

DSC Stroke Performance Measure Data Element Dictionary

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Data Element Name: *Admission Date*

Collected For: All Records

Definition: The month, day and year of admission for inpatient care

Suggested Data Collection Question: What is the date the patient was admitted to inpatient care?

Format: MM-DD-YYYY

Allowable Values: MM = Month (01 – 12)
DD = Day (01 - 31)
YYYY = Year (2000 – 9999)

Notes for Abstraction: The abstractor should NOT assume that the UB-04 claim information for the admission date is correct. If the abstractor determines through chart review that the UB-04 date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct admission date through chart review, she/he should default to the UB-04 admission date.

Suggested Data Sources: Emergency department record
Face sheet
History and physical
Nursing admission assessment
Physician orders
UB-04 (previously UB-92)

Guidelines for Abstraction:

Inclusion	Exclusion
None	Admit to observation Arrival date

Data Element Name: *Admitted for Elective Carotid Intervention*

Collected For: All Records

Definition: Documentation in the medical record that the current hospitalization is solely for the performance of an elective carotid intervention, (e.g., elective carotid endarterectomy, angioplasty, carotid stenting).

Suggested Data

Collection Question: Was this patient admitted for the sole purpose of performance of an elective carotid intervention?

Format: Alphanumeric

Allowable Values: Y (Yes, this patient was admitted solely for the performance of elective carotid intervention)
N (No, this patient was not admitted solely for the performance of elective carotid intervention OR unable to determine from medical record documentation)

Notes for Abstraction: Patients suffering from an acute stroke during this hospitalization are not considered to have been admitted solely for the purpose of the performance of elective carotid intervention. If the patient was being treated for an acute stroke during this hospitalization, even if a carotid intervention was performed, answer “No” for this data element.

Suggested Data Sources:

- History and physical
- OR report
- Progress notes
- Nurses notes

Guidelines for Abstraction:

Inclusion	Exclusion
Patients with an ICD-9-CM procedure code of 38.12, if medical record documentation states that the patient was admitted for the elective performance of this procedure. Patients with an ICD-9-CM procedure code of 00.63, if medical record documentation states that the patient was admitted for the elective performance of this procedure.	Patients with an ICD-9-CM procedure code of 38.12, if medical record documentation indicates that the patient is also being treated for an acute stroke during this hospitalization. Patients with an ICD-9-CM procedure code of 00.63, if medical record documentation indicates that the patient is also being treated for an acute stroke during this hospitalization.

Data Element Name:	<i>Adult Smoking Counseling</i>
Collected For:	DSC/Stroke-09: Smoking Cessation/ Advice/ Counseling
Definition:	Documentation in the medical record that smoking cessation advice or counseling was given to the patient or caregiver during this hospital stay for patients 18 years of age and older.
Suggested Data Collection Question:	Was the adult patient or caregiver given smoking cessation advice or counseling during the hospital stay?
Format:	Alphanumeric
Allowable Values:	Y (Yes, patient received smoking cessation advice/counseling during hospital stay) N (No, smoking cessation advice/counseling was not given OR unable to determine from medical record documentation) NC (No, smoking cessation advice/counseling was not given. A documented reason exists for not performing counseling)
Notes for Abstraction:	<ul style="list-style-type: none"> - If the patient refused smoking cessation advice or counseling during this hospital stay, select “Y” - If the patient has a history of cigarette smoking within the year prior to arrival date but the patient does not currently smoke, he or she should be advised to continue not smoking. For these patients, if this advice/counseling was not done, select “N”. - 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.
Suggested Data Sources:	Consultation notes Discharge instruction sheet Discharge summary Emergency department record History and physical Medication administration record Nursing notes Progress notes Respiratory therapy notes Teaching sheet
	Excluded Data Sources: Any documentation dated/timed after discharge, except discharge summary and operative/procedure/diagnosis test reports (from procedure done during hospital stay).

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Cigarette smoking cessation advice/counseling</p> <ul style="list-style-type: none"> - Direct discussion with patient or caregiver about stopping smoking (e.g., “advised patient to stop smoking”) - Prescription of smoking cessation aid (e.g., Habitrol, NicoDerm, Nicorette, Nicotrol, Prostep, Zyban) during hospital stay or at discharge - Prescription of Wellbutrin/bupropion during hospital stay or at discharge aid or alternative FDA-approved smoking cessation medication if prescribed as smoking cessation - Referral to smoking cessation class/program - Smoking cessation brochures/handouts/video <p>Any of the above interventions directed at the patient’s caregiver if the patient is unable to comprehend qualify as smoking cessation counseling.</p>	

Data Element Name:	<i>Adult Smoking History</i>
Collected For:	DSC/Stroke-09: Smoking Cessation/ Advice/ Counseling
Definition:	Documentation that the adult patient has smoked cigarettes anytime during the year prior to hospital arrival. Adult is defined as 18 years of age or older.
Suggested Data Collection Question:	Did the adult patient smoke cigarettes anytime during the year prior to hospital arrival?
Format:	Alphanumeric
Allowable Values:	<p>Y (Yes, there is documentation that the adult patient smoked cigarettes anytime during the year prior to hospital arrival.)</p> <p>N (No, there is documentation that the adult patient did not smoke cigarettes anytime during the year prior to hospital arrival OR smoking history was not addressed OR unable to determine from medical record documentation.)</p> <p>NOTE: If the ICD-9-CM Other Diagnosis Code 305.1 exists, then default the allowable value to Y (Yes).</p>
Notes for Abstraction:	<p>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:</p> <p style="padding-left: 40px;">Progress note states "history of smoking" and the nursing admission assessment notes "quit 2 years ago" – select "No." Discharge summary states smoker without specifying the type of tobacco and the ED record specifies the type of tobacco as cigar – select "No."</p> <p>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:</p> <p style="padding-left: 40px;">"Current smoker" per H&P, but ED note states "Non-smoker" – select "Yes" "Cigarette Smoking: Yes, 1-2 cigarettes a day" on nursing admission note, but "Smoking – Quit" on H&P – select "Yes." "Recent smoker" in H&P, but progress note states "Smokes – No" – select "Yes."</p> <p>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:</p>

“Current smoker” per H&P, but consultation note states patient “quit 2 years ago” – select “No.”

“ + tobacco use” per ED note, “Smoker – Yes” per nursing admission note, but H&P states, “Quit smoking in 2002” – select “No.”

Progress note states “Still smokes occasionally” but nursing admission assessment has “No” circled next to “Tobacco use within past year” – select “No.”

- 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.

- 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.

- 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.”

Examples:

Nursing admission assessment documents patient as “ex-smoker” or “former smoker,” or simply notes pt. “quit smoking” - select “No.”

“History of tobacco abuse” per H&P, and consultation note states “nonsmoker” - select “No” (not a case of conflicting information).

- Suggested Data Sources:** Consultation notes
 Discharge summary
 Emergency department record
 History and physical
 Nursing admission assessment
 Progress notes
 Respiratory Therapy notes

Guidelines for Abstraction:

Inclusion	Exclusion
Cigarette smoking within one year prior to hospital arrival + smoker, type of product not identified + tobacco use, type of product not identified History of cigarette use without mention of a time frame, if no indication that patient	Cigarette smoking within one year prior to hospital arrival Chewing tobacco use only Cigar smoking only Cigarette smoking within one year prior to arrival or any of the other inclusion terms described using one of the following

<p>History of smoking (type of product not identified), without mention of a time frame, if no indication that patient quit</p> <p>History of smoking and documentation that the patient quit “several months ago”</p> <p>History of smoking within one year prior to arrival, type of product not identified</p> <p>History of tobacco use (type of product not identified), without mention of a time frame, if no indication that patient quit</p> <p>History of tobacco use within one year prior to arrival, type of product not identified</p> <p>Recent smoker</p>	<p>Illegal drug use only (e.g., marijuana)</p> <p>Oral tobacco use only</p> <p>Pipe smoking only</p> <p>Remote smoker (smoked in the past, but greater than one year ago)</p>
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Data Element Name: *Antithrombotic Therapy Administered by End of Hospital Day Two*

Collected For: DSC/Stroke-05: Antithrombotic Therapy Administered by End of Hospital Day Two

Definition: Documentation demonstrates that antithrombotic therapy was administered by the end of hospital day two

Suggested Data Collection Question: Was antithrombotic therapy administered by the end of hospital day two?

Format: Alphanumeric

Allowable Values: Y (Yes, antithrombotic therapy was administered by the end of hospital day 2)
N (No, antithrombotic therapy was not administered by the end of hospital day 2 OR unable to determine from medical record documentation)
NC (No, antithrombotic therapy was not administered. A documented reason exists for not administering this therapy)

Notes for Abstraction: Antithrombotic Therapy:
Aspirin (ASA)
ASA/dipyridamole (Aggrenox) (bid)
warfarin (Coumadin)
clopidogrel (Plavix)
ticlopidine (Ticlid)
Unfractionated heparin IV
Full dose LMW heparin

To compute end of hospital day two, count the arrival date as 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 at the hospital on Monday at 05:00, answer "Yes" if antithrombotic therapy was administered on or before 23:59 on Tuesday. If patient arrived at the hospital at 23:30 on Monday, answer "Yes" if antithrombotic therapy was administered on or before 23:59 on Tuesday.

Reasons for not prescribing antithrombotic therapy must be documented by a physician, advanced practice nurse or physician assistant (physician/APN/PA). If reasons are not mentioned in the context 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.)

Conditions or factors making the administration of antithrombotic therapy inadvisable, inappropriate and/or undesirable are documented (appropriate response is “NC”, a documented reason exists for not administering this therapy). This may include:

- Allergy to or complication r/t antithrombotic (hx/current)
- Aortic dissection (current)
- Bleeding disorder
- Brain/CNS cancer (hx/current)
- CVA, hemorrhagic (hx/current)
- Extensive/metastatic CA (hx/current)
- Hemorrhage, any type (hx/current)
- Intracranial surgery/biopsy (current)
- Patient refusal
- Peptic ulcer (current)
- Planned surgery within 7 days following discharge
- Risk of bleeding (current)
- Unrepaired intracranial aneurysm (hx/current)
- Other (patient/physician)

Suggested Data Sources: Medication records
 Physician orders
 Clinical logs
 Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
	Patients who are prescribed only low doses (5000 units subQ bid) of heparin or equivalent doses for DVT prophylaxis using LMWH.

Data Element Name:	<i>Antithrombotic Therapy Prescribed at Discharge</i>
Collected For:	DSC/Stroke-02: Discharged on Antithrombotic Therapy
Definition:	Documentation demonstrates that antithrombotic therapy was prescribed at discharge
Suggested Data Collection Question:	Was antithrombotic therapy prescribed at discharge?
Format:	Alphanumeric
Allowable Values:	Y (Yes, antithrombotic therapy was prescribed at discharge) N (No, antithrombotic therapy was not prescribed at discharge OR unable to determine from medical record documentation) NC (No, antithrombotic therapy was not prescribed at discharge. A documented reason exists for not administering this therapy)
Notes for Abstraction:	<p>Antithrombotic Therapy: Aspirin (ASA) ASA/dipyridamole (Aggrenox) (bid) warfarin (Coumadin) clopidogrel (Plavix) ticlopidine (Ticlid) Unfractionated heparin IV Full dose LMW heparin</p> <p>Prescribed at discharge: Documentation that patient/caregiver was given a prescription for antithrombotic therapy at time of hospital discharge.</p> <p>Reasons for not prescribing antithrombotic therapy must be documented by a physician, advanced practice nurse or physician assistant (physician/APN/PA). If reasons are not mentioned in the context 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.)</p> <p>Conditions or factors making the administration of antithrombotic therapy inadvisable, inappropriate and/or undesirable are documented (appropriate response is "NC", documented reason for not prescribing antithrombotic) This may include: Allergy to or complication r/t antithrombotic (hx/current) Aortic dissection (current) Bleeding disorder Brain/CNS cancer (hx/current) CVA, hemorrhagic (hx/current)</p>

Extensive/metastatic CA (hx/current)
 Hemorrhage, any type (hx/current)
 Intracranial surgery/biopsy (current)
 Patient refusal
 Peptic ulcer (current)
 Planned surgery within 7 days following discharge
 Risk of bleeding (current)
 Unrepaired intracranial aneurysm (hx/current)
 Other (patient/physician)

Suggested Data Sources: Medication records
 Physician orders
 Clinical logs
 Progress notes
 Discharge summary
 Discharge instructions

Guidelines for Abstraction:

Inclusion	Exclusion
	Patients who are discharged only on low doses (5000 units subQ bid) of heparin or equivalent doses for DVT prophylaxis using LMWH.

Data Element Name: *Arrival Date*

Collected For: All records

Definition: The earliest documented month, day, and year the patient arrived at the hospital (for example hospital, emergency room, observation unit)

Suggested Data Collection Question: What was the **earliest** documented date the patient arrived at the hospital?

Format: MM-DD-YYYY

Allowable Values: MM = Month (01 – 12)
DD = Day (01 - 31)
YYYY = Year (2000 – 9999)

Notes for Abstraction: This may differ from the admission date. 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.

- *Do not use ambulance records to determine arrival date
- * Do not use addressographs/stamps
- * If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy, or an outpatient procedure) and is subsequently admitted to the hospital, use the date the patient presents to the ED or arrives on the floor for inpatient care as arrival date/time.

Suggested Data Sources:

- Any ED documentation (includes ED vital sign record, ED/Outpatient Registration form or triage record)
- Face sheet
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

Guidelines for Abstraction:

Inclusion	Exclusion
	Addressographs/stamps

Data Element Name: *Arrival Time*

Collected For: All records

Definition: The earliest documented time (military time) the patient arrived at the Emergency Department

Suggested Data

Collection Question: What was the **earliest** documented time (military time) the patient arrived at the hospital?

Format: HH:MM

Allowable Values: HH = Hour (00-23)
MM = Minutes (00-59)

Converting clock time to military time:
With the exception of midnight and noon
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour
For example:
Midnight – 00:00
Noon – 12:00
11:59 p.m. – 23:59

Notes for Abstraction:

- 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.
- 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.
- For “Direct Admits” to the hospital, use the earliest time the patient arrives at the hospital.

Suggested Data Sources:

- Any ED documentation
- Face sheet
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record

Guidelines for Abstraction:

Inclusion	Exclusion
	Addressographs/stamps

Data Element Name: *Assessed for Rehabilitation Services*

Collected For: DSC/Stroke-10: Assessed for Rehabilitation

Definition: There is documentation in the record that the patient was assessed for or received rehabilitation services.

Suggested Data Collection Question: Was the patient assessed for and/or did the patient receive rehabilitation services?

Format: Alphanumeric

Allowable Values: Y (Yes, patient was assessed for or received rehabilitation services)
N (No, patient was not assessed for or received rehabilitation services, OR unable to determine from medical record documentation)

Notes for Abstraction: Documentation in the medical record must address rehabilitation services. Examples of this may include items noted in the Guidelines for Abstraction below.

- Suggested Data Sources:**
- Physician orders
 - Progress notes
 - Consultant reports
 - Referral forms
 - Rehabilitation records
 - Clinical logs

Guidelines for Abstraction:

Inclusion	Exclusion
<ul style="list-style-type: none">▪ Consult by rehabilitation services▪ Assessment/treatment by members of the rehabilitation team▪ Patient received rehabilitation services during hospitalization▪ Patient transferred to rehabilitation facility▪ Patient referred to rehabilitation services following discharge▪ Specific documentation that patient was assessed and reasons patient ineligible to receive rehabilitation services (e.g., symptoms resolved, patient returned to prior level of function, poor prognosis, patient unable to tolerate rehabilitation therapeutic regimen)▪ Patient/family refused rehabilitation services	Request for consultation for rehabilitation services that was not performed

<p>Examples of members of a rehabilitation team may include but are not limited to:</p>	
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- Psychiatrist
- Neuro-psychologist
- Physical therapist
- Occupational therapist
- Speech and language pathologist

Data Element Name: *Atrial Fibrillation/Flutter*

Collected For: DSC/Stroke-03: Patients with Atrial Fibrillation/Flutter Receiving Anticoagulation Therapy

Definition: The patient has a history of any atrial fibrillation (i.e., remote, persistent, or paroxysmal), or atrial flutter in the past or currently as documented in the medical record,
 OR
 atrial fibrillation/flutter or paroxysmal atrial fibrillation (PAF) is present during this admission as evidenced by EKG
 OR
 by “Other” ICD-9-CM code of 427.31 or 427.32

Suggested Data Collection Question: Does documentation in the medical record indicate that atrial fibrillation/flutter or a history of atrial fibrillation/flutter was present?

Format: Alphanumeric

Allowable Values: Y (Yes) Atrial fibrillation or history of atrial fibrillation/flutter was present
 N (No) No, atrial fibrillation/flutter or history of atrial fibrillation/flutter was not present, or unable to determine from medical record documentation)

Notes for Abstraction: Any one of the conditions described in the definition statement can be present for the patient to meet this data element.

Patients who have a history of self-limited episode of documented atrial fibrillation or flutter that terminated within 8 weeks following CABG would not meet this data element.

Patients who have a transient and entirely reversible episode of atrial fibrillation or flutter due to thyrotoxicosis would not meet this data element.

- Suggested Data Sources:**
- EKG report
 - History and physical
 - Progress notes
 - Holter monitor report

Guidelines for Abstraction:

Inclusion	Exclusion
Persistent atrial fibrillation Paroxysmal atrial fibrillation	History of self-limited episode of documented atrial fibrillation or flutter that terminated within 8 weeks

<p>PAF History of any episode of documented atrial fibrillation or flutter lasting greater than 30 seconds except w/in 8 wks following CABG</p>	<p>History of transient and reversible episode of documented atrial fibrillation or flutter due to thyrotoxicosis Atrial fibrillation described as remote or self-limited</p>
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Data Element Name: *Birthdate*

Collected For: All records

Definition: The month, day, and year the patient was born.

Suggested Data Collection Question: What is the patient's day of birth?

Format: MM-DD-YYYY

Allowable Values: MM = Month (0-12)
DD = Day (01-31)
YYYY = Year (1880 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for all measures, the abstractor should NOT assume the UB-04 claim information for the birthdate is correct. If the abstractor determines through chart review that the UB-04 day is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birthdate through chart review, she/he should default to the UB-04 date of birth.

- Suggested Data Sources:**
- Emergency department record
 - Face sheet
 - Registration form
 - UB-04, (previously UB-92)

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name: *Case Identifier*

Collected For: All records

Definition: A number that uniquely identifies an episode of care. This identification number should be used in order to allow the health care organization to link this Case Identifier to a specific record for purposes of performance measurement.

Suggested Data Collection Question: What is the unique number that identifies this episode of care?

Format: Numeric

Allowable Values: Value greater than zero (0)

Notes for Abstraction: None

Suggested Data Sources:

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name: *Cholesterol Reducing Therapy Prior To Hospitalization*

Collected For: DSC Stroke-06: Discharged on Statin Medication

Definition: Documentation that a prescribed cholesterol reducing therapy was taken regularly prior to current hospitalization. Cholesterol reducing therapy works by blocking the action of an enzyme in the liver which is needed to make cholesterol, thereby decreasing the level of cholesterol circulating in the blood.

Suggested Data Collection Question: Was the patient on cholesterol reducing therapy prior to this hospitalization?

Format: Alphanumeric

Allowable Values: Y (Yes, Patient was on cholesterol lowering therapy prior to this hospitalization)

N (No, Patient was not on cholesterol lowering therapy prior to hospitalization or unable to determine from medical record documentation)

Notes for Abstraction: 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.

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 data element.

Suggested Data Sources:

- Admission notes
- History and physical
- Medication administration record
- Medication reconciliation records
- Nursing admission assessment
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendices, Table 3 for a comprehensive list of cholesterol reducing drugs.	None

Data Element Name:	<i>Comfort Measures Only</i>
Collected For:	All records
Definition:	Physician/advanced practice nurse/physician assistant (physician, APN, PA) 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, no heroic measure.
Suggested Data Collection Question:	Is there physician/advanced practice nurse/physician assistance documentation the patient was receiving comfort measures only?
Format:	
Allowable Values:	<p>Y (Yes) There is physician/advanced practice nurse/physician assistant documentation that the patient was receiving comfort measures anytime during the hospital stay.</p> <p>N (No) There is no documentation the patient was receiving comfort measures only or unable to determine from medical record documentation</p>
Notes for Abstraction:	<p>If the only mention of comfort measures or hospice is at discharge, select “No” for the answer.</p> <p>If DNR-CC is documented, select “No” unless there is documented clarification that CC stands for “comfort care”</p> <p>If any of the inclusions are documented select “Yes” regardless of other documentation.</p> <p>If “continue supportive care” is documented in the context of a patient’s age, chronic illness or terminal/grave prognosis, select “Yes”.</p> <p>If “comfort measures only” is documented by the end of hospital day two, select “Yes” for measures STK-1: DVT Prophylaxis and STK-5: Antithrombotic Therapy By End of Hospital Day Two. Documentation of comfort measures later than hospital day two = “No”.</p>

Suggested Data Sources: PHYSICIAN/ADVANCED PRACTICE NURSE/PHYSICIAN ASSISTANT DOCUMENTATION ONLY

- Admitting physician orders
- Consultation notes
- Emergency Department record
- History and physical
- Physician admitting note
- Physician orders
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Comfort measures only Comfort measures provided Hospice care Maintain treatment for comfort, terminal care Palliative care 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 Supportive care only</p>	<p>Chemical code only DNR Do not cardiovert Do not defibrillate Do not intubate (DNI) Living will NCR No antiarrhythmic therapy No artificial respirations No cardiac monitoring No chest compressions No code No code 99 No heroic or aggressive measures No intubation and/or ventilation No invasive procedures No other protocols associated with advanced cardiac life support No resuscitative medication No resuscitative measures (NRM) No vasopressors</p>

Data Element Name: *Date IV Thrombolytic Therapy Administered At This Hospital*

Collected For: DSC/Stroke-04: IV Thrombolytic Therapy Administered

Definition: The month, day, and year that IV thrombolytic therapy was initiated to a patient with ischemic stroke

Suggested Data Collection Question: What is the date that IV thrombolytic therapy was initiated for this patient at this hospital?

Format: MM-DD-YYYY

Allowable Values: MM = Month (01 – 12)
DD = Day (01 – 31)
YYYY = Year (2000 – 9999)

Notes for Abstraction: This data element applies only to patients for whom IV thrombolytic therapy was initiated at this hospital. Do not abstract this data element if IV thrombolytic therapy was initiated at another hospital and patient was subsequently transferred to this hospital.

IV t-PA is the only FDA-approved IV thrombolytic therapy.

Suggested Data Sources:

- Medication records
- Emergency department records
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name: *Date Last Known Well*

Collected For: Stroke-04: IV Thrombolytic Therapy Administered

Definition: The date at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her prior baseline.

Suggested Data

Collection Question: What was the date at which the patient was last known to be well or at his or her baseline?

Format: MM-DD-YYYY

Allowable Values: MM = Month (01 – 12)
DD = Day (01 – 31)
YYYY = Year (2000 – 9999)

Notes for Abstraction: For patients with a witnessed onset of symptoms, the date of last known well and the date of symptom discovery will be the same.

- Suggested Data Sources:**
- Emergency Department records
 - History and Physical
 - Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name: *Discharge Date*

Collected For: All records

Definition: The month, day and year the patient was discharged from acute care, left against medical advice, or expired during this stay.

Suggested Data Collection Question: What is the date the patient was discharged from acute care, left against medical advice (AMA) or expired?

Format: MM-DD-YYYY

Allowable Values:
MM = Month (01 – 12)
DD = Day (01 – 31)
YYYY = Year (2000 – 9999)

Notes for Abstraction: Because this data element is critical in determining the population for all measures, the abstractor should NOT assume the UB-04 claim information for 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 downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the UB-04 date.

- Suggested Data Sources:**
- Discharge summary
 - Face sheet
 - Nursing discharge notes
 - Physician orders
 - Progress notes
 - Transfer note
 - UB-04, (previously UB-92)

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Discharge Status</i>
Collected For:	All Records
Definition:	The place or setting to which the patient was discharged
Suggested Data Collection Question:	What was the patient's discharge disposition?
Format:	
Allowable Values:	<p>01 Discharged to home care or self care (routine discharge)</p> <p>02 Discharged/transferred to another short term general hospital for inpatient care</p> <p>03 Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification</p> <p>04 Discharged /transferred to an intermediate care facility</p> <p>05 Discharged/transferred to another type of health care institution (not defined elsewhere in this code list) for inpatient care. <u>Usage note</u>: Cancer hospitals excluded from PPS and children's hospitals are examples of such other types of health care institutions.</p> <p>06 Discharged/transferred to home under care of organized home health service organization</p> <p>07 Left against medical advice or discontinued care</p> <p>20 Expired</p> <p>43 Discharged/transferred to a federal health care facility <u>Usage note</u>: Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.</p> <p>50 Hospice – home</p> <p>51 Hospice – medical facility</p> <p>61 Discharged/transferred to hospital-based Medicare approved swing bed <u>Usage note</u>: Medicare-used for reporting patients discharged/transferred to a SNF level of care within a hospital's approved swing bed arrangement.</p> <p>62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital</p> <p>63 Discharge/transferred to a Medicare certified long term care hospital (LTCH)</p>

- 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- 66 Discharged/transferred to a Critical Access Hospital (CAH)
- 70 Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List (See Code 05)

Notes for Abstraction:

- The values for *Discharge Status* are taken from the National Uniform Billing Committee Manual (NUBC) manual which is used by the billing/HIM to complete the UB-04.
- Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that the UB-04 value is what is reflected in the medical record. For abstraction purposes, it is important that the medical record reflect the appropriate discharge status. If the abstractor determines through chart review that the UB-04 discharge status is not what is reflected in the medical record, she/he should correct and override the downloaded value.
- It would be appropriate to work with your billing office to develop processes that can be incorporated to improve medical record documentation to support the appropriate discharge status and to ensure consistency between the UB-04 discharge status and the medical record.

If state assigned codes are used, it is the organization's responsibility to ensure that one of the allowable values listed is used.

While there are additional UB-04 values for this data element, they are used for these measures at this time.

- Suggested Data Sources:**
- Discharge instruction sheet
 - Discharge summary
 - Face sheet
 - Nursing discharge notes
 - Physician orders
 - Progress notes
 - Social service notes
 - Transfer record
 - UB-04, (previously UB-92)

Guidelines for Abstraction:

Inclusion	Exclusion
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Data Element Name: *DVT Prophylaxis Initiated by End of Hospital Day 2*

Collected For: DSC/Stroke-01: Deep Vein Thrombosis (DVT) Prophylaxis

Definition: The administration of a defined DVT prophylaxis strategy was initiated by the end of hospital day 2.

Suggested Data Collection Question: Was DVT prophylaxis initiated by the end of hospital day 2?

Format: Alphanumeric

Allowable Values: Y (Yes, DVT prophylaxis was initiated by the end of hospital day 2)
 N (No, DVT prophylaxis was not initiated by the end of hospital day 2, OR unable to determine from medical record documentation)
 NC (No, DVT prophylaxis was not initiated by the end of hospital day 2. A documented reason for not administering DVT prophylaxis exists)

Notes for Abstraction:

To compute end of hospital day two, count the arrival date as hospital day one. If DVT prophylaxis was administered by 11:59 PM of hospital day two, answer “Yes” for this data element. E.g, Patient arrives Monday 05:00, DVT prophylaxis must be initiated before 23:59 on Tuesday; if patient arrives at 23:30 on Monday, DVT prophylaxis must be initiated by 23:59 on Tuesday.

Reasons for not prescribing DVT prophylaxis must be documented by a physician, advanced practice nurse or physician assistant (physician/APN/PA). If reasons are not mentioned in the context of DVT prophylaxis, do not make inferences.

If documentation indicates that patient/caregiver refused DVT prophylaxis, choose “NC”.

- Suggested Data Sources:**
- Medication records
 - Physician orders
 - Progress notes
 - Clinical logs
 - Flow charts.

Guidelines for Abstraction:

Inclusion	Exclusion
DVT Prophylaxis Low-dose, subcutaneous (sub-Q), unfractionated (“regular”) heparin	TED hose Compression socks

<p>Low Molecular Weight (LMW) heparin (enoxaparin, dalteparin, nadroparin) Alternative anticoagulants (danaparoid, hirudin, bivalirudin, other heparinoids) Intravenous heparin, IV heparin Pneumatic compression stockings, sequential compression devices, SCDs Already receiving anticoagulation, e.g., admitted on Coumadin and remains on Coumadin Warfarin (Coumadin) Warfarin Sodium Pneumoboots Venodynes</p>	
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Data Element Name:	<i>Dysphagia Screen</i>
Collected For:	DSC/Stroke-07: Dysphagia Screening
Definition:	Stroke patients should be screened for dysphagia before being given any oral intake including food, fluids, or medications.
Suggested Data Collection Question:	Was the patient screened for dysphagia before being given any oral intake, including food, fluids or medications?
Format:	Alphanumeric
Allowable Values:	<p>Y (Yes, patient was screened for dysphagia before being given any oral intake including food, fluids or medications by mouth)</p> <p>N (No, patient was not screened for dysphagia before being given any oral intake including food, fluids or medications by mouth, OR unable to determine from medical record documentation)</p> <p>NC (No, patient was not screened for dysphagia before being given any oral intake including food, fluids or medications by mouth. A documented reason exists for not performing this screen.)</p>
Notes for Abstraction:	<p>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. A screening test need not be a formal evaluation of swallowing by a speech and language pathologist, but should be a standardized method of swallowing assessment accepted by the institution.</p> <p>Reasons for not performing a dysphagia screen must be explicitly documented by a physician, advanced practice nurse, or physician assistant. If reasons are not mentioned in the context of dysphagia screening, do not make inferences unless documentation explicitly states so.</p> <p>If dysphagia screen was offered and documentation exists that the patient or caregiver refused, select "NC".</p>
Suggested Data Sources:	<ul style="list-style-type: none"> - Clinician notes - Referral/consult notes - Physician order sheet - Progress notes - Flow charts
Guidelines for Abstraction:	

Inclusion	Exclusion
<p>A variety of methods may be employed to assess swallowing status. These methods may include but are not limited to:</p> <ul style="list-style-type: none"> Bedside swallowing assessment Simple water swallow test Burke water swallow test Bedside swallowing assessment Simple standardized bedside swallowing assessment (SSA) Barium swallow Video fluoroscopy Double contrast esophagoscopy Radio nucleotide studies Manometry Endoscopy Formal evaluation by a speech and language pathologist 	<p>Patient evaluation using the NIH/NIHSS (National Institute of Health/National Institute of Health Stroke Scale) is NOT considered dysphagia screening</p> <p>Documentation of “gag reflex present” or “positive gag” or “cranial nerves intact” without explicit assessment of swallowing is NOT considered dysphagia screening</p>

Data Element Name:	<i>Education Addresses Activation of Emergency Medical System</i>
Collected For:	Stroke-08: Stroke Education
Definition:	The medical record should include documentation that patient and/or caregiver received written education and/or resource materials that address the need for activation of the emergency medical system (EMS) if signs or symptoms of stroke occur
Suggested Data Collection Question:	Did the patient or caregiver receive written educational materials regarding the need for activation of the emergency medical system (EMS) if signs or symptoms of stroke occur?
Format:	Alphanumeric
Allowable Values:	<p>Y (Yes) The patient or caregiver received written educational and/or resource materials regarding the need for activation of the emergency medical system (EMS) if signs or symptoms of stroke occur</p> <p>N (No) The patient or caregiver did not receive written education and/or resource materials regarding the need for activation of the emergency medical system (EMS) if signs or symptoms of stroke occur, OR unable to determine from medical record documentation</p> <p>NC (No, the patient or caregiver did not receive written education and/or resource materials regarding the need for activation of the emergency medical system (EMS) if signs or symptoms of stroke occur. The patient is unable to comprehend, and no caregiver is available.)</p>
Notes for Abstraction:	<p>Record documentation must reflect that the patient and/or caregiver received written education and/or electronic resource materials. If the organization uses standardized written materials that contain the required component, i.e., the need for activation of the emergency medical system (EMS) if signs or symptoms of stroke occur, then documentation of receipt of these tools is adequate.</p> <p>Electronically formatted media such as videos, CDs and DVDs are acceptable for educational materials. Documentation must clearly convey that (1) the need for activation of the emergency medical system (EMS) if signs or symptoms of stroke occur is included in the material, and (2) the patient was given a copy to take home.</p> <p>If there is documentation that the patient refused education and/or education materials which addressed the need for activation of the emergency medical system (EMS) if signs or symptoms of stroke occur, select "Y".</p>

The caregiver is defined as the patient's family or any other person (e.g., home health/VNA provider) who will be responsible for care of the patient after discharge.

- Suggested Data Sources:**
- Care plans/clinical pathways
 - Progress notes
 - Flow charts
 - Discharge instruction sheet
 - Discharge summary
 - Nursing discharge notes
 - Physical therapy notes
 - Teaching sheet
 - Education record

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name:	<i>Education Addresses Follow-up After Discharge</i>
Collected For:	Stroke-08: Stroke Education
Definition:	The medical record should include documentation that patient and/or caregiver received written education and/or resource materials that address the need for continuing medical care after discharge.
Suggested Data Collection Question:	Did the patient or caregiver receive written educational materials regarding follow-up after discharge?
Format:	Alphanumeric
Allowable Values:	Y (Yes) The patient or caregiver received written educational and/or resource materials regarding follow-up after discharge N (No) The patient or caregiver did not receive written education and/or resource materials regarding follow-up after discharge, OR unable to determine from medical record documentation NC (No, the patient or caregiver did not receive written education and/or resource materials regarding follow-up after discharge. The patient is unable to comprehend, and no caregiver is available.)
Notes for Abstraction:	<p>Record documentation must reflect that the patient and/or caregiver received written education and/or electronic resource materials. If the organization uses standardized written materials that contain the required component, i.e., follow-up after discharge, then documentation of receipt of these tools is adequate.</p> <p>Electronically formatted media such as videos, CDs and DVDs are acceptable for educational materials. Documentation must clearly convey that (1) follow-up after discharge is included in the material, and (2) the patient was given a copy to take home.</p> <p>If there is documentation that the patient refused education and/or education materials which addressed follow-up after discharge, select "Y".</p> <p>The caregiver is defined as the patient's family or any other person (e.g., home health/VNA provider) who will be responsible for care of the patient after discharge.</p>
Suggested Data Sources:	<ul style="list-style-type: none"> - Care plans/clinical pathways - Progress notes - Flow charts - Discharge instruction sheet - Discharge summary

- Nursing discharge notes
- Physical therapy notes
- Teaching sheet
- Education record

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name:	<i>Education Addresses Medications Prescribed At Discharge</i>
Collected For:	Stroke-08: Stroke Education
Definition:	The medical record should include documentation that patient and/or caregiver received education and/or resource materials that address medications prescribed at discharge.
Suggested Data Collection Question:	Did the patient or caregiver receive education and/or resource materials regarding medications prescribed at discharge?
Format:	Alphanumeric
Allowable Values:	Y (Yes) The patient or caregiver received education regarding medications prescribed at discharge N (No) The patient or caregiver did not receive education regarding medications prescribed at discharge, OR unable to determine from medical record documentation NC (No, the patient or caregiver did not receive written education and/or resource materials regarding medications prescribed at discharge. The patient is unable to comprehend, and no caregiver is available.)
Notes for Abstraction:	<p>Record documentation must reflect that the patient and/or caregiver received written education and/or electronic resource materials. If the organization uses standardized written materials that contain the required component, i.e., medications, then documentation of receipt of these tools is adequate.</p> <p>Electronically formatted media such as videos, CDs, and DVDs are acceptable for educational materials. Documentation must clearly convey that (1) medications are included in the material, and (2) the patient was given a copy to take home.</p> <p>If there is documentation that the patient refused education and/or education materials which addressed medications, select "Yes."</p> <p>The caregiver is defined as the patient's family or any other person (e.g., home health/VNA provider) who will be responsible for care of the patient after discharge.</p>
Suggested Data Sources:	<ul style="list-style-type: none"> - Care plans/clinical pathways - Progress notes - Flow charts - Discharge instruction sheet - Discharge summary - Nursing discharge notes - Physical therapy notes - Teaching sheet

- Education record

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name:	<i>Education Addresses Risk Factors for Stroke</i>
Collected For:	Stroke-08: Stroke Education
Definition:	The medical record should include documentation that patient and/or caregiver received education and/or resource materials that address relevant personal risk factors for stroke
Suggested Data Collection Question:	Did the patient or caregiver receive education regarding personal risk factors for stroke?
Format:	Alphanumeric
Allowable Values:	Y (Yes) The patient or caregiver received education regarding relevant personal risk factors for stroke N (No) The patient or caregiver did not receive education regarding relevant personal risk factors for stroke, OR unable to determine from medical record documentation NC (No, the patient or caregiver did not receive written education and/or resource materials regarding relevant personal risk factors for stroke. The patient is unable to comprehend, and no caregiver is available.)
Notes for Abstraction:	<p>Record documentation must reflect that the patient and/or caregiver received education and/or electronic resource materials. If the organization uses standardized written materials that contain the required component, i.e., personal risk factors for stroke, then documentation of receipt of these tools is adequate.</p> <p>Electronically formatted media such as videos, CDs, and DVDs are acceptable for educational materials. Documentation must clearly convey that (1) personal risk factors for stroke are included in the material, and (2) the patient was given a copy to take home. Referral to web-based materials or help-lines would qualify.</p> <p>If there is documentation that the patient refused education and/or educational materials which addressed the risk factors, select "Y".</p> <p>The caregiver is defined as the patient's family or any other person (e.g., home health/VNA provider) who will be responsible for care of the patient after discharge.</p>
Suggested Data Sources:	<ul style="list-style-type: none"> - Care plans/clinical pathways - Progress notes - Flow charts - Discharge instruction sheet - Discharge summary - Nursing discharge notes - Physical therapy notes

- Teaching sheet
- Education record

Guidelines for Abstraction:

Inclusion	Exclusion
Personal risk factors for stroke may include but are not limited to: <ul style="list-style-type: none"> High blood pressure Elevated cholesterol Diabetes Overweight (BMI \geq 25) Physical inactivity Excessive alcohol consumption Carotid artery stenosis Atrial fibrillation Smoking 	

Data Element Name: *Education Addresses Warning Signs and Symptoms of Stroke*

Collected For: Stroke-08: Stroke Education

Definition: The medical record should include documentation that patient and/or caregiver received education and/or resource materials that address the warning signs and symptoms of stroke.

Suggested Data

Collection Question: Did the patient or caregiver receive education and/or resource materials regarding the warning signs and symptoms of stroke?

Format: Alphanumeric

Allowable Values: Y (Yes) The patient or caregiver received education regarding the warning signs of stroke
N (No) The patient or caregiver did not receive education regarding the warning signs and symptoms of stroke OR unable to determine from medical record documentation
NC (No, the patient or caregiver did not receive written education and/or resource materials regarding the warning signs and symptoms of stroke occur. The patient is unable to comprehend, and no caregiver is available)

Notes for Abstraction: Record documentation must reflect that the patient and/or caregiver received education and/or electronic resource materials. If the organization uses standardized written materials that contain the required component, i.e., warning signs of stroke, then documentation of receipt of these tools is adequate.

Electronically formatted media such as videos, CDs, and DVDs are acceptable for educational materials. Documentation must clearly convey that (1) warning signs and symptoms are included in the material, and (2) the patient was given a copy to take home.

If there is documentation that the patient refused education and/or education materials which addressed warning signs and symptoms, select "Y".

The caregiver is defined as the patient's family or any other person (e.g., home health/VNA provider) who will be responsible for care of the patient after discharge.

Suggested Data Sources:

- Care plans/clinical pathways
- Progress notes
- Flow charts
- Discharge instruction sheet
- Discharge summary
- Nursing discharge notes
- Physical therapy notes

- Teaching sheet
- Education record

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Examples of stroke warning signs may include but are not limited to:</p> <ul style="list-style-type: none"> Sudden numbness or weakness of the face, 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 	

Data Element Name:	<i>Evidence of Atherosclerosis</i>
Collected For:	DSC Stroke-06: Discharged on Statin Medication
Definition:	Documentation is present in the medical record that the patient has an atherosclerotic condition.
Suggested Data Collection Question:	Is there documentation that the patient exhibited evidence of atherosclerosis?
Format:	Alphanumeric
Allowable Values:	Y (Yes, documentation indicates that the patient does exhibit evidence of atherosclerosis) N (No, documentation does not indicate that the patient exhibits evidence of atherosclerosis OR unable to determine from medical record documentation)
Notes for Abstraction:	<p>Randomized clinical trials (SPARCL and HPS) support the use of statins in patients with large artery atherosclerotic or small artery branch atherosclerotic (lacunar) stroke. There is no published evidence to recommend the routine use of statins in the treatment of stroke patients who do not have atherosclerosis and do not otherwise qualify for lipid lowering due to other conditions.</p> <p>If documentation exists that the patient has atherosclerosis, as evidenced by documentation of ANY of the conditions listed in the Inclusion table below, select “Y”.</p> <p>If documentation exists that the patient has one or more of the conditions listed in the Exclusion table below AND no other documentation of atherosclerosis (e.g., previous history or newly diagnosed evidence of atherosclerosis) is present in the medical record, select “N”.</p> <p>Documentation of ANY of the conditions listed in the Inclusion table along with one or more documented excluded conditions = “Y”, (e.g. carotid artery atherosclerosis and atrial fibrillation).</p>
Suggested Data Sources:	<ul style="list-style-type: none"> - Emergency Department record - History and physical - Progress notes - Consultation reports - Discharge summary - Face sheet - Transfer sheet

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Carotid stenosis or plaque Vertebral artery stenosis or plaque Intracranial atherosclerosis Small vessel disease Lacunar infarction Artery-to-artery embolism Aortic arch atheroma or plaque Coronary artery / coronary heart disease (CAD / CHD) Peripheral artery / peripheral vascular disease (PAD / PVD) Other documentation indicating the presence of atherosclerosis</p>	<p>Arterial dissection/ Fibromuscular dysplasia Hereditary or acquired hypercoagulability including Antiphospholipid Antibody Syndrome Atrial fibrillation without coronary artery disease Cardioembolism due to <ul style="list-style-type: none"> ○ Severe cardiomyopathy with low ejection fraction not due to coronary artery disease ○ Prosthetic heart valves or clinically significant mitral stenosis ○ Bacterial endocarditis ○ Paradoxical embolism due to intracardiac shunt (atrial septal defects, patent foramen ovale) Migraine Sickle cell anemia Vasculitis Vasospasm or vasoconstriction syndromes Moya-moya Strokes caused by trauma, a revascularization procedure, or subarachnoid hemorrhage</p>

Data Element Name: *Hispanic Ethnicity*

Collected For: All records

Definition: Documentation that the patient is of Hispanic ethnicity or Latino

Suggested Data Collection Question: Is the patient of Hispanic ethnicity or Latino?

Format: Alpha

Allowable Values: Y (Yes) Patient is of Hispanic ethnicity or Latino
N (No) Patient is not of Hispanic ethnicity or Latino OR unable to determine from medical record documentation

Notes for Abstraction: The data element *Race* is required in addition to this data element

Suggested Data Sources:

- Emergency Department record
- Face sheet
- History and physical
- Nursing admission assessment
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino"</p> <p>Examples:</p> <ul style="list-style-type: none"> Black-Hispanic Chicano "H" Hispanic Latin American Latino/Latina Mexican-American Spanish White-Hispanic 	None

Data Element Name: *ICD-9-CM Principal Diagnosis Code*

Collected For: All records

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis of stroke (see Tables 1 and 2 in Appendices)

Suggested Data

Collection Question: What was the ICD-9-CM code selected as the principal diagnosis for this record?

Format:

Allowable Values: Any valid ICD-9-CM diagnosis code

Notes for Abstraction: The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

Suggested Data Sources: Discharge summary
Face sheet
UB-04, (previously UB-92)

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendices for ICD-9-CM Code Tables	

Data Element Name: *IV Thrombolytic Therapy Administered*

Collected For: DSC/Stroke-04: IV Thrombolytic Therapy Administered

Definition: The patient received intravenous (IV) thrombolytic therapy at this hospital during this hospitalization.

Suggested Data Collection Question: Does documentation exist in the medical record stating that the patient received IV thrombolytic therapy at this hospital during the present hospitalization?

Format: Alphanumeric

Allowable Values:

Y	(Yes, IV thrombolytic was administered in this hospital during this hospitalization)
N	(No, IV thrombolytic was not administered in this hospital during this hospitalization, OR unable to determine from medical record documentation)
NC	(No, IV thrombolytic was not administered in this hospital during this hospitalization. A documented reason exists for not administering this therapy)

Notes for Abstraction: This data element applies only to patients for whom IV thrombolytic therapy was initiated at this hospital. Do not abstract this data element if IV thrombolytic therapy was initiated at another hospital and patient was subsequently transferred to this hospital.

Reasons for not administering IV thrombolytic therapy must be explicitly documented by a physician, advanced practice nurse or physician assistant (physician/APN/PA). Conditions or factors making the administration of IV thrombolytic inadvisable, inappropriate and/or undesirable are documented. Such conditions may include:

Contraindications

- IV or IA t-PA given at outside hospital
- Systolic blood pressure > 185 or diastolic blood pressure > 110 mm hg.
- Suspicion of subarachnoid hemorrhage
- CT findings (intracranial hemorrhage, subarachnoid hemorrhage, or major infarct signs)
- Seizure at onset
- Recent surgery/trauma (<15 days)
- Recent intracranial or spinal surgery, head trauma, or stroke (<3 mo.)
- History of intracranial hemorrhage or brain aneurysm or vascular malformation or brain tumor
- Active internal bleeding (<22 days)

- Platelets <100,000, PTT > 40 sec after heparin use, or PT > 15 or INR > 1.7, or unknown bleeding diathesis
- No IV access
- Care-team unable to determine eligibility
- Pt./Family refused

Warnings:

Conditions that might lead to increased risk of bleeding or unfavorable outcomes

- Advanced age
- Rapid improvement
- Stroke severity – Too mild
- Stroke severity – Too severe (e.g., NIHSS >22)
- Glucose < 50 or > 400 mg/dl
- Life expectancy < 1 year or severe co-morbid illness
- Left heart thrombus
- Patient currently receiving oral anticoagulants (e.g. Warfarin sodium, Coumadin)
- Diabetic hemorrhagic retinopathy or other ophthalmic bleeding
- Subacute bacterial endocarditis
- Acute pericarditis
- Pregnancy
- Septic thrombophlebitis or occluded AV cannula at seriously infected site
- Hemostatic defects including those secondary to severe renal or hepatic disease

If reasons are not mentioned in the context of thrombolytics, do not make inferences (e.g., do not assume that thrombolytics are not being administered due to recent intracranial surgery unless documentation explicitly states so.)

Currently, t-PA is the only FDA-approved IV thrombolytic.

Suggested Data Sources: Emergency room records
Medication records
Progress notes
Transfer forms

Guidelines for Abstraction:

Inclusion	Exclusion
IV t-PA Activase	Intra-arterial (IA) t-PA

Data Element Name: *LDL ≥ 100 mg/dL*

Collected For: DSC Stroke-06: Discharged on Statin Medication

Definition: The patient's LDL level was ≥ 100 mg/dL in the first 48 hours of hospitalization

Suggested Data Collection Question: Was the patient's highest LDL level ≥ 100 mg/dL in the first 48 hours of hospitalization or within the past 30 days?

Format: Alphanumeric

Allowable Values: Y (Yes, LDL ≥ 100 in the first 48 hours of hospitalization or in the past 30 days)
 N (No, LDL < 100 in the first 48 hours of hospitalization or in the past 30 days OR unable to determine from medical record documentation)

Notes for Abstraction: For this measurement, look for the highest level in the first 48 hours after admission or if available as a fasting sample within the past 1 month. The cholesterol levels drawn in the first 48 hours after admission do not have to be fasting values.

Total cholesterol measurement is not adequate to answer "Yes" to this data element. If only total cholesterol measurement is documented in the medical record, answer "N".

Suggested Data Sources: Laboratory reports
 Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name: *LDL Measured*

Collected For: DSC Stroke-06: Discharged on Statin Medication

Definition: Documentation of an LDL level measured within the first 48 hours of hospitalization or in the past 30 days is present in the medical record

Suggested Data Collection Question: Was the patient’s LDL level measured within the first 48 hours of hospitalization or in the past 30 days?

Format: Alphanumeric

Allowable Values: Y (Yes, LDL was measured within the first 48 hours of hospitalization or in the past 30 days)
N (No, LDL was not measured within the first 48 hours of hospitalization or in the past 30 days OR unable to determine from medical record documentation)

Notes for Abstraction: For this measurement, look for the highest level in the first 48 hours after admission or if available as a fasting sample within the past 30 days. The cholesterol levels drawn in the first 48 hours after admission do not have to be fasting values.

Total cholesterol measurement is not adequate to answer “Yes” to this data element. If only total cholesterol measurement is documented in the medical record, answer “N”.

Suggested Data Sources: Laboratory reports
Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name: *NPO (Nothing by Mouth) For Entire Hospital Stay*

Collected For: Stroke-07: Dysphagia Screening

Definition: There is documentation to demonstrate that the patient has had **NO** oral intake of food, fluid, or medications for the entire hospitalization.

Suggested Data Collection Question: Was the patient NPO throughout the entire hospital stay?

Format: Alphanumeric

Allowable Values: Y (Yes, the patient was NPO throughout the entire hospital stay.)
 N (No, the patient was not NPO throughout the entire hospital stay OR unable to determine from medical record documentation)

Notes for Abstraction: Answer "Yes" for this data element only if the patient was kept NPO during the entire hospitalization and was discharged/transferred/deceased NPO. This response should not be used in any other circumstances.

The delivery of food, fluid, or medication via a nasogastric tube, orogastric tube, or percutaneous gastrostomy tube should be independent of the assessment of NPO.

Suggested Data Sources:

- Progress notes
- Nurses notes
- Physician orders
- Dietitian notes
- Speech pathology notes
- Discharge summary

Guidelines for Abstraction:

Inclusion	Exclusion
NPO Nothing by mouth Nulle Per Os	

Data Element Name: *Patient Ambulatory at End of Hospital Day Two*

Collected For: DSC/Stroke-01: Deep Vein Thrombosis (DVT) Prophylaxis

Definition: Documentation in the medical record indicates that the patient was ambulatory by the end of hospital day two

Suggested Data Collection Question: Was the patient ambulatory at the end of hospital day two?

Format: Alphanumeric

Allowable Values: Y (Yes, the patient was ambulatory at the end of hospital day two)
N (No, the patient was not ambulatory at the end of hospital day two OR unable to determine from medical record documentation)

Notes for Abstraction:

Ambulatory:

- Patient ambulating without assistance (no help from another person)
- Patient ambulating throughout the day with assistance of another person or assistive device
- Patients ambulating to and from the bathroom throughout the day with or without assistance of another person or assistive device.

Non-ambulatory:

- Patient is on bed rest
- Patient is only transferred/getting out of bed to the bedside commode (or up in chair/bed chair) and is primarily in the bed (or immobile) on the 2nd hospital day

If unable to determine from documentation consider this patient non-ambulatory

To compute end of hospital day two, count the arrival date as hospital day one. If the patient was ambulating by 11:59 PM of hospital day two, answer “Yes” for this data element. E.g, Patient arrives Monday 05:00, patient must be ambulatory before 23:59 on Tuesday; if patient arrives at 23:30 on Monday, patient must be ambulatory by 23:59 on Tuesday

Suggested Data Sources:

- Progress notes
- History and physical
- Nursing assessment
- Nurses notes

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name: *Patient Discharged on Anticoagulation Therapy*

Collected For: Stroke-03 Patients with Atrial Fibrillation/Flutter Receiving Anticoagulation Therapy

Definition: Patient was prescribed anticoagulation therapy at time of hospital discharge

Suggested Data Collection Question: Does documentation indicate that the patient was discharged with a prescription for anticoagulation therapy?

Format: Alphanumeric

Allowable Values: Y (Yes, the patient was discharged on anticoagulation therapy)
 N (No, the patient was not discharged on anticoagulation therapy or unable to determine from medical record documentation)
 NC (No, anticoagulation therapy was not prescribed at discharge. A documented reason for not prescribing anticoagulation therapy exists)

Notes for Abstraction: Documentation that demonstrates that patient/caregiver was given prescription for anticoagulation therapy at time of hospital discharge.

Reasons for not prescribing anticoagulation therapy must be documented by a physician, advanced practice nurse or physician assistant (physician/APN/PA). If reasons are not mentioned in the context of anticoagulation therapy, do not make inferences.

If documentation indicates that patient/caregiver refused prescription for anticoagulation therapy at discharge, choose "NC".

Suggested Data Sources:

- Pharmacy/medication records
- Physician orders
- Clinical logs
- Discharge instructions

Guidelines for Abstraction:

Inclusion	Exclusion
Examples of anticoagulation therapy include: Warfarin/Coumadin Heparin/heparinoids Other anticoagulants, e.g., Lepirudin	Patients who are discharged only on low doses (5000 units subQ bid) of heparin or equivalent doses for DVT prophylaxis using LMWH

Data Element Name: *Patient Received IV/IA Thrombolytic Therapy*

Collected For: DSC/Stroke-5: Antithrombotic Therapy Administered by End of Hospital Day Two

Definition: There is documentation in the record that the patient received intravenous (IV) or intra-arterial (IA) thrombolytic therapy at your hospital or another transferring hospital

Suggested Data Collection Question: Did the patient receive IV/IA thrombolytic therapy?

Format: Alphanumeric

Allowable Values: Y (Yes, patient received IV or IA thrombolytic therapy)
N (No, patient did not receive IV or IA thrombolytic therapy, OR unable to determine from medical record documentation)

Notes for Abstraction: Documentation in the medical record must reflect that the patient received IV or IA thrombolytic therapy at your hospital or another transferring hospital (i.e., drip and ship). Examples of this may include items noted in the Guidelines for Abstraction below.

Suggested Data Sources:

- Emergency room records
- Medication records
- Progress notes
- Transfer forms

Guidelines for Abstraction:

Inclusion	Exclusion
IV t-PA Intra-arterial (IA) t-PA Activase	

Data Element Name:	<i>Point of Origin for Admission or Visit</i>
Collected For:	All records
Definition:	A code indicating the point of patient origin for this admission.
Suggested Data Collection Question:	What was the point of origin for this admission?
Format:	Length: 1 Type: Alphanumeric Occurs: 1
Allowable Values:	<p>1 Non-Health Care Facility Point of Origin The patient was admitted to this facility upon order of a physician. <u>Usage Note:</u> Includes patients coming from home, a physician's office, or workplace.</p> <p>2 Clinic The patient was admitted to this facility as a transfer from a freestanding or non-freestanding clinic.</p> <p>4 Transfer From a Hospital (Different Facility) The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient. <u>Usage Note:</u> Excludes Transfers from Hospital Inpatient in the Same Facility (See Code D).</p> <p>5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) The patient was admitted to this facility as a transfer from a SNF or ICF where he or she was a resident.</p> <p>6 Transfer from another Health Care Facility The patient was admitted to this facility as a transfer from another type of health care facility not defined elsewhere in this code list.</p> <p>7 Emergency Room The patient was admitted to this facility after receiving services in this facility's emergency room. <u>Usage Note:</u> Excludes patients who came to the emergency room from another health care facility.</p> <p>8 Court/Law Enforcement The patient was admitted to this facility upon the direction of court of law, or upon the request of a law enforcement agency. <u>Usage Note:</u> Includes transfers from incarceration facilities.</p>

9 Information not Available

The means by which the patient was admitted to this hospital is unknown.

D Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer

The patient was admitted to this facility as a transfer from hospital inpatient within this hospital resulting in a separate claim to the payer.

Usage Note: For purposes of this code, "Distinct Unit" is defined as a unique unit or level of care at the hospital requiring the issuance of a separate claim to the payer. Examples could include observation services, psychiatric units, rehabilitation units, a unit in a critical access hospital, or a swing bed located in an acute hospital.

E Transfer from Ambulatory Surgery Center

The patient was admitted to this facility as a transfer from an ambulatory surgery center.

F Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program

The patient was admitted to this facility as a transfer from hospice.

Notes for Abstraction:

(The abstractor should NOT assume that the UB-04 claim information for the admission date is correct. If the abstractor determines through chart review that the UB-04 date is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct admission date through chart review, she/he should default to the UB-04 admission date.

The intent of this data element is to focus on patients' place or point of origin rather than the source of a physician order or referral.

The point of origin is the direct source for the particular facility.

Example 1:

A SNF patient experiences sudden right-sided numbness and weakness of the extremities and is taken to the emergency department of Hospital A where it is determined that she is suffering an acute ischemic stroke. The patient is then transferred to Hospital B for admission as an inpatient. The Point of Origin for Hospital A would be 5 – Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF); the point of origin code for Hospital B would be 4 – Transfer from a Hospital.

Example 2:

An acute ischemic stroke patient was taken to the emergency department of Hospital A by EMTs, then transferred to Hospital B where he receives additional treatment in the ED, and then is admitted as an inpatient to Hospital B. The Point of Origin code for Hospital A is 7 – Emergency Room; the point of origin for Hospital B would be 4 – Transfer from a Hospital.

The emergency room code is limited to patients who receive unscheduled emergency services in the ED not originating from another health care facility. As in the example above, a patient brought to the ED would be coded as 7 since the patient was not previously at any other kind of health care facility. Code 7 also includes self-referrals in emergency situations that require immediate medical attention.

Usage Notes/Cases:

I. Transfers – From an Another Facility

Overall Scenario

While at another acute care hospital/facility, the patient is seen by the emergency room physicians. The patient is then transferred to our facility through the emergency room.

The Point of Origin code would be Code 4 – Transfer from a Hospital (Different Facility) due to the patient being seen at the other acute care facility's emergency room.

If the decision to admit was not made by the other facility's emergency room personnel and instead was made by our facilities emergency room doctor, the Point of Origin code would still be 4. Even though the decision to admit was not made by the other facility, the patient was still seen by the other facility's emergency room personnel and a decision to transfer was made by them.

The patient is seen by the other facility's emergency room physician; the patient arrives at our emergency room, but receives no additional emergency room care at our facility. Instead, the patient is transferred immediately to the Stroke Unit of our facility, the Point of Origin code would still be 4. Since the patient is seen by a different hospital's emergency room personnel, the decision to transfer the patient is first made by the other facility. The arrival of the patient at the receiving hospital's emergency room and subsequent transfer to the Stroke Unit is secondary to the transfer from the previous facility transfer.

II. Transfers – Skilled Nursing Facility

Overall Scenario

A resident from a skilled nursing facility is taken to an acute care hospital for medical care.

The Point of Origin code would be Code 5 – Transfer from a Skilled Nursing Facility.

The patient's family stopped by to pick-up the patient for a routine doctor's office visit (regularly scheduled); but while at the doctor's office the doctor sends the patient to the emergency room of the acute care hospital. The Point of Origin code would be 5 as the original Point of Origin is the skilled nursing facility. The

III. Transfer by Law Enforcement or Court

Overall scenario

A patient arrives at the health care facility accompanied by police.

The Point of Origin code would be Code 8 – Court/Law Enforcement as the patient is under the supervision of law enforcement.

If the patient was simply transported by law enforcement to our facility, the patient is neither under arrest nor serving any jail time, then the Point of Origin code would be 7 – Emergency Room.

Law enforcement is simply transporting the patient for emergency/urgent care treatment. The patient is not incarcerated (that is, neither under arrest nor serving any jail time).

Suggested Data Sources: Emergency department record
Face sheet
History and physical
Nursing admission notes
Progress notes
UB-04, Field Location: 15

Guidelines for Abstraction:

Inclusion	Exclusion
None	If the patient was transferred from an emergency department of another hospital, do not use "7". "7" is only for patients admitted upon recommendation of this facility's emergency department physician.

Data Element Name:	<i>Race</i>
Collected For:	All records
Definition:	Documentation of the patient's race
Suggested Data Collection Question:	What is the patient's race?
Format:	Alphanumeric
Allowable Values:	<ol style="list-style-type: none"> 1 White: Patient's race is White or the patient has origins in Europe, the Middle East or North Africa 2 Black: Patient's race is Black or African American 3 American Indian or Alaska Native: Patient's race is American Indian/Alaska Native. 4 Asian: Patient's race is Asian 5 Native Hawaiian or Pacific Islander: Patient race is Native Hawaiian/Pacific Islander 7 UTD: Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).
Notes for Abstraction:	<ul style="list-style-type: none"> - The data element <i>Hispanic Ethnicity</i> is required in addition to this data element - If documentation indicates the patient has more than one race (e.g., Black-White, Indian-White), select the first listed race. - Although the terms "Hispanic" and "Latino" are actually descriptions of the patient's ethnicity, it is not uncommon to find them referenced as race. If the patient's race is documented only as Hispanic/Latino, select "White". If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic – select "Black") Other terms for Hispanic/Latino include Chicano, Cuba, H (for Hispanic), Latin American, Latina, Mexican, Mexican-American, Puerto Rican, South or Central American, and Spanish
Suggested Data Sources:	<ul style="list-style-type: none"> - Emergency Department record - Face sheet - History and physical - Nursing admission assessment - Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion
<p>Black or African American A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black or African American”</p> <p>American Indian or Alaska Native 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).</p> <p>Asian A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.</p> <p>White A person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White).</p> <p>Native Hawaiian or Pacific Islander A person having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</p>	<p>None</p>

Data Element Name: *Report Period*

Collected For: All records

Definition: A quarter within the year

Suggested Data Collection Question: For what report period are these data reported?

Format: q-yyyy

Allowable Values:

- 1 (January – March)
- 2 (March – June)
- 3 (July – September)
- 4 (October – December)

YYYY = Year (2000 – 9999)

Notes for Abstraction: Inpatients are included in the quarter in which they were discharged.

Suggested Data Sources:

- Face sheet
- Discharge data

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name: Sex

Collected For: All records

Definition: The patient's sex

Suggested Data Collection Question: What is the patient's sex?

Format: Alphanumeric

Allowable Values: M = Male
F = Female
U = Unknown

Notes for Abstraction: None

- Suggested Data Sources:**
- Consultation notes
 - Emergency department record
 - Face sheet
 - History and physical
 - Nursing admission notes
 - Progress notes
 - UB-04, (previously UB-92)

Guidelines for Abstraction:

Inclusion	Exclusion
None	None

Data Element Name:	<i>Statin Medication Prescribed at Discharge</i>
Collected For:	DSC Stroke-06: Discharged on Statin Medication
Definition:	Documentation that statin medication was prescribed at discharge. Statins are a class of pharmaceutical agents that modify LDL cholesterol by blocking the action of an enzyme in the liver which is needed to synthesize cholesterol thereby decreasing the level of cholesterol circulating in the blood.
Suggested Data Collection Question:	Is there documentation that statin medication was prescribed at discharge?
Format:	Alphanumeric
Allowable Values:	Y (Yes, statin medication was prescribed at discharge) N (No, statin medication was not prescribed at discharge OR unable to determine from medical record documentation) NC (No, statin medication was not prescribed at discharge. A documented reason exists for not administering this therapy)
Notes for Abstraction:	<ul style="list-style-type: none"> - If the patient refused prescription for statin medication at discharge, select “NC”. - In determining whether statin medication was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list a drug that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor. - In cases where there is statin medication noted in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select “Yes”) unless documentation elsewhere in the medical records suggest that it was NOT prescribed at discharge – Consider it a discharge medication in the absence of contradictory documentation. - If documentation is contradictory (e.g., MD noted discontinuation of statin medication in the discharge medication orders, but it is listed in the discharge summary’s discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed “unable to determine” (select “No”). - When there is a documented plan to delay initiation/restarting of statin medication for a time period after discharge, select “No”. - Reasons for not prescribing statin medication at discharge must be explicitly documented by a physician, advanced practice nurse, or physician assistant (physician/APN/PA). If documentation by a physician, advanced practice nurse, or physician assistant is

present in the chart that indicates that the patient has no evidence of atherosclerosis, select "NC".

- Suggested Data Sources:**
- Discharge instruction sheet
 - Discharge summary
 - Nursing discharge notes
 - Physician orders sheet
 - Transfer sheet

Guidelines for Abstraction:

Inclusion	Exclusion
Refer to Appendices, Table 4 for a comprehensive list of statin medications.	None

Data Element Name: *Time IV Thrombolytic Therapy Administered at This Hospital*

Collected For: DSC/Stroke-04: IV Thrombolytic Therapy Administered

Definition: The time that IV thrombolytic therapy was initiated at the reporting hospital.

Suggested Data Collection Question: At what time was IV thrombolytic therapy administered at this hospital?

Format: HH:MM
Alphanumeric

Allowable Values: HH = Hour (00-23)
MM = Minutes (00-59)
ND = Time not documented or unknown

Converting clock time to military time:
With the exception of midnight and noon
- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour
For example:
Midnight – 00:00
Noon – 12:00
11:59 p.m. – 23:59

Notes for Abstraction: This data element applies only to patients for whom IV thrombolytic therapy was initiated at this hospital. Do not abstract this data element if IV thrombolytic therapy was initiated at another hospital and patient was subsequently transferred to this hospital.

Use the time at which the initiation of the medication was first documented

If a discrepancy exists in time documentation from different sources, choose the earliest time.

Suggested Data Sources: - Emergency Department record
- Medication administration record
- Progress notes

Guidelines for Abstraction:

Inclusion	Exclusion

Data Element Name:	<i>Time Last Known Well</i>
Collected For:	DSC/Stroke-04: IV Thrombolytic Therapy Administered
Definition:	The time at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her prior baseline.
Suggested Data Collection Question:	At what time was the patient last known to be well or at his or her prior baseline?
Format:	HH:MM Alphanumeric
Allowable Values:	<p>HH = Hour (00-23) MM = Minutes (00-59) ND = Time not documented or unknown at the time treatment decision was made</p> <p>Converting clock time to military time: With the exception of midnight and noon - If the time is in the a.m., conversion is not required - If the time is in the p.m., add 12 to the clock time hour For example: Midnight = 00:00 Noon = 12:00 11:59 p.m. = 23:59</p>
Notes for Abstraction:	<p>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 “onset time” should be treated as a “time of symptom discovery” rather than a time of last known well and “ND” should be selected for the time last known well.</p> <p>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.</p> <p>When the onset of symptoms is clearly witnessed, then the time last known well is identical to the time of symptom discovery.</p> <p>If the time 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.</p>

If the time 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.

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 last known well, use the time recorded according to the following hierarchy:

1. stroke team/neurology
2. admitting physician
3. emergency department physician
4. ED nursing notes
5. EMS

- Suggested Data Sources:**
- History and physical
 - Emergency department records
 - Progress notes
 - Transfer documents.

Guidelines for Abstraction:

Inclusion	Exclusion