoking or tobacco use, and the type of product is not specified, assume this refers to cigarette smoking.<br>- Do not include documentation of smoking history referenced as a "risk factor" (e.g., "risk factor: tobacco," "risk factor: smoking," "risk factor: smoker"), where current smoking status is indeterminable.<br>- If there is a history of smoking and documentation that the patient quit "several months ago," infer the patient smoked within one year prior to arrival, and select "Yes."- If there is a history of smoking and documentation indicates the patient quit, but the timeframe in which the patient quit is not clear, select "No."<br>Examples:<br>- Nursing admission assessment documents patient as "ex-smoker" or "former smoker," or simply notes pt. "quit smoking" - select "No."<br>- "History of tobacco abuse" per H&P, and consultation note states "nonsmoker" - select "No" (not a case of conflicting information). |

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| | | | | | Examples of '**Yes** to adult smoking history:<br>• + smoker, type of product not identified<br>• + tobacco use, type of product not identified<br>• History of cigarette use without mention of a time frame, if no indication that patient quit<br>• History of smoking (type of product not identified), without mention of a time frame, if no indication that patient quit<br>• History of smoking and documentation that the patient quit "several months ago"<br>• History of smoking within one year prior to arrival, type of product not identified<br>• History of tobacco use (type of product not identified), without mention of a time frame, if no indication that patient quit<br>• History of tobacco use or indication that patient quit within one year<br>• History of smoking and documentation that the patient quit "several months ago"<br>• History of smoking within one year prior to arrival, type of product not identified<br>• History of tobacco use (type of product not identified), without mention of a time frame, if no indication that patient quit<br>• History of tobacco use within one year prior to arrival, type of product not identified |

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| | | | | | • Recent smoker<br>Examples of 'No' to cigarette smoking history:<br>• Chewing tobacco use only<br>• Cigar smoking only<br>• Cigarette smoking within one year prior to arrival or any of the other inclusion terms described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect or suspicious<br>• Illegal drug use only (e.g., marijuana)<br>• Oral tobacco use only<br>• Pipe smoking only<br>• Remote smoker (smoked in the past, but greater than one year ago)<br><br>For patients who have smoked at least one cigarette within the past year (TJC), code to indicate that patient received counseling to stop smoking or smoking cessation advice during the hospitalization as documented in progress notes or physician orders at discharge or admissions. It does not meet criteria of "Yes" to simply advise the patient that smoking is bad for their health.<br><br>Smoking cessation therapies such as patch, gum, etc, are also equivalent to counseling.<br><br>If the patient refused smoking cessation advice or counseling during this hospital stay, select "Yes"<br>-If the patient has a history of cigarette smoking within the year prior to arrival date but the patient does not currently |

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| | | | | | smoke, they should be advised to continue not smoking. For these patients, if this advice/counseling was not done, select "No".<br>If the patient is prescribed Wellbutrin (bupropion), it should not be assumed that this is a smoking cessation aid unless specifically noted as such. It is sometimes used as an antidepressant unrelated to smoking.<br><br>Acceptable forms of advice and counseling include:<br>- Direct discussion with patient or caregiver about stopping smoking (e.g., "advised patient to stop smoking")<br>- Prescription of smoking cessation aid (e.g., Habitrol, NicoDerm, Nicorette, Nicotrol, Prostep, Zyban) during hospital stay or at discharge<br>- Prescription of Wellbutrin/bupropion during hospital stay or at discharge aid or alternative FDA-approved smoking cessation medication if prescribed as smoking cessation<br>- Referral to smoking cessation class/program<br>- Smoking cessation brochures/handouts/video<br>**Any of the above interventions directed at the patient's caregiver if the patient is unable to comprehend**<br><br>Example: Patient 025 is admitted to the in-patient unit with right hemiparesis and dysarthria. His pre-admission medications were lisinopril, aspirin, metformin and furosemide. His metformin is held but all other medications are continued. He hasn't smoked |

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| | | | | | in 3 months, but was a pack a day smoker until then. The nursing notes document a discussion with the patient about the risks of smoking and its relationship to his stroke. He is given quit smoking pamphlet. He is discharged on day 5 on his original pre-admission medications and pravastatin plus a low-cholesterol diet. Data Entry will be to check "counseling".<br><br>This information is usually listed in the Admission notes, Consultation progress notes, Discharge summary, Nurses progress notes, Physician progress notes, Physical or Occupational therapy progress notes. |
| **12.8** | Core<br><MedHisDL><br><br><br><LipAdmYN><br><br><br><br><br><br><br><LipLDL><br><LipTotal><br><LipHDL><br><LipTri><br><Hb1AC> | Is there a medical history of Dyslipidemia?<br><br>Was patient on cholesterol reducing or cholesterol controlling medication prior to this hospitalization?<br><br>Record lipid levels done within 48 hours of admission or within 30 days prior to admission.<br>LDL \|__\|__\|__\| mg/dl<br>Total Cholesterol \|__\|__\|__\| mg/dl<br>HDL \|__\|__\|__\| mg/dl<br>Triglycerides \|__\|__\|__\|__\| mg/dl<br>Glycosylated Hb \|__\|__\|.\|__\| % | Numeric # 1-digit<br><br>Numeric # 1-digit<br><br><br><br><br><br>Numeric ### 3-digit<br>Numeric ### 3-digit<br>Numeric ### 3-digit<br>Numeric #### 4-digit | 1 - Yes<br>0 - No/Not documented<br><br>1 - Yes<br>0 - No/Not documented | Can be obtained from patient's medical history. The intent of the question is to identify patients with a documented history of hyperlipidemia. Dyslipidemia is taken to mean elevated cholesterol, high cholesterol, high triglycerides, etc.<br><br>If documentation in the medical record indicates that cholesterol-reducing therapy has been prescribed but patient has not filled the prescription or is otherwise noncompliant, answer "No" to this 'LipAdmYN'.<br><br>Example: Patient 025 is admitted to the in-patient unit with right hemiparesis and dysarthria. His pre-admission medications were lisinopril, aspirin, metformin and furosemide. His metformin is held but all other medications are continued. LDL is noted to be 180 and he has a recent non-q wave MI. He is discharged on day 5 on his original pre-admission medications and pravastatin plus a low-cholesterol diet. Data entry will be to check "No".<br>Determined from lab results in a patient's hospital record. |

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| | <LipDisYN> | Is there documentation that cholesterol-reducing or cholesterol controlling medication was prescribed at discharge?<br><br>If medication was prescribed, please answer which medication classes were prescribed: | Numeric # 1-digit | 1 – Yes<br>0 – No or Not Documented<br>2 – NC - Contraindicated | If there is more than one lipid profile, select the one performed closest to hospital admission date, which could be a fasting level reported within the preceding 30 days, or the first one drawn after admission, or drawn at initial evaluation.<br><br>Actual lipid values must be available in the medical record for this question to be answered.<br><br>Reasons must be documented by a physician, nurse practitioner or physician assistant. If reasons are not mentioned in the context of cholesterol reducing drugs, do not make inferences (e.g., do not assume that cholesterol reducing drugs are not being prescribed because of a particular condition unless documentation explicitly states so.)<br>Evidence in the medical record of a medication in the cholesterol lowering class at a given dosage and frequency of administration is adequate to answer "Yes" to this data element.<br><br>If LipDisYN is checked 'Yes', then you must answer <LipStatn>, and <LipOthRx>.<br><br>If documentation by a physician, nurse practitioner, or physician assistant is present in the chart that indicates that the stroke was not of an atherosclerotic origin or that the patient does not meet NCEP ATP III criteria for lipid lowering therapy, select "NC".<br><br>Example: Patient 025 is admitted to the in-patient unit with right hemiparesis and dysarthria. His pre-admission medications were lisinopril, aspirin, metformin and furosemide. His metformin is held but all other medications are continued. LDL is noted to be 180 and he has a recent non-q wave MI. He is discharged on day 5 on his original pre-admission medications and pravastatin plus a |
| | <LipStatn> | Statin | Numeric # 1-digit | 1 - Yes | |
| | <LipOthRx> | Other medication | Numeric # 1-digit | 0 - No/Not documented | |

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| | | | | | low-cholesterol diet. Data entry will be to select "Statin".<br>This information is usually listed in the Consultation progress notes, Discharge summary, Medication list or orders, Discharge orders, Nurses progress notes, Physician progress notes, Physical or Occupational therapy progress notes.<br><br>If patient/family refuses treatment, record this as 'NC'. |
| **12.9** | Core<br><MedHisHT><br><br><HBPAdmYN><br><br><HBPTreat> | Is there a documented past medical history of hypertension?<br><br>Was patient on antihypertensive medication prior to admission?<br><br>Is there documentation that antihypertensive medication was prescribed at discharge? | Numeric # 1-digit<br><br>Numeric # 1-digit<br><br>Numeric # 1-digit | 1 - Yes<br>0 - No/Not documented<br><br>1 - Yes<br>0 - No/Not documented<br><br>1 - Yes<br>0 - No/Not documented | Hypertension: Hypertension (HTN) is present if the patient has a history of high blood pressure whether or not the patient is on prescribed medications. Defined as systolic blood pressure greater than 140 and diastolic blood pressure greater than 90 in the non-acute setting on at least 2 occasions, current use of antihypertensive pharmacological therapy, history of HTN diagnosed and treated with medication, diet, and/or exercise. Do not base this decision solely on blood pressure recordings taken in the ED or in the first few days of admission after stroke, since many normotensive patients will have elevated BP after stroke.<br>Example 1: Patient 025 is admitted to the in-patient unit with right hemiparesis and dysarthria. His pre-admission medications were lisinopril, aspirin, metformin and furosemide. His metformin is held but all other medications are continued. Paroxysmal atrial fibrillation (PAF) is noted during admission but he returns to sinus rhythm spontaneously. He is discharged on day 5 on his original pre- |

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| | | | | | admission medications and the DASH diet. Data Entry will be to multi-select "Yes" for antihypertensive medication at discharge. Example 2: The notes for patient 019 document critical intracranial stenosis. At discharge his blood pressure is 100/60 and his lisinopril and furosemide were held with a plan to restart if BP increases. Data entry would be to select "None"<br>This information is usually listed in the stroke pathway documentation, Admission sheet, Diagnostic reports, Discharge summary, ED Nurses notes, ED Physician notes, Medication order sheets, Nurses progress notes, Physician order sheets, Physician progress |

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| **12.10** | Core<br><AthAdmYN> | Was patient taking antithrombotic medication prior to admission? | Numeric # = 1-digit | 1 -Yes<br>0 – No<br>9 – Not documented | Prior to admission: If documentation in the medical record indicates that antithrombotic medication has been prescribed but patient has not filled the prescription or is otherwise noncompliant, answer "No" to this 'AthAdmYN'.<br><br>Prescribed at discharge: Documentation that patient/caregiver was given prescription for antithrombotic therapy at time of hospital discharge.<br><br>**Only the following are considered acceptable antithrombotic therapy:**<br><br>▪ Aspirin (ASA)<br>▪ ASA/dipyridamole (Aggrenox) BID<br>▪ Warfarin (Coumadin)<br>▪ Clopidogrel (Plavix)<br>▪ Ticlopidine (Ticlid)<br>▪ Unfractionated heparin IV<br>▪ Full dose LMW heparin<br><br>If patient/family refuses treatment, record this as 'NC'.<br><br>Example: Patient 025 is admitted to the in-patient unit following treatment with thrombolytic therapy. He is discharged on day 5 with instructions to start aspirin in one week due to the risk of bleeding from his large stroke. Data Entry will be to check "None - contraindicated."<br><br>Reasons for not prescribing antithrombotic therapy must be documented by a physician, nurse practitioner or physician assistant. If reasons are not mentioned in the context |
| | <AthDscYN> | Was antithrombotic medication prescribed at discharge? | Numeric # = 1-digit | 1 -Yes<br>0 – No - None prescribed or not documented in the medical record<br>2 –NC – Documented reason for not administering exists in the record. | |

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| | | | | | of antithrombotics, do not make inferences (e.g., do not assume that antithrombotics are not being prescribed because of a bleeding disorder unless documentation explicitly states so.)<br><br>Acceptable reasons for not giving include:<br><br>• Risk of bleeding<br>• Allergy to or complication r/t aspirin, Ticlopidine, Clopidogrel, dipyridamole and Warfarin (hx or current)<br>• Patient receiving terminal or comfort care only<br><br>This information is usually listed in the Consultation progress notes, Discharge summary, Medication list or orders, Discharge orders, Nurses progress notes, Physician progress notes, Physical or Occupational therapy progress notes |

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| **12.11** | Core<br><MedHisAF><br><br><AFibYN><br><br><AFibRx> | Is there documentation in the patient's medical history of atrial fibrillation/flutter?<br><br>Was atrial fibrillation/flutter or paroxysmal atrial fibrillation (PAF), documented during this episode of care?<br><br>If a history of atrial fibrillation/flutter or PAF is documented in the medical history or if the patient experienced atrial fibrillation/flutter or PAF during this episode of care, was patient prescribed anticoagulation medication upon discharge?<br><br>▪ Warfarin (Coumadin)<br>▪ Full dose unfractionated heparin IV<br>▪ Full dose LMW heparin | Numeric # = 1-digit<br><br>Numeric # = 1-digit<br><br>Numeric # = 1-digit | 1 – Yes<br>0 – No / Not documented<br><br>1 – Yes<br>0 – No / Not documented<br><br>1 -Yes<br>0 – No / Not documented<br>2 –NC – Documented reason for not prescribing anticoagulation medication exists in the record | If <AFibRx> is answered 'Documented reason for not prescribing anticoagulation medication exists in the record', then one of the following should be documented in the medical record as the reason for not prescribing anticoagulation:<br><br>▪ Risk for bleeding or discontinued due to bleeding<br>▪ Risk for falls<br>▪ Mental status<br>▪ Patient refused<br>▪ Terminal Illness<br>▪ Patient refused<br>▪ Allergy<br>▪ Serious side effect to medication<br><br>Do not record a history of Atrial Fib/Flutter if the episode was transient and entirely reversible (due to thyrotoxicosis or within 8 weeks of CABG.<br><br>Any Atrial Fib/Flutter: The patient has any history of atrial fibrillation OR atrial flutter in the past or currently (i.e., remote, paroxysmal or persistent.)<br><br>Persistent Atrial Fibrillation/flutter documented during current admission, or history of paroxysmal atrial fibrillation (PAF). Atrial Fibrillation is irregular, disorganized electrical activity of the atria. P waves are absent and the electro-cardiographic baseline consists of irregular waveforms, which consistently change in shape, duration, amplitude, and direction. In the presence of advanced or complete AV block, the resulting ventricular response is irregular (random). |

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| | | | | | IF atrial fibrillation/flutter is described as remote or self-limited, or if there is only a history of a self-limited episode of documented atrial fibrillation or flutter that terminated within 8 weeks following CABG, then do not check that the patient has a history of atrial fibrillation.<br><br>Example 1: Patient 019 was admitted with the diagnosis of acute ischemic stroke and atrial fibrillation. The Attending neurologist has documented new onset atrial fibrillation in a consult to cardiology. The patient is discharged on Coumadin for non-valvular atrial fibrillation. Data entry will be to select “No” for the medical history and "Yes" for AF during this episode of care.<br>Example 2: Patient 020 was admitted with the diagnosis of acute ischemic stroke, a history of paroxysmal atrial fibrillation, but the EKG in the ED shows sinus rhythm. The Attending neurologist has documented paroxysmal atrial fibrillation as a possible cause of the stroke in a consult to cardiology. The patient is discharged on Coumadin for non-valvular paroxysmal atrial fibrillation. Data entry will be to select "Yes” for the medical history, and “No” for AF during this episode of care.<br>Example 3: Patient 021 was admitted with the diagnosis of acute ischemic stroke and a remote history of a brief period of self-limited atrial fibrillation after bypass surgery 6 years ago and negative Holter monitoring in the years since. The patient is in sinus rhythm and on no current |

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| | | | | | management for AF. There is no evidence of atrial fibrillation during the hospitalization. Data entry for medical history and this episode of care are both "No".<br><br>This information is usually listed in the stroke pathway documentation, Admission sheet, Diagnostic reports, Discharge summary, ED Nurses notes, ED Physician notes, Medication order sheets, Nurses progress notes, Physician order sheets, Physician progress, the Cardiology progress notes, consultation progress notes, Diagnostic reports, Discharge summary, Physician progress notes. For patients that have had Echocardiography, either Transeophageal Echo (TEE) or Transthoracic Echo (TTE), Cardiac Monitoring or Holter Monitoring, look for the diagnostic reports or physician/nursing documentation of the printed cardiac rhythm strips. |
| **12.12** | Core<br><br><EducRF><br><br><EducSSx><br><EducEMS><br><EducCC><br><EducMeds> | Was there documentation that the patient and/or caregiver received education and/or resource materials regarding all of the following:<br><br>▪ Personal modifiable risk factors for stroke<br>▪ Stroke Warning Signs and Symptoms<br>▪ How to activate EMS for stroke<br>▪ Need for follow-up after discharge<br>▪ Their prescribed medications | Numeric # 1-digit<br><br>Numeric # 1-digit<br>Numeric # 1-digit<br>Numeric # 1-digit<br>Numeric # 1-digit | 1 - Yes<br>0 – No/ Not documented<br>2 - NC | **DID THE PATIENT RECEIVE?**<br>1. Education regarding personal modifiable **risk factors** for stroke (hypertension, hyperlipidemia, overweight or obesity, cigarette smoking, physical inactivity, diabetes, atrial fibrillation, carotid artery stenosis, excessive alcohol consumption)?<br>2. Education on the **warning signs and symptoms** for stroke?<br>3. Education on how to activate **EMS** for signs/symptoms (sudden weakness, sudden dimness of vision, facial droop, sudden numbness or weakness of the face, |

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| | | | | | arm or leg, especially on one side of the body, sudden confusion, trouble speaking or understanding, sudden trouble seeing in one or both eyes, sudden trouble walking, dizziness, loss of balance or coordination, sudden, severe headache with no known cause)?<br>4. Education on the need for **follow-up** after discharge?<br>5. Education regarding their medications<br><br>Suggested Data sources: Medical record – flow sheets, clinician encounter notes, teaching sheets, consult notes (e.g., social work consult), care plans.<br><br>Hints to abstractors: Record documentation must reflect that the patient and/or caregiver have received education and/or resource materials. If the organization uses standardized written materials that contain the required components, i.e., etiology, risk factor modification, social service resources, then documentation of receipt of these tools is adequate.<br><br>The proportion of patients and/or caregivers that receive education specific to their type of stroke and their individual risk factors for secondary prevention of stroke, as well as education regarding their medications. Risk factors for secondary prevention of stroke are the following: hypertension, diabetes, hypercholesterolemia, alcohol consumption, obesity, and physical activity. Patients with hypertension should be counseled to lose weight, have a diet rich in fruits, vegetables, and low-fat dairy products, regular physical activity, limited alcohol consumption, and be discharged on antihypertensives. Patients with a history of diabetes should be advised to control hypertension and cholesterol, maintain a healthy diet, exercise regularly, and be discharged on oral hypoglycemic medication or insulin. Patients with hypercholesterolemia should be counseled to increase levels of physical activity, maintain a healthy diet, and discharged on a statin. Patients that can be classified as heavy drinkers (> 5 drinks/day), should be advised to reduce intake. Patients classified as obese (BMI >30 kg/m2), should be advised to lose weight in order to achieve a BMI of |

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| | | | | | 18.5 - 24.9 kg/m2 and a waist circumference of <35 (women) and <40 (men). Lastly, patients that are physically inactive should be advised to participate in 30 minutes of moderate-intensity physical exercise on most days of the week. Those with disabilities related or unrelated to the recent stroke should participate in a supervised therapeutic exercise regimen. [Source: Guidelines for Prevention of Stroke in Patients with ischemic stroke or transient ischemic attack: A statement for healthcare professionals for the AHA/ASA Council on Stroke:<br><br>Co-sponsored by the Council on Cardiovascular Radiology and Intervention: The American Academy of Neurology affirms the value of this guideline. Sacco et al., 2006. Stroke 2006;37;577-617].<br><br>The NC option should only be used for those circumstances where the patient is obtunded or otherwise not able to receive stroke education, and there are no family members or caregivers able to receive stroke education. This may occur in instances of undomiciled persons or those with no identifiable family/caregivers. |
| **12.13** | Core<br><br><RehaPlan> | Is there documentation in the record that the patient was assessed for or received rehabilitation services? | Numeric # 1-digit | 1 - Yes<br>0 – No/ Not documented | Answer "Yes" only if there is evidence that specific plans for rehabilitation were made, or if there is a reason for not needing rehabilitation and it is documented in the chart. A note stating "rehabilitation should be considered" does not qualify as "Yes" answer.<br><br>Suggested Data sources: Physician orders, progress notes, consultant reports, referral forms, clinical logs, multidisciplinary progress notes.<br><br>Examples of rehabilitation team members include: Physiatrist, Neuro-psychologist, Occupational Therapist, Physical Therapist, Nursing, Speech Therapist, Other |

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| | | | | | Acceptable indications in the chart that patient was assessed for or received rehabilitation services includes:<br>▪ Consult by rehabilitation services<br>▪ Assessment/treatment by members of the rehabilitation team<br>▪ Patient received rehabilitation services during hospitalization<br>▪ Patient transferred to rehabilitation facility<br>▪ Patient referred to rehabilitation services following discharge<br>▪ Specific documentation that patient was assessed and reasons patient ineligible to receive rehabilitation services (e.g., symptoms resolved or patient returned to prior level of function, poor prognosis, patient unable to tolerate rehabilitation therapeutic regimen)<br>▪ Patient/family refused rehabilitation services<br><br>Examples of members of a rehabilitation team may include:<br>o Physiatrist<br>o Neuro-psychologist<br>o Physical therapist<br>o Occupational therapist<br>Speech and language pathologist<br><br>The following **does not qualify** as a 'Yes" answer:<br>• Request for consultation for rehabilitation services that was not been performed |
| **12.14** | Core | *Please answer all of the following:* | | | Rehabilitation services include, but are not |

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| | <Rehrecei> | Did patient received rehabilitation services during hospitalization? | Numeric # = 1-digit | 1 - Yes<br>0 – No/ Not documented | limited to physical therapy, occupational therapy, and speech and language therapy. |
| | <Rehtrans> | Was patient transferred to rehabilitation facility? | Numeric # = 1-digit | 1 - Yes<br>0 – No/ Not documented | |
| | <Rehrefer> | Was patient referred to rehabilitation services following discharge? | Numeric # = 1-digit | 1 - Yes<br>0 – No/ Not documented | |
| | <Rehineli> | Was patient ineligible to receive rehabilitation services (e.g., symptoms resolved, poor prognosis, patient unable to tolerate rehabilitation therapeutic regimen)? | Numeric # = 1-digit | 1 - Yes<br>0 – No/ Not documented | |