

The New Jersey Acute Stroke Registry (NJASR), Version 1.0

Data Collection Manual

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GENERAL INFORMATION

This document contains definitions and specifications for the New Jersey Acute Stroke Registry (NJASR), Version 1.0, and the file layout for electronic data submission. The data elements and definitions closely match CDC's Paul Coverdell Stroke Data Registry.

NJASR is designed to collect data for outcomes based quality assessment of services provided by facilities in New Jersey. The registry will be an integral part of the Department of Health and Senior Services' cardiac services database system.

The Office of Health Care Quality Assessment staff is available to assist you with any questions on the data collection form. If you have any questions or comments please contact the Office of Health Care Quality Assessment at:

NJ Cardiac Catheterization Data Registry
Office of Health Care Quality Assessment
New Jersey Department of Health & Senior Services
P. O. Box 360
240 W. State Street, 11th Floor
Trenton, NJ 08625-0360

Phone: (609) 984-7334 Toll Free: 800-418-1397
Fax: (609) 984-7735

DATA SUBMISSION

Starting with the first Quarter, 2010 data submission, all hospitals designated as Primary or Comprehensive Stroke Centers are required to submit data specified in the NJASR (See Appendix VI) and following the format specified in Appendix V of this document. Data are to be submitted every quarter to the Department within forty five (45) days after the close of the quarter. **Please report data only for patients 18 years or older.** The data submission schedules are as follows:

| <u>Quarter</u> | <u>Months Included in Data Submission</u> | <u>Due Date</u> |
|----------------|---|-----------------|
| First | January – March | May 15 |
| Second | April - June | August 15 |
| Third | July - September | November 15 |
| Fourth | October - December | February 15 |

The data collection form provided in Appendix VI of this document is a guide for data collection and is not intended to be completed or submitted as a substitute to the electronic data file. Data may be collected using any vendor provided program, but must be submitted following the file format specified in Appendix V of this document. The Electronic data file may be submitted on a 3.5" diskette, on a CD or can be sent as an attachment to an e-mail through secure website. If you need to compress the data file, you may use the file compression program WINZIP in order for Department staff to access your file.

The preferred file format is comma delimited text file with text qualifier (“) and should include field names on the first row. Also, cumulative data must be submitted for the calendar year to minimize data handling. For example, the second quarter data submission must also contain first quarter data and the fourth quarter data submission must also contain data from the first three quarters. **Data submission in any other format will not be acceptable.**

If you are mailing the data on a diskette or a CD, please send by overnight mail to:

Stroke Registry Data Coordinator
Office of Health Care Quality Assessment
New Jersey Department of Health & Senior Services
240 W. State Street, 11th Floor
Trenton, NJ 08608

QUARTERLY ACTIVITY

Following each quarterly submission, the Department will run an error report. This program generates hospital specific reports showing data entry errors. Each hospital will be sent a quarterly report for verification and/or correction. **Hospitals will have ten (10) business days to respond to this error report by submitting a corrected file along with a signed letter or note certifying that the corrections identified in the error report are made.** Failure to submit corrected data may result in hospitals not meeting stroke designation requirements.

Quarterly summary tables showing key indicators will be sent to each hospital for review and verification.

ANNUAL ACTIVITY

In the spring of each year, an error report will be generated for the four quarters of data in the previous calendar year. A copy of the annual error report will be sent to the respective hospitals' data managers for final verification, correction and certification.

Hospitals will be given fifteen (15) business days to respond to this mailing. If a hospital's revised data are not received as requested, the Department will assume that there are no corrections to be made to the hospital's data.

In addition, the Department will perform an internal review of the data by matching records against the *Uniform Bill records* and the State Death Registry file to verify mortality status. If any discrepancies are identified, the Department will contact the hospital(s) for corrections and/or clarifications.

The only corrections accepted after the database closure will be those requested by the Department. Any exceptions to this policy must be submitted in writing to the Director, Office of Health Care Quality Assessment. Accompanying this request should be any medical record documentation (if applicable) which may be reviewed by the Department's Stroke Advisory Panel. It is at the Department's discretion to accept or reject any request for a change on records after the database is closed.

AUDIT

The Department will review the annual data submission to ensure that all requested corrections are made and frequencies of data elements are consistent with statewide frequencies. Inconsistent data elements will be reviewed further with the facility to ensure correct reporting of data. The state reserves the right to have a sample of the hospital data reviewed by an independent auditor to validate the accuracy of data reported. In the event of such external review, the hospital will be required to provide all relevant documents to the auditor, correct discrepancies in data reporting, and send the data within 20 business days after the audit is completed.

THE STROKE SERVICES REPORT

The Department uses the final data to produce the Stroke Services Report. This report will assess risk-adjusted outcome measures by hospital and by selected population groups. The risk-adjusted outcome estimates will result from rigorous statistical models which take into account risk-factors of patients as well as their socio-demographic characteristics.

| NJ Acute Stroke Registry | |
|---|---|
| Quarterly Activity | Annual Activity |
| Quarterly data submission due to the Department 45 days after close of quarter. | Run error report; produce summary frequency tables; verify cases through data matching. |
| Run error reports, distribute to hospitals. | Hospitals have 15 business days to respond to end of year error reports and other inconsistencies identified. |
| Hospitals respond to error report within 15 business days. | Database closed for analysis 90 days after end of year. |
| Quarterly summary tables produced 60 days following end of quarter. | Final data analysis performed. |
| | Stroke Services Report produced |

DATA DEFINITIONS AND SPECIFICATIONS

A. DEMOGRAPHIC DATA

1. Hospital Type [HOSPTYPE]

Indicate hospital licensing designation. If hospital is not a licensed designated Stroke Center select other.

- 1 = Primary
- 2 = Comprehensive
- 3 = Other

2. Hospital Code [HOSPNUM]

Indicate hospital code where stroke center services were provided. The assigned codes are consistent with Medicare provider numbers and are the same used in the UB-92 discharge form. (See Appendix I for complete list of hospital codes).

— — — —

3. Transferred from [TXFROM]

Enter the hospital code the patient transferred from the list provided in Appendix I. **Please note that the last digit refers to the hospital division code.** (See Appendix I for complete list of hospital codes). Enter 0000 if no transfer.

— — — —

4. Medical Record [MEDRECNO]

Indicate the patient's medical record number.

_____ (Medical Record #)

5. Patient's Last Name [LNAME]

_____ Last Name

6. Patient's First Name [FNAME]

_____ First Name

7. Patient's Middle Initial [MI]

____ Middle Initial

8. Patient Date of Birth [DOB]

Indicate the month, day, and year of the patient’s date of birth.

____/____/____
MM / DD / YYYY

9. Patient Social Security Number [SSNUM]

Indicate the patient’s social security number in the USA. For patients that have no social security number or are non-US residents, you may use 999-99-9999.

XXX – XX – XXXX (nine digits)

10. Patient Zip Code [ZIP]

Indicate the patient’s five digit zip code of residence. Use the hospital’s zip code if the patient is transient/homeless.

__ __ __ __ __ (5 digit zip code)

11. Gender [Sex]

Indicate the patient’s gender or sex. Gender/sex will be captured as it is written in the medical record – if there is conflict, document with the identified gender.

1 = Male
2 = Female

12. Race [RACE]

Enter the patient’s race as stated by the patient. If multiple races are provided by the patient, enter the race the patient identifies with the most. Select only one.

1 = White
2 = Black
3 = Asian (e.g., Indian, Pakistani, Chinese, Korean, ect.)
4 = Native American/Alaska Native
5 = Hawaiian/Other Pacific Islander
6 = Other

13. Hispanic or Latino [Hispanic]

This field refers to whether or not a patient identifies himself/herself as Hispanic or Latino. A person who answers white, black, Asian, etc. in the race category may answer yes for Hispanic or Latino origin.

0 = No (Not Hispanic or Latino)

1 = Yes (Hispanic or Latino)

14. Primary Payor [INSURER]

Indicate the primary insurer of the patient (See Appendix II for additional explanation of insurer classification).

- 1 = Blue Cross
- 2 = Commercial
- 3 = HMO
- 4 = Medicaid
- 5 = Medicare
- 6 = Self Pay
- 7 = Tricare (CHAMPUS)
- 8 = Uninsured/Indigent
- 9 = Other

B. PRE-HOSPITAL/EMERGENCY MEDICAL SYSTEM (EMS) DATA

15. Where was the patient when the stroke was detected or when symptoms were discovered? [PlcOccur]

In the case of a patient transferred to your hospital where they were an inpatient, ED patient, or nursing home/long-term care resident, from where was the patient transferred? 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. If the patient was resident of a nursing home, but was out with family for the day and suffered a stroke and the family/EMS brought patient to your hospital, choose 1. If the patient was a resident of a nursing home, long-term care facility, inpatient rehab facility and the stroke occurred at one of these facilities, and the patient came from one of these facilities to your hospital, choose 3.

- 1 = Not in healthcare setting
- 2 = Another acute care facility
- 3 = Chronic health care facility
- 4 = Stroke occurred while patient was an inpatient in your hospital
- 5 = Outpatient healthcare setting
- 9 = Cannot be determined

If Answer is 1, 2, 3 or 9 on Item #15:

16. How did the patient get to your hospital for treatment of their stroke? [ArrMode]

Choose Emergency Medical Services (EMS) whenever the patient was brought to your hospital by EMS, whether by ground EMS or Air EMS. “Other” includes private transportation (e.g., cab, bus, car, walk-in, etc.).

- 1 = EMS
- 2 = Private transportation/taxi/other
- 3 = Transferred from another hospital

9 = Not Documented or unknown

If patient arrived by EMS on Item # 16, then complete Items 17, 18 and 19.

17. Date call received by Emergency Medical System (EMS) [EMSRecD]

As recorded on the EMS trip sheet or other similar documentation.

____/____/_____
MM/DD/YYYY

18. Time call received by EMS [EMSRecT]

As recorded on the EMS trip sheet or other similar documentation. This should be on a 24-hour time or military time.

____ : ____
H H M M

Date and time that the call first was received by the EMS dispatcher OR the date and time of the EMS vehicle dispatch as recorded on the EMS trip sheet or other documentation. This data element is looking to capture the data and time that EMS was first called to the scene of the stroke (and not meant to capture those patients that are transferred between hospitals via EMS). This should be on a 24-hour time or military time.

19. Was there EMS pre-notification to your hospital? [EMSNote]

1 = Yes

0 = No

Whether EMS has notified the receiving hospital prior to arrival of a possible stroke patient. **Options include:** Yes: EMS notified the receiving hospital prior to arrival. No / Not Documented: EMS either did not pre-notify the receiving hospital or this was not documented.

Example: The stroke patient was picked up by the EMTs at 08:10. On their departure to the hospital at 08:20, they call the ED to inform them they are bringing in a potential stroke patient. They arrive at the ED at 08:30. The hospital was therefore pre-notified that a potential stroke patient was arriving.

This information can usually be found in the ED record, ED nursing notes, ED triage notes, ED physician notes, or EMS trip record.

C. HOSPITALIZATION

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 hospital 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 inpatients care as arrival time. For “Direct Admits” to the hospital, use the earliest time the patient arrives at the hospital.

20. Date of Arrival at hospital/Emergency Department [EDTriagD]

Document the earliest **date** ED or hospital was aware that there was a patient at their facility who needed to be evaluated. This may differ from admission date. **For a patient who experienced stroke while inpatient, report the date of the current stroke.**

____/____/____
MM/DD/YYYY

21. Time of Arrival to Hospital/Emergency Department [EDTriagT]

Document the earliest **time** ED or hospital was aware that there was a patient at their facility who needed to be evaluated. **For a patient who experienced stroke while inpatient, report the time the patient was evaluated for the current stroke.**

____:____ (military time)
HH MM

22. Hospital admission date [ADMDATE]

Date of official admission to a hospital’s **inpatient** service.

____/____/____
MM/DD/YYYY

Hospital admission date refers to 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 actual date of admission to the hospital for the admission date, not the arrival date to the ED.

Example: Patient 019 is seen in the ED of your institution on November 30, 2009 at 22:35. After the ED evaluation, the patient is a candidate for intra-arterial thrombolytic administration and is taken to Neurovascular Catheterization Lab at 23:45 and treatment is completed. The patient is admitted to the Stroke Unit of your institution on December 1, 2009 at 04:10. The hospital admission date will be 12/01/2009.

23. In what area of your hospital was the patient first evaluated? [PlaceRcd]

- 1 = Emergency
- 2 = Direct Admit (DA)
- 3 = Imaging suite prior to ED arrival or DA
- 9 = Cannot be determined

This question refers to route of patient arrival. Direct admit refers to type of admission that circumvents 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 en route to go directly to imaging prior to ED triage.

24. Was the presumptive hospital admission diagnosis at the time of admission either ischemic stroke, TIA, or no stroke related diagnosis? Select only one. [PreDx]

- 1 = Intracerebral Hemorrhage
- 2 = Transient Ischemic Attack
- 3 = Subarachnoid Hemorrhage
- 4 = Stroke Not Otherwise Specified
- 5 = Ischemic Stroke
- 6 = No Stroke Related Diagnosis

The presumptive hospital admission diagnosis tries to identify the 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.”

Preferred order of documents to abstract from is as follows:

- 1. Code Stroke Sheet
- 2. ED physician note
- 3. History and Physical (H&P) (**presumptive diagnosis only**)
- 4. Face Sheet.

25. Was patient ambulatory prior to current stroke/TIA [AmbStatA]

- 1 = Able to ambulate independently with or without device
- 2 = With assistance (from a person)
- 3 = Unable to ambulate (non-ambulatory)
- 9 = Not documented

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. Non-ambulatory: Patient is on bed rest; patient is only getting out of bed to the bedside commode (or up in chair) and is primarily in the bed (or immobile).

D. IMAGING

26. Was brain imaging performed at your hospital after arrival as part of the initial evaluation of this episode of care or this event? [ImageYN]

This question applies to initial brain image for this event. If patient did not receive any brain imaging at this hospital/facility, then Image YN should be “No.” If yes, answer 27 and 28.

1 = Yes

0 = No

2 = NC – if outside imaging performed subsequent to onset of current symptom or prior to transfer or patient is DNR/CMO

If “Yes”, to question #26, answer numbers 27 – 31 below.

27. Date of initial brain imaging [ImageD]

Enter date stamped on initial brain CT/MRI performed at your institution. Record only CT/MRI date the first study was performed at your hospital. **Please note: If the first brain image is done at an outside hospital, i.e., you answered ‘NC’ or ‘2’ on number 26, skip this field.** If time is not available, leave this field blank.

____/____/____
MM/DD/YYYY

28. Time of initial brain imaging (military time) [ImageT]

Enter time stamped on initial brain CT/MRI performed at your institution. Record only CT/MRI time the first study was performed at your hospital. **Please note: If the first brain image is done at an outside hospital, i.e., you answered ‘NC’ or ‘2’ on number 26, skip this field.** If time is not available, leave this field blank.

____ : ____
H H M M

29. Initial brain imaging findings? [ImageRes]

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.

1 = Hemorrhage

0 = No hemorrhage

9 = Not available

30. Date of Brain Imaging Results/Findings [ImagResD]

The earliest documented date of image reading.

____/____/____
MM/DD/YYYY

31. Time of Brain Imaging Results/Findings (military time) [ImagResT]

Please record the earliest documented time of initial brain imaging findings.

____ : ____
HH MM

E. SYMPTOM TIMELINE

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”(# 32 and # 33). 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” (# 34 and #35) rather than a time of “last known well.”

32. Patient Last Known Well Date [LKWD]

When was the date 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-like symptoms? 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.”

____/____/_____
MM/DD/YYYY

33. Patient Last Known Well Time (military time) [LKWT]

Enter this time in the specified format.

____ : ____
HH MM

If there is a specific reference to the patient having been discovered with symptoms already present, then this time should be treated as “time of symptom discovery” rather than a time of “last known well.”

When the onset of symptoms is clearly witnessed, then the time “last known well” is identical to the time of symptom discovery.

If the time of “last known well” is documented as being a specific number of hours prior to the 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.”

If the time of “last known well” is noted to be a range of time prior to the hospital 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 of “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

34. When was the patient first discovered to have the current stroke or stroke-like symptoms [DiscD]

____/____/____
MM/DD/YYYY

35. Time the patient was first discovered to have the current stroke or stroke-like symptoms [DiscT]

____:____
HH MM

(in Military Time)

(to within 15 minutes of exact time is acceptable)

36. NIH Stroke Scale [NIHStrkS]

If NIH scale is performed, what is the first NIH Stroke Scale total score recorded by hospital personnel? Total score maximum is 2-digits.

__ __ (enter score: 00 – 42)

NIHSS can be recorded by either a doctor or a member of the “stroke team” (including a Physician Assistant (PA) or a Registered Nurse (RN)).

F. THROMBOLYTIC TREATMENT

37. Was IV tPA initiated for this patient at this hospital? [TrmIVM]

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.

If documented reason exist for not giving IV thrombolytic therapy at this hospital, then complete section G after finishing the remaining questions in Section F.

1 = Yes

0 = No

2 = NC – Documented reasons exists for not giving IV thrombolytic

If IV tPA was initiated at this hospital or ED, answer # 38 and 39:

38. Date IV tPA administered [TrmIVMD]

____/____/____
MM/DD/YYYY

39. Time IV tPA administered (military time) [TrmIVMT]

Record the time of the initial bolus of tPA or the initiation of infusion if no bolus is given.

____ : ____
HH MM

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 the patient was an instance of “drip and ship” IV tPA in this hospital, you may skip the remaining after section F Thrombolytic Treatment and complete section K Discharge Data # 107-111.

40. Was other thrombolytic therapy administered [OTrmlADM] [This field is no longer required to be reported]

1 = Yes

0 = No

41. IV tPA at an outside hospital [TrmIVT]

1 = Yes

0 = No

THE FOLLOWING INSTRUCTION APPLIES TO #S 42 – 47 ONLY:

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 angiogram 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.

42. IA catheter-based reperfusion at this hospital? [TrmlAM]

- 1 = Yes
- 0 = No

If yes on number 42, answer #s 43 – 44

43. Date IA catheter-based reperfusion [TrmlAMD]

____/____/____
MM/DD/YYYY

44. Time IA catheter-based reperfusion (military time) [TrmlAMT]

____ : ____
H H M M

45. IA catheter-based reperfusion at outside hospital [TrmlAT]

- 1 = Yes
- 0 = No

46. Investigational or experimental protocol for thrombolysis [TrmExp]

- 1 = Yes
- 0 = No

47. If yes to number 46, please specify investigational/experimental thrombolysis [ExpType]

48. Other investigative therapy for ischemic or hemorrhagic stroke [Othtrial]

For ischemic or hemorrhagic stroke determined by documentation of an IRB-approved study as indicated by the presence of an informed consent form or a physician note that the patient is entering a therapeutic stroke study. Includes but not limited to studies involving neuroprotectants, perfusion augmentation, surgery or the use of lysis in intracerebral hemorrhage. **Exclude studies of thrombolysis for ischemic stroke reported in item number 47.**

1 = Yes

0 = No

Complications of thrombolytic therapy

49. Symptomatic intracranial hemorrhage [ThrmCmpS]

0 = No

1 = Yes (\leq 36 hours of tPA)

9 = Unknown

CT hemorrhage shows intracranial bleed AND physician's notes indicate clinical deterioration due to hemorrhage. Indicate if hemorrhagic complications of tPA occurred as a result of IV tPA administration within 36 hours from the time of tPA bolus or a complication as a result of catheter based (IA) reperfusion with mechanical thrombolysis or clot retrieval procedures (Merci or Penumbra). 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. Indicate if no serious complications occurred. If no tPA given, then this element is not applicable, select Unknown.

50. Life threatening, serious systemic hemorrhage [ThrmCmpL]

0 = No

1 = Yes (\leq 36 hours of tPA)

9 = Unknown

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 or a complication as a result of catheter based (IA) reperfusion with mechanical thrombolysis or clot retrieval procedures (Merci or Penumbra). Indicate if no serious complications occurred. If no tPA given, then select Unknown.

Check "No" to indicate that patient did not experience symptomatic intracranial hemorrhage or life threatening, serious systemic hemorrhage as complications of thrombolytic therapy.

Example: The patient received intravenous tPA in the ED on 07/01/09. 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.

G. NON-TREATMENT WITH THROMBOLYTICS

ANSWER #S 51-74 ONLY IF THROMBOLYTIC THERAPY WAS NOT GIVEN OR STARTED.

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.

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/advanced practice nurse, or physician assistant's notes in the patient's chart? (**Answer each as Yes or No**). 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 played a factor in the decision-making process for not giving thrombolytic therapy.

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.

“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 definitely established, or time of last known well (LKW) is unknown. If in this instance, if unable to determine please leave the field blank.

Contraindications, which may include any of the following:

Intent of this question is to capture documented contraindications answer # 51 – 74.

51. SBP > 185 or DBP > 110 mmHg despite treatment [NonTrtBP]

1 = Yes
0 = No

52. Recent intracranial or spinal surgery, head trauma, or stroke (<3 mo.) [NonTrtTr]

1 = Yes
0 = No

53. Recent surgery/trauma (<15 days) [NonTrtSurg]

1 = Yes
0 = No

54. Active internal bleeding (<22 days) [NonTrtBl]

1 = Yes

0 = No

55. Suspicion of subarachnoid hemorrhage [NonTrtSuHem]

1 = Yes

0 = No

56. History of intracranial hemorrhage or brain aneurysm or vascular malformation or brain tumor [NonTrtHxHem]

1 = Yes

0 = No

57. Platelets <100,000, PTT >40 seconds after heparin use, or PT > 15 or INR > 1.7, or known bleeding diathesis [NonTrtPlat]

1 = Yes

0 = No

58. CT findings (ICH, SAH, or major infarct signs) [NonTrtCT]

1 = Yes

0 = No

59. Seizure at onset [NonTrtS]

1 = Yes

0 = No

Warnings: conditions that might lead to unfavorable outcomes:

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 <NonTrtPlat>. 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 <NonTrtROM>.

60. Stroke severity – too severe (e.g., NIHSS >22) [NonTrtSev]

If tPA not administered because of stroke severity or if there is a time delay due to the patient's condition that required other treatment (e.g., intubation, resuscitation), answer "Yes."

1 = Yes

0 = No

61. Glucose , < 50 or > 400 mg/dl [NonTrtG]

1 = Yes

0 = No

62. Left heart thrombus [NonTrtLHT]

1 = Yes

0 = No

63. Care-team unable to determine eligibility [NonTrtNC]

If 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.

1 = Yes

0 = No

64. Rapid improvement or stroke severity too mild [NonTrtSM]

1 = Yes

0 = No

65. Advanced Age [NonTrtAG]

1 = Yes

0 = No

Advanced age is a warning condition – it must be clearly stated in the chart this was the reason the patient did not receive tPA, and not checked only because the patient is above a certain age.

66. Patient/Family refused [NonTrtFR]

If patient declines IV tPA in favor of catheter-based reperfusion or other investigational therapy, then select option “patient/family refused.” 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 (Answer “Yes” on # 64 (NonTrtSM))

1 = Yes

0 = No

67. IV or IA tPA given at outside hospital [NonTrtOH]

1 = Yes

0 = No

68. Increased risk of bleeding due to comorbid conditions [NonTrtROM]

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. Comorbid conditions: acute pericarditis; subacute bacterial endocarditis; hemostatic defects including those secondary to severe hepatic or renal disease; pregnancy; diabetic hemorrhage retinopathy, or hemorrhagic ophthalmic conditions; septic thrombophlebitis or occluded AV cannula at seriously infected site; patient currently receiving oral anticoagulant, e.g., Warfarin sodium.

1 = Yes
0 = No

69. Life expectancy < 1 year or severe co-morbid illness or CMO on admission

If documented reason is something like dementia, then select severe co-morbid condition.

1 = Yes
0 = No

Hospital-Related or Other Factors:

70. Failure to diagnose within the tPA window [NonTrtDx]

If the diagnosis was unclear during the ED evaluation or at the time of admission, select “failure to diagnose within tPA window”, <NonTrtDX>. This might be an admitting diagnosis such as “rule out migraine” for the admission diagnosis.

1 = Yes
0 = No

71. In-hospital Time Delay [NonTrtTD]

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>. If there are delays in patient arrival or in-hospital processes, select “Time Delay”.

1 = Yes
0 = No

72. Delay in patients arrival [NonTrtA]

1 = Yes
0 = No

73. No IV access [NonTrtIV]

1 = Yes

0 = No

74. Other (25 characters) [NonTrtOt]

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. Remember to only abstract reasons that are specifically stated as the reason for not giving thrombolytic therapy. 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 <NonTrNC>, cannot determine eligibility.

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.

H. MEDICAL HISTORY

Check item if documented by physician or nurse in admission or discharge notes. 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.

(Answer #s 75–83 as Yes or No) Answer “Yes” only for conditions that were known to be present prior to the current event. Do not record “Yes” for conditions that were newly diagnosed on the admission.

75. Diabetes Mellitus [MedHisDM]

1 = Yes
0 = No

Diabetes Mellitus (DM): Physician diagnosed diabetes mellitus (Types I or II) regardless of duration of disease (includes patient treatment with 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.

76. Prior Stroke/Transient ischemic attack/VBI= vertebral-basilar insufficiency [MedHisSt]

1 = Yes
0 = No

77. Carotid stenosis [MedHisCS]

1 = Yes
0 = No

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.

78. Heart failure (includes CHF) [MedHisHF]

1 = Yes
0 = No

79. Myocardial Infarction (MI) or coronary artery disease (CAD) [MedHisMI]

1 = Yes

0 = No

CAD/prior MI: CAD/Prior MI if there is a history of coronary artery disease, or a physician diagnosed MI or ECG evidence of an old MI prior to this event.

80. Peripheral arterial disease (PAD) [MedHisPA]

1 = Yes

0 = No

Peripheral Vascular Disease (PVD) 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.

81. Heart valve prosthesis [MedHisVP]

1 = Yes

0 = No

82. Sickle Cell disease (sickle cell anemia) [MedHisSS]

Include both sickle cell disease or sickle cell trait, or sickle cell anemia.

1 = Yes

0 = No

83. Did this event occur during pregnancy or within 6 weeks after delivery or termination of pregnancy? [MedhisPG].

Pregnancy includes women who are currently pregnant, or within six weeks post partum.

1 = Yes

0 = No

84. Record patient's height in centimeters [HgtUnit]

_____ cms

Enter the patient's height in centimeters (cms). This information is usually listed in the Admission sheet, ED nurses notes, ED Physicians' notes, Medication order sheets, Nurses progress notes, Physician order sheets, Physician progress notes, Dietary or nutrition services, Physical therapy or Occupation.

85. Record patient's weight in kilograms [WgtUnit]

_____ Kilograms

Enter the patient's weight in kilograms (KGs). 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 Occupational therapy.

I. IN-HOSPITAL PROCEDURES AND TREATMENT

Patient 019 was admitted directly to the floor from private internal medicine practice (that has admitting privileges at the 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 the stroke unit, to the neurologist's care. The Data Entry will be "Yes" for 'Neurologist Admit' (SUnitB), "Yes" for 'Other Service Admit' (SUnitC), and "Yes" for 'n Stroke Unit' (SUnit F).

Where was the patient cared for and by whom?

86. Neurologist Admit [SUnitA]

1 = Yes
0 = No

87. Other Service Admit [SUnitB]

1 = Yes
0 = No

88. Stroke Consult [SUnitC]

1 = Yes
0 = No

89. No Stroke Consult [SUnitD]

1 = Yes
0 = No

90. In Stroke Unit [SUnitE]

1 = Yes
0 = No

91. Not in Stroke Unit [SUnitF]

1 = Yes
0 = No

92. Unable to Determine [SUnitND] [This field is no longer required to be reported]

1 = Yes

0 = No

93. Is there evidence that the patient's care was restricted to comfort measures only (CMO) anytime prior to the end of Hospital day 2? [CMODay2]

1 = Yes

0 = No

**94. Is there evidence that the patient's care was restricted to CMO at the time of discharge?
[CMO]**

1 = Yes

0 = No

If the only mention of comfort measures or hospice is at discharge, select "No" in # 94. Physician/nurse practitioner/advanced practice nurse/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. If DNR-CC is documented, select "No" unless there is documented clarification that CC stands for "comfort care."

If any of the inclusions are documented, select "Yes" regardless of other documentation.

If "continue supportive care" is documented in the context of a patient's age, chronic illness or terminal/grave prognosis, select "Yes".

Comfort measures include:

- 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

Comfort measures DO NOT include:

- 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

95. Was antithrombotic therapy received by the end of hospital day 2? [Athr2Day]

1 = Yes

0 = No/Not documented

2 = NC – Documented reason for not giving antithrombotic therapy exists in the medical record

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, they should not actively search in the patient's record for contraindications. **If patient/family refuses treatment, record this as 'NC'.**

Only the following are considered acceptable antithrombotic therapy:

1. Aspirin (ASA)
2. ASA/dipyridamole (Aggrenox) BID
3. Warfarin (Coumadin)
4. Clopidogrel (Plavix), Prasugrel (Effient)
5. Ticlopidine (Ticlid)
6. Full dose unfractionated heparin IV
7. Full dose LMW heparin, Fondaparinux (Arixtra)
8. Other newly FDA approved agents falling within antithrombotic drug classes

To compute end of hospital day two, count the day of arrival at this hospital as 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.

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”.

Reasons for patients not receiving antithrombotic medication must be documented by a physician, nurse practitioner/advanced practice nurse or physician assistant. If reasons are not mentioned in the context 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).

Acceptable reasons for not giving antithrombotic medication by the end of the 2nd hospital day include:

Acceptable reasons for not giving include:

- Risk of bleeding
- Allergy to or complication r/t aspirin, Ticlopidine, Clopidogrel, dipyridamole and Warfarin (hx or current)
- Patient receiving terminal or comfort care only

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.

96. Was the patient ambulatory at the end of hospital day 2 [DVTAmbul]

1 = Yes

0 = No/Not documented

Ambulatory:

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

Non-ambulatory:

- Patient is on bed rest
- Patient is only getting out of bed to the bedside commode (or up in 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.

Hospital Day 2:

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, you will answer “Yes” to this question.

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".

97. Was DVT prophylaxis initiated by the end of the second hospital day [DVTProYN]

1 = Yes

0 = No

2 = NC – Documented reason for not administering DVT prophylaxis was present in medical record

Determination if medication and/or devices were ordered and initiated by the end of the second hospital day of hospital admission for prophylaxis against the formation of deep venous thrombosis. Inclusion:

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.
2. Intravenous heparin, IV heparin.
3. Pneumatic Compression Stockings, compression socks, Intermittent compression devices, ICDs, (TED Hose do NOT apply)
4. Warfarin, Aldocumar, Anisindione, Anisindine, Athrombin, Athrombin-K, Barr Warfarin Sodium, Barr's Warfarin Sodium, Carfin, Coufarin, Coumadin, SodicoCoumadin, Coumadina, Coumadine, Dicumarol, Dicoumarol, Indandione, Liquamar, Marevam, Marevan, Miradon, Orfarin, Panwarfin, Panwarfarin, Phenprocoumon, Sefarin, Sofarin, Uniwarfarin, Waran, Warfarin, Warfarin Sod, Warfarin Sodium, Warfilone Sodium, Warifilone

Select:

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.

No = if none of the above methods are ordered and initiated for the patient.

If patient/family refuses treatment, record this as 'NC'.

To compute end of hospital day two, count the day of arrival at this 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 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.

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”

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

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”.

This information may be found in the Medication Order Sheets, Printed or Electronic Order Sheets, Physician or Nurses notes, Physical or Occupational therapy notes.

98. Was the patient NPO throughout the entire hospital stay (i.e., this patient never received foods, fluids or medication by mouth at any time) [NPO]

1 = Yes
0 = No or Not Documented

99. Was patient screened for dysphagia prior to any oral intake, including food, fluids, or medications? [DysphaYN]

1 = Yes
0 = No or Not Documented
2 = NC – documented reason for screening not required, but exists in the medical record

Answer “Yes” for number 99 only if the patient was kept NPO during the entire hospitalization and was discharged, 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.

Patients receiving nothing by mouth should be considered NPO even if NG, OG or gastrostomy tube is being used. 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.

Reasons for not performing a dysphagia screen must be explicitly documented or clearly implied by a physician, nurse practitioner/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. Acceptable reasons for not performing dysphagia screening include the presence of a previously placed gastrostomy tube, and complete recovery of all symptoms and neurological deficits.

A variety of methods may be employed to assess swallowing status. These methods may include but are not limited to:

- Bedside swallow 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 speech language pathologist

The following are not acceptable as swallow screening:

- Patient evaluation using the NIH/NIHSS (National Institute of Health/National Institute of Health Stroke Scale) is NOT considered dysphagia screening
- Documentation of “Cranial nerves intact” is NOT considered dysphagia screening
- Positive gag reflex noted

If patient/family refuses treatment, record this as ‘NC’.

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". 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".

100. IV therapeutic heparin administered?

Was IV–heparin, low molecular-weight heparin or another heparinoid used for full anticoagulation? Exclude agents that were used subcutaneously at low doses for DVT prophylaxis.

1 = Yes
0 = No

101. Was the patient’s cardiac rhythm monitored continuously? [Telemetric]

There is documentation of at least 24 hours of continuous telemetry monitoring. This may be done at any designated unit that includes cardiac monitoring whether the monitoring is local (i.e.” Fixed” monitoring) or remotely if the patient is monitored via a telemetry device (i.e.” Remote” monitoring).” This does not include holter monitoring.

1 = Yes
0 = No

J. OTHER IN-HOSPITAL COMPLICATIONS

ITEMS 102 THROUGH 106 BELOW 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.

102. Did patient experience a DVT or pulmonary embolus (PE) during this admission [DVTDocYN]

This refers to DVT or PE confirmed by ultrasound or venous imaging.

1 = Yes

0 = No

Objectively confirmed DVT based on duplex ultrasound, contrast venography, CT with contrast venogram, MR imaging or MR venography]

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." Example: Patient 019 was prescribed DVT prophylaxis on admission to hospital for ischemic stroke. On day 4 of admission the patient had tender calf, ultrasound negative for DVT. Answer would be "No."

103. Was there documentation that the patient was treated for pneumonia during this admission? [PneumYN]

1 = Yes

0 = No

9 = Not documented

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

No: There was clinical mention of hospital-acquired pneumonia by the physician, but treatment with an antibiotic was not prescribed

Not Documented: If there was no clinical mention of hospital-acquired pneumonia, select "ND."

Example: Patient 019 is admitted with stroke symptoms and started on an oral diet after passing a dysphagia screen. A chest X-ray from day 2 describes "pneumonia vs. atelectasis." 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". 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.

104. Was patient treated for a urinary tract infection (UTI) during this admission? [UTI]

- 1 = Yes
- 0 = No
- 9 = Not documented

Indicate if patient was treated for urinary tract infection that developed following admission:

Yes: There was clinical mention of UTI by the physician, and treatment with an antibiotic for UTI.

No: There was clinical mention of UTI by the physician, but treatment with an antibiotic was not prescribed.

Not Documented: There was no clinical mention of UTI "ND."

105. If patient was treated for UTI, did the patient have Foley catheter during this admission? [UTIFoley]

- 1 = Yes
- 2 = Yes, but only after admission
- 0 = No
- 9 = Unable to determine

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.

106. Secondary symptomatic intracerebral hemorrhage [SecHemorrh] [This filed is no longer required to be reported]

Following an acute ischemic stroke and the administration of thrombolysis, did the patient develop secondary hemorrhage into the site (demonstrable on CT scan) resulting in significant clinical deterioration. CT hemorrhage within 36 hours shows intracranial bleed AND physicians' notes indicate clinical deterioration due to hemorrhage.

- 1 = Yes
- 0 = No

K. DISCHARGE DATA

Indicate the date the patient was discharged from acute care, left against medical advice, or expired during this stay.

The discharge date is the day that patient is discharged from your institution's acute unit OR the date of the patient's expiration OR the patient's discharge OR the date of transfer to, a rehabilitation unit, skilled nursing or hospice unit in your institution, even if that hospital is affiliated with your own. Record the date as MM/DD/YYYY.

Example: Patient 019 is admitted to your in-patient neurology floor from your ED, with a diagnosis of acute ischemic stroke, on January 10, 2009 (01/10/2009). Due to extension of the infarct, need for jejunostomy and placement, the patient is still in the inpatient unit on January 30, 2009 (01/30/2009). The patient expires from complications of aspiration pneumonia on February 12, 2009 (02/12/2009). Date of discharge is entered as 02/12/2009. This information is usually listed in the Discharge Summary, Physician Order Sheets, Physician Progress Notes.

[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 value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the UB-04 date. Use the UB-04 date only as a last resort.]

107. Date of discharge from hospital [DATEDC]

____/____/____
MM/DD/YYYY

108. ICD-9-CM discharge diagnosis related to stroke (see Appendix III) [ICD9StDx]

_____ - _____

Notes: 1) Primary stroke and primary TIA diagnoses are required for reporting while secondary stroke diagnoses are only strongly encouraged for reporting during the first year of reporting with a strong possibility of phasing in secondary stroke diagnosis reporting in future years. 2) Secondary TIA is not required for reporting in this registry. However, this field should not affect your responses on field number 110.

If the patient was admitted solely for elective carotid surgery and is coded as ICD-9-CM 433.10 (as the primary code) and did not develop stroke like symptoms before, during or after surgery, then do not report this patient.

109. Principal discharge ICD-9-CM diagnosis (see Appendix III) [ICD9PrDx]

This is the principal diagnosis at the time of discharge.

_____ - _____

110. Clinical hospital diagnosis related to stroke that was ultimately responsible for this admission (check only one item) [DisDx]

This is the clinical admission diagnosis after completion of all diagnostic procedures, examinations and consultations. Note that this may be different from the presumptive hospital admission diagnosis and the final ICD-9-CM code. Do not change the presumptive diagnosis based on this information.

- 1 = Subarachnoid hemorrhage
- 2 = Intracerebral hemorrhage
- 3 = Ischemic stroke
- 4 = Transient ischemic attack
- 5 = Stroke not otherwise specified
- 6 = No stroke related diagnosis

111. Discharge designation or discharge status (Select only one) [Dcwhere]

- 01 = Discharged/Transferred to home/self care (routine discharge)
- 02 = Discharge/Transferred to short-term general hospital for inpatient care
- 03 = Discharged/Transferred to skilled nursing facility (SNF) Discharged/Transferred to a Facility that provides Custodial or Supportive Care – effective with discharges on/after 10/1/2009
- 04 = Discharged/Transferred to an Intermediate Care Facility (ICF) – effective with discharges on/before 9/30/2009
- 05 = Discharged/Transferred to a designated Cancer Center or Children’s Hospital
- 06 = Discharged to home under care of organized home health service provider
- 07 = Left against medical advice
- 09 = Admitted as an inpatient to this hospital (outpatient only)
- 20 = Expired
- 21 = Discharged/Transferred to Court/Law Enforcement
- 30 = Still a patient
- 43 = Discharged/Transferred to federal hospital
- 50 = Hospice – home
- 51 = Hospice – medical facility
- 61 = Discharged/Transferred within this institution to hospital-based Medicare approved swing bed
- 62 = Discharged/Transferred to another rehabilitation facility
- 63 = Discharged/Transferred to Medicare certified long term care hospital (LTCH)
- 64 = Discharge/Transferred to a long term care facility 65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- 66 = Discharged/Transferred to a Critical Access Hospital
- 70 = Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list

The discharge designation codes correspond to the latest Uniform Bill (UB-04) codes for discharge status. 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.

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).

Example 1: 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, 2009 (12/21/2009) 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 "06 - Discharged/transferred to home under organized home care."

112. Ambulation status at discharge [AmbStatD]

- 1 = Able to ambulate independently
- 2 = With assistance (from one person)
- 3 = Unable to ambulate
- 9 = Not documented

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

Non-ambulatory:

- Patient is on bed rest
- Patient is only getting out of bed to the bedside commode (or up in chair) and is primarily in the bed (or immobile). If item 111 – Code 20 and patient expired during hospitalization, item 112 can be skipped.

113. Is there documented past medical history of smoking – did the adult patient smoke at least one cigarette during the year prior to hospital arrival? [MedHisSM] (Please refer to Appendix IV)

- 1 = Yes
- 0 = No/Not documented

114. If past medical history of smoking is checked as yes, was the adult patient or their care giver given smoking cessation advise or counseling during the hospital stay? [SmkCesYN] (Please refer to Appendix IV)

- 1 = Yes
- 0 = No or not documented in the medical record
- 2 = NC – A documented reason exists for not performing counseling

115. Is there a past medical history of dyslipidemia? [MedHisDL]

Dyslipidemia is taken to mean elevated cholesterol, high cholesterol, high triglycerides, etc.

- 1 = Yes
- 0 = No/Not documented

116. Was the patient on cholesterol reducing or cholesterol controlling medication prior to this hospitalization? [LipAdmYN]

1 =Yes
0 = No

117. Record lipid levels during hospital admission or within 30 days prior to admission. LDL [LipLDL]

___ __ __ mg/dl. If no documented **LDL**, enter -1.

118. HDL [LipHDL]

___ __ __ mg/dl . If no documented **HDL**, enter -1.

119. Total Cholesterol [LipTotal]

___ __ __ mg/dl . If no documented **Total Cholesterol**, enter -1.

120. Triglycerides [LipTri]

___ __ __ mg/dl. If no documented **Triglycerides**, enter -1.

121. Glycosylated Hb [HbA1c] Complete this field if patient has a history of diabetes (# 75); is a newly diagnosed diabetic or if this test result is available.

___ . __ % . If no documented **HbA1c**, enter -1.

122. Is there documentation that cholesterol – reducing or cholesterol controlling medication was prescribed at discharge? [LipDisYN]

1 = Yes
0 = No/Not documented
2 = NC – Contraindicated

If medication was prescribed, please answer which medication classes were prescribed:

123. Statin [LipStatn]

1 = Yes
0 = No

124. Other medication [LipOthRx]

1 = Yes

0 = No

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.

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'.

Example: Patient 025 is admitted to the inpatient 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" as determined from lab results in a patient's hospital record.

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.

Actual lipid values must be available in the medical record for this question to be answered.

Reasons must be documented by a physician, nurse practitioner/advanced practice nurse 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.) 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 LipDisYN is 'Yes', then answer <LipStatn>, and <LipOthRx

If documentation by a physician, nurse practitioner/advanced practice nurse, 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".

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 select "Statin".

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. Answer 'NC' for refusals.

125. Is there a documented history of hypertension? [MedHisHT]

- 1 = Yes
- 0 = No/Not documented

126. Was patient on antihypertensive medication prior to admission? [HBPAadmYN]

- 1 = Yes
- 0 = No/Not documented

127. Is there documentation that antihypertensive medication was prescribed at discharge? [HBPTreat]

- 1 = Yes
- 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.

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-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 "No/Not documented."

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.

128. Was the patient taking antithrombotic medication prior to admission? [AthAdmYN]

- 1 = Yes
- 0 = No
- 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 field.

Only the following are considered acceptable antithrombotic therapy:

1. Aspirin (ASA)
2. ASA/dipyridamole (Aggrenox) BID
3. Warfarin (Coumadin)
4. Clopidogrel (Plavix), Prasugrel (Effient)
5. Ticlopidine (Ticlid)
6. Unfractionated heparin IV
7. Full dose LMW heparin, Fondaparinux (Arixtra)
8. Other newly FDA approved agents falling within antithrombotic drug classes

129. Was antithrombotic medication prescribed at discharge? [AthDscYN]

1 = Yes

0 = No

2 = NC – Documented reason for not administering exists in record

Prescribed at discharge: Documentation that patient/caregiver was given prescription for antithrombotic therapy at time of hospital discharge. **See the list of acceptable antithrombotic therapy medications following # 128.**

If patient/family refuses treatment, record this as ‘NC’.

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."

Reasons for not prescribing antithrombotic therapy must be documented by a physician, nurse practitioner/advanced practice nurse or physician assistant. 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.)

Acceptable reasons for not giving include:

- Risk of bleeding
- Allergy to or complication r/t aspirin, Ticlopidine, Clopidogrel, dipyridamole and Warfarin (hx or current)
- Patient receiving terminal or comfort care only

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.

130. Is there documentation in the patient's medical history of atrial fibrillation/flutter or paroxysmal atrial fibrillation (PAF)? [MedHisAF]

1 = Yes

0 = Not/Not documented

131. Was atrial fibrillation/flutter or paroxysmal atrial fibrillation (PAF) documented during this episode of care? [AFibYN]

1 = Yes

0 = No/Not documented

132. If a history of atrial fibrillation/flutter or PAF is documented in the medical history of the patient or the patient experienced atrial fibrillation/flutter or PAF during this episode of care, was patient prescribed anticoagulation medication discharge? [AFibRx]

1 = Yes

0 = No/Not documented

2 = Documented reason for not prescribing anticoagulation exist in medical 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:

1. Risk for bleeding or discontinued due to bleeding
2. Risk for falls
3. Mental status
4. Patient refused
5. Terminal Illness
6. Family refused
7. Allergy
8. Serious side effects to medication

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.)

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).

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.

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. **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. **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 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”.

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 Transesophageal 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.

Was there documentation that the patient and/or caregiver received education and/or resource materials regarding any of the following?

133. Personal modifiable risk factors for stroke [EducRF]

Education regarding personal modifiable **risk factors** for stroke include hypertension, hyperlipidemia, overweight or obesity, cigarette smoking, physical inactivity, diabetes, atrial fibrillation, carotid artery stenosis, excessive alcohol consumption.

- 1 = Yes
- 0 = No/Not documented
- 2 = NC

134. Stroke warning signs [EducSSx]

Warning signs and symptoms for stroke include sudden weakness, sudden dimness of vision, facial droop, 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.

- 1 = Yes
- 0 = No/Not documented
- 2 = NC

135. How to activate EMS [EducEMS]

Education on how to activate **EMS** for signs/symptoms include sudden weakness, sudden dimness of vision, facial droop, 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.

- 1 = Yes
- 0 = No/Not documented
- 2 = NC

136. Need for follow-up after discharge [EducCC]

- 1 = Yes
- 0 = No/Not documented
- 2 = NC

137. Their prescribed medications [EducMeds]

- 1 = Yes
- 0 = No/Not documented
- 2 = NC

138. Is there documentation in the record that the patient was assessed for or received rehabilitation services? [RehabPlan]

- 1 = Yes
- 0 = No/Not documented

139. Did patient receive rehabilitation services during hospitalization? [Rehrecei]

Rehabilitation services include, but are not limited to physical therapy, occupational therapy, and speech and language therapy. The following does not qualify as a “Yes” answer: request for consultation for rehabilitation services that **was not performed** limited to physical therapy, occupational therapy, and speech therapy.

- 1 = Yes
- 0 = No/Not documented

Acceptable indications in the chart that a patient was assessed for or received rehabilitation services include:

- 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 the 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)

- Patient/family refused rehabilitation services.

Examples of members of a rehabilitation team may include:

- Psychiatrist
- Neuro-psychologist
- Physical therapist
- Occupational therapist
- Speech and language pathologist

140. Was patient transferred to a rehabilitation facility? [Rehtrans]

1 = Yes

0 = No/Not documented

141. Was patient referred to rehabilitation services following discharge? [Rehrefer]

1 = Yes

0 = No/Not documented

142. Was patient ineligible to receive rehabilitation services (e.g., symptoms resolved, poor prognosis, patient unable to tolerate rehabilitation therapeutic regimen)? [Rehinel]

1 = Yes

0 = No/Not documented

143. Modified Rankin Scale at discharge [ModRank]

The scale will measure functional outcome after stroke based upon the event of disability or disabling symptoms experienced by the patient following the event, measured using the Modified Rankin Tool.

Information can be obtained from the patient's medical record, Stroke Team, or nurse notes

0 = No symptoms at all

1 = No significant disability despite symptoms; able to carry out all usual and activities

2 = Slight disability; unable to carry out previous activities, but able to look after own affairs without assistance

3 = Moderate disability; requiring some help, but able to walk without assistance

4 = Moderately severe disability, unable to walk without assistance and unable to attend to own bodily needs without assistance

5 = Severe disability, bedridden, incontinent and requiring constant nursing care and attention

6 = Dead

The following fields are reserved for important technologies, therapies, complications or other emerging stroke-related issues that were not anticipated at this time by the department.

144. Reserved Field 1 [**Reserved1**]

145. Reserved Field 2 [**Reserved2**]

146. Reserved Field 3 [**Reserved3**]

APPENDIX I: LIST HOSPITALS IN NEW JERSEY

Item # 2: Hospital Code (HOSPNUM) & Item # 3: Hospital Transferred From Code

Indicate the hospital code where stroke center services were performed (or the patient was transferred from) using the list below. The assigned codes are consistent with Medicare provider numbers and are the same used in UB-92 discharge form.

| Hospital Code | Hospital Name |
|---------------|--|
| 0642 | AtlantiCare Regional Medical Center-City |
| 0641 | AtlantiCare Regional Medical Center-Mainland |
| 0250 | Bayonne Medical Center |
| 1120 | Bayshore Community Hospital |
| 0580 | Bergen Regional Medical Center |
| 0110 | Cape Regional Medcial center |
| 0920 | Capital Health System at Fuld |
| 0440 | Capital Health System at Mercer |
| 1110 | CentraState Medical Center |
| 0170 | Chilton Memorial Hospital |
| 0160 | Christ Hospital |
| 0090 | Clara Maass Medical Center |
| 0410 | Community Medical Center |
| 0140 | Cooper Hospital/University Medical Center |
| 0310 | Deborah Heart and Lung Center |
| 0830 | East Orange General Hospital |
| 0450 | Englewood Hospital and Medical Center |
| 0010 | Hackensack University Medical Center |
| 1150 | Hackettstown Community Hospital |
| 0400 | Hoboken University Medical Center |
| 0080 | Holy Name Hospital |
| 0050 | Hunterdon Medical Center |
| 0740 | Jersey City Medical Center |
| 0730 | Jersey Shore University Medical Center |
| 1080 | JFK Medical Center (Edison) |
| 0862 | Kennedy Memorial Hospitals UMC-Cherry Hill |

APPENDIX I (Continued)

| Hospital Code | Hospital Name |
|----------------------|--|
| 0863 | Kennedy Memorial Hospitals UMC-Stratford |
| 0861 | Kennedy Memorial Hospitals UMC-Wash. Twp. |
| 0840 | Kimball Medical Center |
| 0610 | Lourdes Medical Center of Burlington Cty. |
| 1180 | Meadowlands Hospital Medical Center |
| 0910 | Memorial Hospital of Salem County |
| 0750 | Monmouth Medical Center |
| 0150 | Morristown Memorial Hospital |
| 0540 | Mountainside Hospital |
| 0020 | Newark Beth Israel Medical Center |
| 0280 | Newton Memorial Hospital |
| 0522 | Ocean Medical Center |
| 0290 | Our Lady of Lourdes Medical Center |
| 0510 | Overlook Hospital |
| 0030 | Palisades General Hospital of New York |
| 0392 | Raritan Bay Medical Center-Old Bridge |
| 0391 | Raritan Bay Medical Center-Perth Amboy |
| 0340 | Riverview Medical Center |
| 0380 | Robert Wood Johnson University Hospital |
| 1100 | RWJ University Hospital at Hamilton |
| 0240 | RWJ University Hospital at Rahway |
| 0470 | Shore Memorial Hospital |
| 0480 | Somerset Medical Center |
| 0322 | South Jersey Healthcare -Bridgeton |
| 0690 | South Jersey Healthcare -Elmer |
| 0324 | South Jersey Healthcare Regional MC - Vineland |
| 1130 | Southern Ocean County Hospital |
| 0760 | St. Barnabas Medical Center |
| 0500 | St. Clare's Hospital-Denville |
| 0670 | St. Clare's Hospital-Dover |
| 1200 | St. Clare's Hospital-Sussex |
| 0210 | St. Francis Medical Center |
| 0190 | St. Joseph's Hospital and Medical Center |

APPENDIX I (Continued)

| Hospital Code | Hospital Name |
|---------------|---|
| 1160 | St. Joseph's Wayne Hospital |
| 0060 | St. Mary's Hospital (Passaic) |
| 0960 | St. Michael's Medical Center |
| 0700 | St. Peter's University Hospital |
| 0270 | Trinitas Hospital |
| 1190 | UMDNJ-University Hospital |
| 0810 | Underwood - Memorial Hospital |
| 0100 | University Medical Center at Princeton |
| 0120 | Valley Hospital |
| 0570 | Virtua-Memorial Hospital Burlington Cty. |
| 0222 | Virtua-West Jersey Hospital Berlin |
| 0224 | Virtua-West Jersey Hospital Marlton |
| 0221 | Virtua-West Jersey Hospital Voorhees |
| 0600 | Warren Hospital |
| 8888 | VA hospital |
| 9999 | Out-of-state hospital (For Transfers Only) |
| 0000 | Non Transfers |

APPENDIX II: HEALTH INSURANCE STATUS PAYOR CLASSIFICATION

Item # 14 (Health Insurance Status Payor Classification)

Indicate the primary payor as being Medicare, Medicaid, HMO, Blue Cross, Commercial, Self Pay, CHAMPUS, Uninsured or Other using the following classifications:

Medicare

Title XVII Part A
Title XVII Part B

Medicaid

Title XIX

Health Maintenance Organizations (HMO)

Americaid Inc.
American Preferred Provider Plan Inc.
HIP/RHP of New Jersey
HMO Blue (Medigroup - Central)
HMO of PA/NJ (U.S. Health Care)
Aetna Health Plans of NJ, Inc.
CIGNA Health Plan of New Jersey
Metra Health Care Plan of Upstate NY
Prucare of New Jersey
Garden State Health Plan
HMO Blue Medigroup - Metro
HMO Blue Medigroup - North
HMO Blue Medigroup - South
HMO Blue Medigroup - Shore line
Metra Health Care Plan of NJ
NYL Care Health Plans of NJ, Inc.
Oxford Health Plan
Sanus of New Jersey
CIGNA Health Plan of Southern N.J.
Greater Atlantic Health Services
Amerihealth HMO Inc.
Atlanticare Health Plan
Chubb Health Plan
Community Health Care & Devt. Corp.
First Option Health Plan
Harmony Health Plan
HMO Blue (BC/BS of NJ)
Liberty Health Plan
Managed Health Care Systems of NJ,
Inc.
Physician Health Care Plan of NJ
Physician Health Services of NJ, Inc
University Health Plan Inc.
Other HMO

Blue Cross Plan

Alaska
Alabama
Arizona

Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey-All other groups
NJ Non-Group Line of Business
New Jersey FEP
Garden State
Host
New Mexico
New York
North Carolina
North Dakota
Ohio
Cleveland
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
Tennessee
Texas
Utah
Virginia
Vermont
Washington
West Virginia

Wisconsin
Wyoming
Puerto Rico
Other Blue Cross

Commercial

AARP
Aetna
NJ Carpenters Health Fund
Connecticut General
Continental Assurance
Equitable
Guardian Life
Intercontinental
John Hancock
Massachusetts Mutual
Metropolitan Life
Mutual of Omaha
New York Life
Provident Alliance
Prudential
Travelers
Washington National Insurance
New Jersey Auto Dealers Association
Allstate
Mutual Life of New York
National Association of Letter Carriers
Local Union Insurance
Lincoln National
New Jersey Turnpike Authority
Rasmussen
Inter County Health Plan
American Postal Workers
Leader Administrators
Fred S. James (James Benefit)
Mail Handlers Benefit Plan
Other Commercial Insurance

Self Pay

Direct
Other Source of Patient Pay

Tricare (Formerly CHAMPUS)

Uninsured/Indigent

Charity Care

Other

Department of Vocational Rehabilitation
New Jersey State Health Benefits Plan
Other Government
Premier Preferred Care of New Jersey
Union Insurance
Personnel Health Program
Magnet (Magna Care)
Hospital Responsibility
QualCare
Other
No Fault
Allstate
New Jersey Manufacturers
State Farm
Other No Fault
Workers Compensation
Aetna
Insurance Company of North America
Liberty Mutual
Employers Mutual
New Jersey Manufacturers
Travelers
Other Workers Compensation

APPENDIX III: TYPICAL STROKE ICD-9-CM CODES

Items #108 and 109: Typical Stroke ICD-9-CM Codes

| ICD-9-CM CODE | DESCRIPTION |
|-----------------------------|--|
| 430 | SUBARACHNOID HEMORRHAGE |
| 431 | INTRACEREBRAL HEMORRHAGE |
| 432 | OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE |
| 432.9 | UNSPECIFIED INTRACRANIAL HEMORRHAGE |
| 433 | OCL PRECEREBRAL ART |
| 433.00 | OCL BSLR ART WO INFRCT |
| 433.01 | OCL BSLR ART W INFRCT |
| 433.10 | OCL CRTD ART WO INFRCT |
| 433.11 | OCL CRTD ART W INFRCT |
| 433.20 | OCL VRTB ART WO INFRCT |
| 433.21 | OCL VRTB ART W INFRCT |
| 433.30 | OCL MLT BI ART WO INFRCT |
| 433.31 | OCL MLT BI ART W INFRCT |
| 433.80 | OCL SPCF ART WO INFRCT |
| 433.81 | OCL SPCF ART W INFRCT |
| 433.90 | OCL ART NOS WO INFRCT |
| 433.91 | OCL ART NOS W INFRCT |
| 434.00 | CEREBRAL THROMBOSIS W/O INFARCTION |
| 434.01 | THROMBOSIS WITH CEREBRAL INFARCTION |
| 434.10 | CEREBRAL EMBOLISM W/O INFARCTION |
| 434.11 | CEREBRAL EMBOLISM WITH INFARCTION |
| 434.90 | CRBL ART OC NOS WO INFRCT |
| 434.91 | CRBL ART OCL NOS W INFRCT |
| 435 | TRANSIENT CEREBRAL ISCHEMIA |
| 435.0 | BASILAR ARTERY SYNDROME |
| 435.1 | VERTEBRAL ARTERY SYNDROME |
| 435.2 | SUBCLAVIAN STEAL SYNDROM |
| 435.3 | VERTEBROBASILAR ARTERY SYNDROME |
| 435.8 | TRANS CEREB ISCHEMIA NEC |
| 435.9 | TRANS CEREB ISCHEMIA NOS |
| 436 | ACUTE, BUT ILL-DEFINED, CEREBROVASCULAR DISEASE |
| 671.5 x (where x=0,1,2,3,4) | CEREBRAL VENOUS SINUS THROMBOSIS DURING PREGNANCY OR IN THE PUERPERIUM |
| 674.0x (where x=0,1,2,3,4) | CEREBROVASCULAR COMPLICATIONS OF THE PUERPERIUM |

APPENDIX IV: SMOKING STATUS

Items # 114 and 115: Is there documentation for past medical history or smoking – did the adult patient smoke at least one cigarette during the year prior to hospital arrival

“Cigarette Smoking: Yes, 1-2 cigarettes a day” on nursing admission
“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.”

- 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:

“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 not a case of conflicting information).

Examples of ‘Yes’ to adult smoking history:

- 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 quit
- History of smoking (type of product not identified), without mention of a time frame, if no indication that patient quit
- History of smoking and documentation that the patient quit “several months ago”
- History of smoking within one year prior to arrival, type of product not identified
- History of tobacco use (type of product not identified), without mention of a time

- frame, if no indication that patient quit
- History of tobacco use or indication that patient quit within one year
- History of smoking and documentation that the patient quit “several months ago”
- History of smoking within one year prior to arrival, type of product not identified
- History of tobacco use (type of product not identified), without mention of a time frame, if no indication that patient quit
- History of tobacco use within one year prior to arrival, type of product not identified
- Recent smoker

Examples of ‘No’ to cigarette smoking history:

- 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 qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect or suspicious
- Illegal drug use only (e.g., marijuana)
- Oral tobacco use only
- Pipe smoking only
- Remote smoker (smoked in the past, but greater than one year ago)

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.

Smoking cessation therapies such as patch, gum, etc, are also equivalent to counseling.

If the patient refused smoking cessation advice or counseling during this hospital stay, select “Yes”

- If the patient has a history of cigarette smoking within the year prior to arrival date but the patient does not currently smoke, they should be advised to continue not smoking. For these patients, if this advice/counseling was not done, select “No”.

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.

Acceptable forms of advice and counseling include:

- 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

Any of the above interventions directed at the patient's caregiver if the patient is unable to comprehend

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 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".

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.

**APPENDIX V: THE NEW JERSEY ACUTE STROKE REGISTRY FILE
LAYOUT**

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|------------------------|---------------|---|------------|--|
| A. Demographics | | | | |
| 1 | HOSPTYPE | Hospital Type (state added) | Numeric | 1 = Primary 2 = Comprehensive 3 = Other |
| 2 | HOSPNUM | Hospital Code (Appendix I) (state added) | Numeric | 0000-9999 |
| 3 | TXFROM | Hospital Transferred From Code (state added) | Numeric | 0000-9999 |
| 4 | MEDRECNO | Medical Record Number (state added) | Character | Any 12 character codes used by hospital |
| 5 | LNAME | Patient Last Name (state added) | Character | 15 characters |
| 6 | FNAME | Patient First Name (state added) | Character | 10 characters |
| 7 | MI | Middle Initial (state added) | Character | 1 character |
| 8 | DOB | Date of Birth | Date | MM/DD/YYYY |
| 9 | SSNUM | Social Security Number | Character | 11 digits XXX-XX-XXXX |
| 10 | ZIP | Patient's Zip Code | Character | 5 digits |
| 11 | Sex | Gender | Numeric | 1 = Male 2 = Female |
| 12 | Race | Patient's self identified Race | Numeric | 1 = White 2 = Black 3 = Asian 4 = Native American/Alaska Native 5 = Hawaiian/Other Pacific Islander 6 = Other |
| 13 | Hispanic | Hispanic or Latino origin | Numeric | 1 = Yes (Hispanic or Latino) 0 = No (Not Hispanic or Latino) |
| 14 | Insurer | Health insurance status (Appendix II) (state added) | Numeric | 1 = Blue Cross/ Blue Shield 2 = Commercial 3 = HMO 4 = Medicaid 5 = Medicare 6 = Self Pay 7 = Tricare (Champus) 8 = Uninsured/Indigent 9 = Other |

APPENDIX V (CONT.)

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|--|----------------------|---|-------------------|---|
| B. Pre-hospital/Emergency Medical System (EMS) Data | | | | |
| 15 | PlcOccur | Patient location when stroke was detected /symptoms were discovered | Numeric | 1 = Not in a healthcare setting, 2 = Another acute care facility 3 = Chronic health care facility 4 = Stroke occurred while patient was an inpatient in your hospital 5 = Outpatient healthcare setting 9 = Cannot be determined |
| 16 | ArrMode | How did patient arrival to hospital? | Numeric | 1 = EMS 2 = Private transportation/taxi/ other 3 = Transferred from another hospital 9 = ND or unknown |
| 17 | EMSRecD | Date call received by EMS | Date | MM/DD/YYYY |
| 18 | EMSRecT | Time call received by EMS | Military Time | HH:MM (military time) |
| 19 | EMSNote | EMS pre-notification to your hospital | Numeric | 1 = Yes 0 = No |
| C. Hospitalization | | | | |
| 20 | EDTriagD | Date of Emergency Department triage | Date | MM/DD/YYYY |
| 21 | EDTriagT | Time of Emergency Department triage | Military Time | HH:MM (military time) |
| 22 | ADMDATE | Hospital admission date | Date | MM/DD/YYYY |
| 23 | PlaceRcd | Were in your hospital was the patient first evaluated? | Numeric | 1 = Emergency Department 2 = Direct Admit (DA) 3 = Imaging suite prior to ED arrival or DA 9 = Cannot be determine |
| 24 | PreDx | Presumptive hospital admission diagnosis | Numeric | 1 = Intracerebral Hemorrhage 2 = Transient Ischemic Attack 3 = Subarachnoid Hemorrhage 4 = Stroke Not Otherwise Specified 5 = Ischemic Stroke 6 = No Stroke Related Diagnosis |
| 25 | AmbStatA | Was patient ambulatory prior to the current stroke/TIA? | Numeric | 1 = Able to ambulate independently w/or w/o device 2 = With assistance (from person) 3 = Unable to ambulate 9 = Not documented |

APPENDIX V (CONT.)

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|----------------------------|----------------------|--|-------------------|--|
| D. Imaging | | | | |
| 26 | ImageYN | Was brain imaging performed after arrival/initial evaluation? | Numeric | 1 = Yes 0 = No 2 = NC – if outside imaging prior to transfer or patient is DNR/CMO |
| 27 | ImageD | If Yes, Date of initial brain imaging (not date dictated) | Date | MM/DD/YYYY |
| 28 | ImageT | If Yes, Time of initial brain imaging (not time dictated) | Military Time | HH:MM (military time) |
| 29 | ImageRes | Initial brain imaging findings | Numeric | 1 = Hemorrhage 0 = No hemorrhage 9 = Not available |
| 30 | ImagResD | Date of brain image findings | Date | MM/DD/YYYY |
| 31 | ImagResT | Time of brain image findings | Military time | HH:MM (military time) |
| E. Symptom Timeline | | | | |
| 32 | LKWD | Date patient last known to be well (i.e., in their usual state of health or at their baseline) | Date | MM/DD/YYYY |
| 33 | LKWT | Time last known to be well (i.e., in their usual state of health or at their baseline), to within 15 minutes of exact time is acceptable. | Military time | HH:MM (military time) |
| 34 | DiscD | Date patient first discovered to have the current stroke or stroke like symptoms | Date | MM/DD/YYYY |
| 35 | DiscT | Time patient first discovered to have current stroke or stroke like symptoms (to within 15 minutes of exact time of discovery is acceptable) | Military time | HH:MM (military time) |
| 36 | NIHStrkS | (If performed) NIH Stroke Scale total score recorded | Numeric | Range: 00 to 42 2 digits |

APPENDIX V (CONT.)

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|---|----------------------|--|-------------------|---|
| F. Thrombolytic Treatment | | | | |
| 37 | TrmIVM | Was IV tPA initiated for this patient at this hospital? | Numeric | 1 = Yes 0 = No 2 = NC – Documented reason exists for not giving IV thrombolytic |
| 38 | TrmIVMD | If IV tPA was initiated at this hospital or ED, date: | Date | MM/DD/YYYY |
| 39 | TrmIVMT | If IV tPA was initiated at this hospital or ED, time: | Military time | HH:MM (military time) |
| 40 | OTrmIADM | Was other thrombolytic therapy administered? | Numeric | 1 = Yes 0 = No |
| 41 | TrmIVT | IV tPA at an outside hospital | Numeric | 1 = Yes 0 = No |
| 42 | TrmIAM | IA catheter-based reperfusion at this hospital | Numeric | 1 = Yes 0 = No |
| 43 | TrmIAMD | If yes for IA catheter-based reperfusion, please record date | Date | MMDDYYYY |
| 44 | TrmIAMT | If yes for IA catheter-based reperfusion, please record time | Military time | HHMM (military time) |
| 45 | TrmIAT | IA catheter-based reperfusion at outside hospital | Numeric | 1 = Yes 0 = No |
| 46 | TrmExp | Investigational or experimental protocol for thrombolysis | Numeric | 1 = Yes 0 = No |
| 47 | ExpType | If yes for experimental thrombolysis, Specify | Text | Total of 50 characters |
| 48 | Othtrial | Other investigative therapy for ischemic or hemorrhagic stroke (state added) | Numeric | 1 = Yes 0 = No |
| Complications of thrombolytic therapy: | | | | |
| 49 | ThrmCmpS | Symptomatic intracranial hemorrhage | Numeric | 1=Yes (≤ 36 hours) of t-PA 0=No 9 = Unknown/Unable to Determine |
| 50 | ThrmCmpL | Life threatening, serious systemic hemorrhage | Numeric | 1=Yes (≤ 36 hours) of t-PA 0 = No 9 = Unknown/Unable to Determine |

APPENDIX V (CONT.)

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|--|----------------------|--|-------------------|---------------------|
| G. Non-Treatment with Thrombolytics | | | | |
| Contraindications | | | | |
| 51 | NonTrtBP | SBP > 185 or DBP > 110 mHg | Numeric | 1 = Yes 0 = No |
| 52 | NonTrtTr | Recent intracranial or spinal surgery, head trauma or stroke (<3 mo.) | Numeric | 1 = Yes 0 = No |
| 53 | NonTrtSurg | Recent surgery/trauma (<15 days) | Numeric | 1 = Yes 0 = No |
| 54 | NonTrtBl | Active internal bleeding (<22 days) | Numeric | 1 = Yes 0 = No |
| 55 | NonTrtSuHem | Suspicion of subarachnoid hemorrhage | Numeric | 1 = Yes 0 = No |
| 56 | NonTrtHxHem | History of intracranial hemorrhage or brain aneurysm or vascular malformation or brain tumor | Numeric | 1 = Yes 0 = No |
| 57 | NonTrtPlat | Platelets <100,000, PTT> 40 sec after heparin use or PT >15 or INR > 1.7 or known bleeding diathesis | Numeric | 1 = Yes 0 = No |
| 58 | NonTrtCT | CT findings (ICH, SAH or major infarct signs) | Numeric | 1 = Yes 0 = No |
| 59 | NonTrtS | Seizure at onset | Numeric | 1 = Yes 0 = No |
| Warnings: conditions that might lead to unfavorable outcomes: | | | | |
| 60 | NonTrtSev | Stroke severity – Too Severe (e.g. NIHSS>22) | Numeric | 1 = Yes 0 = No |
| 61 | NonTrtG | Glucose <50 or > 400 mg/dl | Numeric | 1 = Yes 0 = No |
| 62 | NonTrtLHT | Left heart thrombus | Numeric | 1 = Yes 0 = No |
| 63 | NonTrtNC | Care team unable to determine eligibility | Numeric | 1 = Yes 0 = No |
| 64 | NonTrtSM | Rapid improvement of Stroke severity too mild | Numeric | 1 = Yes 0 = No |
| 65 | NonTrtAG | Advanced age | Numeric | 1 = Yes 0 = No |
| 66 | NonTrtFR | Patient/family refused | Numeric | 1 = Yes 0 = No |
| 67 | NonTrtOH | IV or IA tPA given at outside hospital | Numeric | 1 = Yes 0 = No |
| 68 | NonTrtROM | Increased risk of bleeding due to comorbid conditions | Numeric | 1 = Yes 0 = No |
| 69 | NonTrtIL | Life expectancy < 1 year or severe co-morbid illness or CMO on admission | Numeric | 1 = Yes 0 = No |

APPENDIX V (CONT.)

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|---|----------------------|---|-------------------|---------------------|
| Hospital-Related or Other Factors: | | | | |
| 70 | NonTrtDX | Failure to diagnose in 3 hour time frame | Numeric | 1 = Yes 0 = No |
| 71 | NonTrtTD | In-hospital Time Delay | Numeric | 1 = Yes 0 = No |
| 72 | NonTrtA | Delay in patient arrival | Numeric | 1 = Yes 0 = No |
| 73 | NonTrtIV | No IV access | Numeric | 1 = Yes 0 = No |
| 74 | NonTrtOt | Other documented medical history | Text | Total 25 characters |
| H. Medical History | | | | |
| 75 | MedHisDM | Diabetes Mellitus | Numeric | 1 = Yes 0 = No |
| 76 | MedHisST | Prior Stroke/Transient ischemic Attack/VBI | Numeric | 1 = Yes 0 = No |
| 77 | MedHisCS | Carotid stenosis | Numeric | 1 = Yes 0 = No |
| 78 | MedHisHF | Heart failure | Numeric | 1 = Yes 0 = No |
| 79 | MedHisMI | Myocardial infarction (MI) or coronary artery disease (CAD) | Numeric | 1 = Yes 0 = No |
| 80 | MedHisPA | Peripheral arterial disease (PAD) | Numeric | 1 = Yes 0 = No |
| 81 | MedHisVP | Heart valve prosthesis | Numeric | 1 = Yes 0 = No |
| 82 | MedHisSS | Sickle cell disease | Numeric | 1 = Yes 0 = No |
| 83 | MedHisPG | Event occur during pregnancy or within 6 weeks after delivery or termination of pregnancy | Numeric | 1 = Yes 0 = No |
| 84 | HgtUnit | <u>Record patients height</u> □□□□ Record height in cms | Numeric | 3 digits |
| 85 | WgtUnit | Record patient's weight □□□□ Record weight in kgs | Numeric | 3 digits |

APPENDIX V (CONT.)

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|--|---------------|---|------------|--|
| I. In-hospital Procedures and Treatment | | | | |
| Where was patient cared for? (#s 86-92) | | | | |
| 86 | SUnitA | Neuro Admit | Numeric | 1 = Yes 0 = No |
| 87 | SUnitB | Other Service Admit | Numeric | 1 = Yes 0 = No |
| 88 | SUnitC | Stroke Consult | Numeric | 1 = Yes 0 = No |
| 89 | SUnitD | No Stroke Consult | Numeric | 1 = Yes 0 = No |
| 90 | SUnitE | In Stroke Unit | Numeric | 1 = Yes 0 = No |
| 91 | SUnitF | Not in Stroke Unit | Numeric | 1 = Yes 0 = No |
| 92 | SUnitND | Unable Determine | Numeric | 1 = Yes 0 = No |
| 93 | CMODay2 | Evidence of patient care restricted to comfort measures only prior to end of hospital day 2 | Numeric | 1 = Yes 0 = No |
| 94 | CMO | Evidence patient care restricted to CMO at the time of discharge | Numeric | 1 = Yes 0 = No |
| 95 | AThr2Day | Antithrombotic therapy received by the end of hospital day 2 | Numeric | 1= Yes 0 = No/Not documented 2 = NC – Documented reason for not giving antithrombotic therapy exists in the medical record |
| 96 | DVTAmbul | Was patient ambulatory at the end of hospital day two? | Numeric | 1=Yes 0=No/ Not documented |
| 97 | DVTProYN | Was DVT prophylaxis initiated by the end of the 2 nd hospital day? | Numeric | 1 = Yes 0 = No – Not Documented 2 = NC – Documented reason for not administering DVT prophylaxis was present in the medical record |
| 98 | NPO | Was the patient NPO throughout the entire hospital stay? | Numeric | 1 = Yes 0 = No or Not documented |
| 99 | DysphaYN | Was patient screened for dysphagia prior to any oral intake? | Numeric | 1 = Yes 0 = No/Not documented 2 = NC – documented reason for screening not required exists in the medical record |
| 100 | IVHep | IV Therapeutic heparin administered (state added) | Numeric | 1 = Yes 0 = No |
| 101 | Telemetric | Was Cardiac rhythm monitored continuously? (state added) | Numeric | 1= Yes 0 = No |

APPENDIX V (CONT.)

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|---|----------------------|---|-------------------|--|
| J. Other in-hospital Complications | | | | |
| 102 | DVTDocYN | Experience a DVT or pulmonary embolus (PE) during this admission? | Numeric | 1 = Yes 0 = No 9 = Not documented |
| 103 | PneumYN | Was patient treated for pneumonia during this admission? | Numeric | 1 = Yes 0 = No 9 = Not Documented |
| 104 | UTI | Treated for a urinary tract infection (UTI) during this admission? | Numeric | 1 = Yes 0 = No 9 = Not documented |
| 105 | UTIFoley | If treated for a UTI, did patient have a Foley catheter? | Numeric | 1 = Yes, and patient had catheter in place on arrival 2 = Yes, but only after admission 0 = No 9 = Unable to determine |
| 106 | SecHemorrh | Secondary symptomatic intracerebral hemorrhage (state added) | Numeric | 1 = Yes 0 = No |
| K. Discharge Data | | | | |
| 107 | DATEDC | Date of discharge from hospital | Date | MMDDYYYY |
| 108 | ICD9StDx | ICD-9-CM discharge diagnosis related to stroke (Appendix III) | Character | 5 characters |
| 109 | ICD9PrDx | Principal discharge ICD-9-CM diagnosis | Character | 5 characters |
| 110 | DisDx | Clinical hospital diagnosis related to stroke that was ultimately responsible for this admission (Select only one item) | Numeric | 1 = Subarachnoid hemorrhage 2 = Intracerebral hemorrhage 3 = Ischemic stroke 4 = Transient ischemic attack 5 = Stroke not otherwise specified 6 = No stroke related diagnosis |

APPENDIX V (CONT.)

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|------|---------------|--|------------|--|
| 111 | DCWHERE | Discharge destination (Select only one) | Numeric | 01 = Discharged/Transferred to home/self care (routine discharge) 02 = Discharge/Transferred to short-term general hospital for inpatient care 03 = Discharged/Transferred to skilled nursing facility (SNF) Discharged/Transferred to a Facility that provides Custodial or Supportive Care – effective with discharges on/after 10/1/2009 04 = Discharged/Transferred to an Intermediate Care Facility (ICF) – effective with discharges on/before 9/30/2009 05= Discharged/Transferred to a designated Cancer Center or Children’s Hospital 06 = Discharged to home under care of organized home health service provider 07 = Left against medical advice 09 = Admitted as an inpatient to this hospital (outpatient only) 20 = Expired 21 = Discharged/Transferred to Court/Law Enforcement 30 = Still a patient 43 = Discharged/Transferred to federal hospital 50 = Hospice – home 51 = Hospice – medical facility 61 = Discharged/Transferred within this institution to hospital-based Medicare approved swing bed 62 = Discharged/Transferred to another rehabilitation facility 63 = Discharged/Transferred to Medicare certified long term care hospital (LTCH) 64 = Discharge/Transferred to a long term care facility 65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66 = Discharged/Transferred to a Critical Access Hospital 70 = Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list |
| 112 | AmbStatD | Ambulation status at Discharge | Numeric | 1 = Able to ambulate independently w/or w/o device 2 = With assistance (from person) 3 = Unable to ambulate 9 = Not documented |

APPENDIX V (CONT.)

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|--|----------------------|--|-------------------|--|
| 113 | MedHisSM | Documented past medical history of Smoking – a year prior to hospital arrival? (Appendix IV) | Numeric | 1 = Yes 0 = No/Not documented |
| 114 | SmkCesYN | Was patient or the care giver given smoking cessation advice or counseling during the hospital stay? | Numeric | 1 = Yes 0 = No or not documented in the medical record 2 = NC A documented reason exists for not performing counseling |
| 115 | MedHisDL | Is there a medical history of Dyslipidemia? | Numeric | 1 = Yes 0 = No/Not documented |
| 116 | LipAdmYN | Patient on cholesterol medication prior to their hospitalization? | Numeric | 1 = Yes 0 = No/Not documented |
| Record lipid levels done within 48 hours of admission or within 30 days prior to admission. | | | | |
| 117 | LipLDL | LDL __ __ __ mg/dl | Numeric | 3 digits |
| 118 | LipHDL | HDL __ __ __ mg/dl | Numeric | 3 digits |
| 119 | LipTotal | Total Cholesterol __ __ __ mg/dl | Numeric | 3 digits |
| 120 | LipTri | Triglycerides __ __ __ __ mg/dl | Numeric | 4 digits |
| 121 | HbA1c | Glycosylated Hb __ __ . __ % | Numeric | 3 digits |
| 122 | LipDisYN | Documentation that cholesterol medication was prescribed at discharge? | Numeric | 1 = Yes 0 = No or Not Documented 2 = NC - Contraindicated |
| 123 | LipStatn | Statin prescribed as cholesterol-reducing medication | Numeric | 1 = Yes 0 = No |
| 124 | LipOthRx | Other cholesterol-reducing medication prescribed | Numeric | 1 = Yes 0 = No/Not documented |
| 125 | MedHisHT | Documented past medical history of hypertension | Numeric | 1 = Yes 0 = No/Not documented |
| 126 | HBPAdmYN | Antihypertensive medication prior to admission | Numeric | 1 = Yes 0 = No/Not documented |
| 127 | HBPTreat | Documentation antihypertensive medication was prescribed at discharge? | Numeric | 1 = Yes 0 = No/Not documented |

APPENDIX V (CONT.)

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|--|----------------------|--|-------------------|--|
| 128 | AthAdmYN | Taking antithrombotic medication prior to admission? | Numeric | 1 = Yes 0 = No 9 = Not documented |
| 129 | AthDscYN | Was antithrombotic medication prescribed at discharge? | Numeric | 1 = Yes 0 = No - None prescribed or not documented in the medical record 2 = NC – Documented reason for not administering exists in the record |
| 130 | MedHisAF | Documented medical history of atrial fibrillation/flutter | Numeric | 1 = Yes 0 = No / Not documented |
| 131 | AFibYN | Atrial fibrillation/flutter or paroxysmal atrial fibrillation (PAF), during this episode of care? | Numeric | 1 = Yes 0 = No / Not documented |
| 132 | AFibRx | If a history of atrial fibrillation/flutter or PAF is documented was patient prescribed anticoagulation medication upon discharge? -Warfarin (Coumadin) -Full dose unfractionated heparin IV -Full dose LMW heparin | Numeric | 1 = Yes 0 = No / Not documented 2 = Documented reason for not prescribing anticoagulation medication exists in the record |
| Was there documentation that the patient and/or caregiver received education and/or resource materials regarding all of the following: | | | | |
| 133 | EducRF | Personal modifiable risk factors for stroke | Numeric | 1 = Yes 0 = No/ Not documented 2 = NC |
| 134 | EducSSx | Stroke warning signs and symptoms | Numeric | 1 = Yes 0 = No/ Not documented 2 = NC |
| 135 | EducEMS | How to activate EMS for stroke | Numeric | 1 = Yes 0 = No/ Not documented 2 = NC |
| 136 | EducCC | Need for follow-up after discharge | Numeric | 1 = Yes 0 = No/ Not documented 2 = NC |
| 137 | EducMeds | Their prescribed medications | Numeric | 1 = Yes 0 = No/ Not documented 2 = NC |
| 138 | RehaPlan | Was the patient assessed for or received rehabilitation services? | Numeric | 1 = Yes 0 = No/ Not documented |

APPENDIX V (CONT.)

| Item | Variable name | Text Prompt | Field Type | Legal Values |
|-------------|----------------------|---|-------------------|---|
| 139 | Rehrecai | Received rehabilitation services during hospitalization | Numeric | 1= Yes 0 = No/ Not documented |
| 140 | Rehtrans | Transferred to rehabilitation facility | Numeric | 1 = Yes 0 = No/ Not documented |
| 141 | Rehrefer | Referred to rehabilitation services following discharge | Numeric | 1 = Yes 0 = No/ Not documented |
| 142 | Rehineli | Patient ineligible to receive rehabilitation services | Numeric | 1 = Yes 0 = No/ Not documented |
| 143 | ModRank | Modified Rankin at discharge (state added) | Numeric | 0 = No Symptoms at all 1 = No significant disability despite symptoms; able to carry out all usual duties and activities 2 = Slight disability, unable to carry out previous activities, but able to look after own affairs without assistance 3 = Moderate disability, requiring some help, but able to walk without assistance 4 = Moderately severe disability, unable to walk without assistance and unable to attend to own bodily needs without assistance 5 = Severe disability; bedridden, incontinent and requiring constant nursing care and attention 6 = Dead |
| 144 | Reserved1 | To be Determined as needed | Numeric | |
| 145 | Reserved2 | To be Determined as needed | Numeric | |
| 146 | Reserved3 | To be Determined as needed | Character | 20 characters |

APPENDIX VI: THE NEW JERSEY ACUTE STROKE REGISTRY

**New Jersey Department of Health and Senior Services
ACUTE STROKE REGISTRY (NJASR, VERSION 1.0)**

A. DEMOGRAPHIC DATA

*Hospital Type (1): 1=Primary 2=Comprehensive 3=Other _____
*Hospital Code (2): _____ *Hospital Transferred From Code (3): _____ *Medical Record #(4): _____
*Patient: Last Name (5): _____ *First Name (6): _____ *MI (7): _____
Date of Birth (8): (mm/dd/yyyy) ___/___/___ *SS# (9): ___-___-___ *Zip Code (10): _____
Gender (11): 1=Male 2=Female _____
Race (12): 1=White 2=Black 3=Asian 4=Native American/Alaska Native 5=Hawaiian/Other Pacific Islander 6=Other _____
Hispanic or Latino (13): 1=Yes 0= No _____
Health Insurance Status (14): 1=Blue Cross/Blue Shield 2=Commercial 3=HMO 4=Medicaid 5=Medicare
6=Self-pay 7=Tricare (Champus) 8=Uninsured/Indigent 9=Other _____

B. PRE-HOSPITAL/EMERGENCY MEDICAL SYSTEM (EMS) DATA

Where was the patient when stroke was detected or when symptoms were discovered (15)?
1=Not in a health care setting 4=Stroke occurred while patient was an inpatient in your hospital
2=Another acute care facility 5=Outpatient health care setting
3=Chronic health care facility 9=Cannot be determined _____
If answer is 1, 2, 3 or 9 on #15:
How did the patient get to your hospital for treatment of his/her stroke (16)?
1=EMS 2=Private transportation/taxi other 3=Transferred from another hospital 9=ND or unknown _____
If patient arrived by EMS, then complete questions 17, 18 and 19:
Date and time call received by EMS: Date (17): (mm/dd/yyyy) ___/___/___ Time (18): (hh:mm) ___:___
Was there EMS pre-notification to your hospital (19)? 1=Yes 0=No _____

C. HOSPITALIZATION

Date of arrival to Hospital/ED: Date (20): (mm/dd/yyyy) ___/___/___ Time (21): (hh:mm) ___:___
Hospital Admission Date (22): (mm/dd/yyyy) ___/___/___
In what area of the hospital was the patient first evaluated (23)?
1=Emergency Department 3=Imaging suite prior to ED arrival or DA
2=Direct Admit (DA) 9=Cannot be determined _____
What was the presumptive hospital admission diagnosis at the time of admission (select only one) (24)?
1=intracerebral Hemorrhage 3=Subarachnoid Hemorrhage 5=Ischemic Stroke
2=Transient Ischemic Attack 4=Stroke not otherwise specified 6=No stroke related diagnosis _____
Was patient ambulatory prior to the current stroke/TIA (25)?
1=Able to ambulate independently w/or w/o device 3=Unable to ambulate
2=With assistance 9=Not documented _____

**ACUTE STROKE REGISTRY (NJASR, VERSION 1.0)
(CONTINUED)**

D. IMAGING

Was brain imaging performed at your hospital after arrival as part of the initial evaluation for this episode of care or this event (26)?

1=Yes 0=No 2=NC-if outside imaging prior to transfer or patient is DNR/CMO _____

If yes,

Date and time of initial brain imaging: Date (27): (mm/dd/yyyy) ___/___/___ Time (28): (hh:mm) ___:___

Initial brain image findings (29): 1=Hemorrhagic 0=No hemorrhage 9=Not available _____

Date and time of brain image findings: Date (30): (mm/dd/yyyy) ___/___/___ Time (31): (hh:mm) ___:___

E. SYMPTOM TIMELINE

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)

Date (32): (mm/dd/yyyy) ___/___/___ Time (33): (hh:mm) ___:___

When was the patient first discovered to have the current stroke or stroke-like symptoms? (within 15 min of exact time)

Date (34): (mm/dd/yyyy) ___/___/___ Time (35): (hh:mm) ___:___

(If performed): What is the first NIH Stroke Scale total score recorded by hospital personnel (36)? (00-42) _____

F. THROMBOLYTIC TREATMENT

Was IV tPA initiated for this patient at this hospital (37)?

1=Yes 0=No 2=NC-Documented reason exists for not giving IV Thrombolytic _____

If IV tPA was initiated at this hospital or ED, please complete this section:

Date (38): (mm/dd/yyyy) ___/___/___ Time (39): (hh:mm) ___:___

Was other thrombolytic therapy administered (40)? 1=Yes 0=No _____

IV tPA at an outside hospital (41): 1=Yes 0=No _____

IA catheter-based reperfusion at this hospital (42): 1=Yes 0=No _____

If yes, record date and time: Date (43): (mm/dd/yyyy) ___/___/___ Time (44): (hh:mm) ___:___

IA catheter-based reperfusion at outside hospital (45): 1=Yes 0=No _____

Investigational or experimental protocol for thrombolysis (46): 1=Yes 0=No _____

If yes, specify: (47): (Text 50) _____

*Other investigative therapy for ischemic or hemorrhagic stroke (48): 1=Yes 0=No _____

Complications of thrombolytic therapy:

Symptomatic intracranial hemorrhage (49): 0=No 1=Yes (≤ 36 hours of tPA) 9=Unknown _____

Life threatening, serious systemic hemorrhage (50): 0=No 1=Yes (≤ 36 hours of tPA) 9=Unknown _____

**ACUTE STROKE REGISTRY (NJASR, VERSION 1.0)
(CONTINUED)**

G. NON-TREATMENT WITH THROMBOLYTICS

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 patient's chart? (*Check all that apply*)

Contraindications, which may include any of the following:

| | | | |
|--|-------|------|-------|
| SBP >185 or DBP >110 mmHg despite treatment (51) | 1=Yes | 0=No | _____ |
| Recent intracranial or spinal surgery, head trauma, or stroke (52) (<3 mo.) | 1=Yes | 0=No | _____ |
| Recent surgery/trauma (53) (<15 days) | 1=Yes | 0=No | _____ |
| Active internal bleeding (54) (<22 days) | 1=Yes | 0=No | _____ |
| Suspicion of subarachnoid hemorrhage (55) | 1=Yes | 0=No | _____ |
| History of intracranial hemorrhage or brain aneurysm or vascular malformation or brain tumor (56) | 1=Yes | 0=No | _____ |
| Platelets <100,000, PTT >40 sec after heparin use, or PT >15 or INR >1.7, or known bleeding diathesis (57) | 1=Yes | 0=No | _____ |
| CT findings (ICH, SAH, or major infarct signs) (58) | 1=Yes | 0=No | _____ |
| Seizure at onset (59) | 1=Yes | 0=No | _____ |

Warnings: conditions that might lead to unfavorable outcomes:

| | | | |
|---|-------|------|-------|
| Stroke severity - too severe (e.g., NIHSS >22) (60) | 1=Yes | 0=No | _____ |
| Glucose < 50 or > 400 mg/dl (61) | 1=Yes | 0=No | _____ |
| Left heart thrombus (62) | 1=Yes | 0=No | _____ |
| Care-team unable to determine eligibility (63) | 1=Yes | 0=No | _____ |
| Rapid improvement of Stroke severity too mild (64) | 1=Yes | 0=No | _____ |
| Advanced age (65) | 1=Yes | 0=No | _____ |
| Patient/Family refused (66) | 1=Yes | 0=No | _____ |
| IV or IA tPA given at outside hospital (67) | 1=Yes | 0=No | _____ |
| Increased risk of bleeding due to comorbid conditions (68) (see coding instructions) | 1=Yes | 0=No | _____ |
| Life expectancy <1 year or severe co-morbid illness or CMO on admission (69) | 1=Yes | 0=No | _____ |

Hospital-Related or Other Factors:

| | | | |
|---|-------|------|-------|
| Failure to diagnose in 3 hour time frame (70) | 1=Yes | 0=No | _____ |
| In-hospital Time Delay (71) | 1=Yes | 0=No | _____ |
| Delay in patient arrival (72) | 1=Yes | 0=No | _____ |
| No IV access (73) | 1=Yes | 0=No | _____ |
| Other (25 characters) (74): _____ | | | |

**ACUTE STROKE REGISTRY (NJASR, VERSION 1.0)
(CONTINUED)**

Ambulation status at Discharge (112):

- 1 = Able to ambulate independently w/or w/o device
- 2 = With assistance (from one person)
- 3 = Unable to ambulate
- 9 = Not documented

Is there documentation for past medical history of smoking - did the adult patient smoke at least one cigarette during the year prior to hospital arrival (113)?

- 1=Yes 0=No/Not documented

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 (114)?

- 1=Yes 0=No or not documented in the medical record
2=NC- A documented reason exists for not performing counseling

Is there a past medical history of Dyslipidemia (115)?

- 1=Yes 0=No/Not documented

Was the patient on cholesterol-reducing or cholesterol-controlling medication prior to this hospitalization (116)?

- 1=Yes 0=No

***Record lipid levels during hospital admission or within 30 days prior to admission:**

- LDL (3-digit) (117) _____ mg/dl
HDL (3-digit) (118) _____ mg/dl
Total Cholesterol (3-digit) (119) _____ mg/dl
Triglycerides (4-digit) (120) _____ mg/dl
Glycosylated Hb (4-digit) (121) _____ %

Is there documentation that cholesterol-reducing or cholesterol-controlling medication was prescribed at discharge (122)?

- 1=Yes 0=No/Not documented 2=NC-Contraindicated

If medication was prescribed, please answer which medication classes were prescribed:

- Statin (123) 1=Yes 0=No
Other medication (124) 1=Yes 0=No

Is there a documented history of hypertension (125)?

- 1=Yes 0=No/Not documented

Was patient on antihypertensive medication prior to admission (126)?

- 1=Yes 0=No/Not documented

Is there documentation that antihypertensive medication was prescribed at discharge (127)?

- 1=Yes 0=No/Not documented

Was the patient taking antithrombotic medication prior to admission (128)?

- 1=Yes 0=No 9=Not documented

Was antithrombotic medication prescribed at discharge (129)?

- 1=Yes 0=No
2=NC- Documented reason for not administering exists in the record

**ACUTE STROKE REGISTRY (NJASR, VERSION 1.0)
(CONTINUED)**

Is the documentation in the patient's medical history of atrial fibrillation/flutter (130)?

1=Yes 0=No/Not documented

Was atrial fibrillation/flutter or paroxysmal atrial fibrillation (PAF) documented during this episode of care (131)?

1=Yes 0=No/Not documented

If a history of atrial fibrillation/flutter or PAF is documented in the medical history of the patient or the patient experienced atrial fibrillation/flutter or PAF during this episode of care, was patient prescribed anticoagulation medication upon discharge (132)?

1=Yes 0=No/Not documented

2=Documented reason for not prescribing anticoagulation exist in medical record

Was there documentation that the patient and/or caregiver received education and/or resource materials regarding any of the following?

Personal modifiable risk factors for stroke (133) 1=Yes 0=No/Not documented 2=NC

Stroke warning signs (134) 1=Yes 0=No/Not documented 2=NC

How to activate EMS (135) 1=Yes 0=No/Not documented 2=NC

Need for follow-up after discharge (136) 1=Yes 0=No/Not documented 2=NC

Their prescribed medications (137) 1=Yes 0=No/Not documented 2=NC

Is there documentation in the record that the patient was assessed for or received rehabilitation services (138)?

1=Yes 0=No/Not documented

Did patient receive rehabilitation services during hospitalization (139)?

1=Yes 0=No/Not documented

Was patient transferred to a rehabilitation facility (140)?

1=Yes 0=No/Not documented

Was patient referred to rehabilitation services following discharge (141)?

1=Yes 0=No/Not documented

Was patient ineligible to receive rehabilitation services (e.g., symptoms resolved, poor prognosis, patient unable to tolerate rehabilitation therapeutic regimen) (142)?

1=Yes 0=No/Not documented

***Modified Rankin Scale at Discharge (143):**

0=No symptoms at all

1=No significant disability despite symptoms; able to carry out all usual duties and activities

2=Slight disability; unable to carry out previous activities, but able to look after own affairs without assistance

3=Moderate disability; requiring some help, but able to walk without assistance

4=Moderately severe disability, unable to walk without assistance and unable to attend to own bodily needs without assistance

5=Severe disability; bedridden, incontinent and requiring constant nursing care and attention

6=Dead

***Reserved field 1 (144):** _____

***Reserved field 2 (145):** _____

***Reserved field 3 (146):** _____

*** State Added/Modified Item**