Primary Stroke Service

Stroke Patient Management Tool(TM) Coding Instructions

Updated 4/29/2010

Legend

Stroke PMT fields

Suggested Sources for Abstraction

Entry Criteria

Patients with a primary diagnosis of the following can be included:

- Ischemic Stroke
- Transient Ischemic Attack (TIA)
- Subarachnoid Hemorrhage
- Intracerebral Hemorrhage
- Stroke not otherwise specified

For a full description of the stroke diagnoses refer to the definition for <u>Clinical hospital diagnosis related to</u> <u>stroke</u>.

Include:

- Patients initially admitted to the hospital for one of the diagnoses even if they later transfer or expire.
- Patients directly admitted to nursing units within the hospital without first being seen in the Emergency Department (ED). This includes patients with acute ischemic stroke who receive treatment at another hospital and are transferred to your hospital.
- Patients who refuse treatment or who have Do Not Resuscitate orders.
- Patients evaluated and treated in the ED with the intention of being admitted, even if they expire or are subsequently transferred to another acute care hospital prior to being admitted to the hospital.
- You may include or exclude in-hospital stroke. Please note in-hospital strokes are excluded from all Performance Measures.

Exclude:

- Patients who die in the ED who don't meet any of the inclusion criteria.
- Patients who present with stroke-like symptoms but who do not end up being diagnosed with a stroke or TIA.
- Patients < 18 years of age.

• Patients admitted for the sole purpose of the performance of elective carotid endarterectomy or any revascularization.

Note: You are not required to enter patients only seen in observation unit, but if you do enter them, these patients will be accountable to all measures.

Note for Coverdell users: At this point in time, based upon the recommendations of PCNASR clinical consultants, PCNASR encourages but does not require hospitals to include patients who are observation patients in the registry.

Additional Entry Criteria and case assertainment information is available under the following links: Massachusetts Primary Stroke Service Licensure Registry (PSS)

General notation:

- ND or No/ND = Not Documented. Select ND when there is no documentation in the medical record to explain why a treatement or intervention is not performed or evidence of a condition.
- NC = A reason for non-treatment was documented in the medical record (e.g. not indicated, contraindicated, patient/family refused).
- UTD = Unable to determine.
- IV t-PA = Intravenous Tissue Plasminogen Activator
- PMT = Patient Management Tool

Abstraction Guidelines:

- Make use of the Suggested Sources for Abstraction as a guide to help find medical documentation for each data element. **Only** abstract data which is clearly documented in the medical records. When in doubt, consult with your local Stroke champion or Stroke team leader for clarification.
- **Date Precisions**: Date and Time fields have an additional "Precision" drop-down right above the MM/DD/YYYY HH:MI blanks. The Precision is used to indicate how much of the Date and Time data is known and can be abstracted. For most of the Stroke Date and Time fields, there are three Precision levels.
 - The default level is "MM/DD/YYYY HH:MI". This is used if the entire Date and Time information is available. Time should be entered in 24hr/Military format.



 If the Time is ND, select a Precision of "MM/DD/YYYY". The "HH:MI" blanks will become grayed-out.



 If the Date is ND, select a Precision of "Unknown". The whole "MM/DD/YYYY HH:MI" field will become grayed-out.

*Date/Time of Patient Arrival at your ED:	Unknown		~			
		1	1		:	
	MM	DD	YYYY	HH	MN	

Suggested Sources:

Pre-hospital Data may include EMS Patient Care records (also known as transport sheets, trip sheets, or trip records).

Admission Data may include:

- Admission sheet
- Physician documentation (including Admitting physician notes, consultation notes, ED physician notes, Physician's hospital admission, transfer, or ED discharge notes, progress notes)
- ED documentation (including ED nurse notes, ED order sets or pathway documentation, ED physician notes, ED record, ED triage sheet, Registration form, ED vital signs graphical record)
- Inpatient documentation (including physician notes, history and physical, mediction documentation, nurse progress notes, nursing admission assessment note, physical or occupational therapy consultation or progress notes, speech pathology consultation or progress notes, diet or nutrition services consultation or progress notes)

Hospitalization Data may include:

- Physician documentation (including Acute physician or nursing notes, Acute Stroke Pathway documentation, Consulation progress notes, Diagnostic report, Physician progress notes, Progress notes)
- Inpatient documentation (including physician notes, history and physical, mediction documentation, nurse progress notes, nursing admission assessment note, physical or occupational therapy consultation or progress notes, speech pathology consultation or progress notes, diet or nutrition services consultation or progress notes)
- Medication Results (including Medication order sheets, Medication ordering system in the computer)
- Orders (including Physician order sheets, Printed or Electronic order sheets, rt-PA Protocol Sheets)
- Lab Results
- Social services notes

Discharge Data may include:

- Care plans
- Clinical logs
- Clinician encounter sheets
- Consultant reports
- Discharge face sheet
- Discharge form
- Discharge instruction sheet
- Discharge orders
- Discharge summary
- Flow sheets

- Multidisciplinary progress notes
- Nursing discharge notes
- Physician summary
- Referral notes
- Teaching sheets
- Transfer note
- Transfer record
- Physical or occupational therapy consultation or progress notes
- Diet or nutrition services consultation or progress notes

Patient ID

The patient identification number is a unique patient ID number assigned to the patient by the site for that admission. Enter a de-identified number in order to track your patient. Do NOT use date of birth, social security numbers, or medical record numbers. It is recommended that you create a Stroke Registry Log to match up the Patient IDs you create for the Stroke PMT (Patient Management Tool) with actual identifiers. For hospitals participating in the Coverdell registry, Patient ID cannot exceed 9 characters.

Example: You might use numbers, letters or any combination, e.g. 019A. The Patient ID is case-sensitive

S The Stroke Registry Log is kept confidential and in a secure location at the hospital site. This log is the only means the hospital site has to correlate data in the registry with a specific patient.

Arrival and Admission Information

Patient location when stroke symptoms discovered (Where was the patient when stroke was detected or when symptoms were discovered?)

Indicate the type of facility or setting from which the patient came from when stroke like symptoms were discovered.

- 1. Not in a healthcare setting
- 2. Another acute care facility
- 3. Chronic healthcare facility
- 4. Outpatient healthcare setting
- 5. Stroke occurred while patient was an inpatient in your hospital
- 6. ND or Cannot be determined

Notes for Abstraction

 If the patient was a resident of a nursing home, but was out with family for the day and suffered a stroke and the family/EMS brought the patient to your hospital, choose "Not in a healthcare setting".

- If the patient was at home, at work, or even a visitor in your hospital and had stroke symptoms, then choose "Not in a healthcare setting".
- If the patient was transferred to your hospital from another hospital's ED or inpatient unit but was outside of a healthcare facility when the stroke occurred, choose "Not in a healthcare setting".
- If the patient was a resident of a nursing home and the stroke occurred at the NH, choose "Chronic healthcare facility".
- A chronic care facility would include nursing home, long-term care facility, inpatient rehab facility, and assisted-living facility.
- If the patient is at a clinic or physician office visit, or at your hospital but receiving outpatient procedure or service that did not require the patient to be admitted as an inpatient, select "Outpatient healthcare setting".
- If the patient was an inpatient in your hospital choose "Stroke occured while patient was an inpatient in your hospital". If the patient was already within your ED or hospital and experienced new onset of stroke symptoms, then this is considered an inpatient stroke or TIA. Only those hospitals that are interested in collecting information regarding inpatient stroke care should enter these patients. Patients who have transient symptoms that are present on arrival to the ED but resolve, and then later return during the hospitalization and meet criteria for ischemic stroke should all be entered as inpatient strokes.
- The answer to this question is independent of the answer for Point of Origin for Admission or Visit. That question asks where the patient was located prior to arriving at your hospital, not where the patient was when they first developed stroke symptoms.

SPre-hospital Data, Admission Data

How patient arrived at your hospital (How did the patient get to your hospital for treatment of their stroke?)

Indicate the type of transport used to bring the patient to your facility.

- o EMS from home/scene
- o Private transportation/taxi/other from home/scene
- o Transfer from other hospital
- o ND or unknown

Choose "EMS from home/scene" whenever the patient was brought to your hospital from home/scene by EMS, whether by ground EMS or Air EMS. If a patient is transferred from another hospital by EMS choose "Transfer from other hospital".

'Private transportation/taxi/other from home or scene includes cab, bus, car, walk-in, etc.

SPre-hospital Data, Admission Data

Arrival Date/Time (Date & time of arrival to this Hospital)

The earliest documented month, day, and year, and time the patient arrived at the hospital.

- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (2001 Current Year)

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- HH = Hour (00-23)
- MM = Minutes (00-59)
- UTD = Unable to Determine

Time must be recorded in military time format.

With the exception of Midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

- Midnight 00:00, Noon 12:00
- 5:31 am 05:31, 5:31 pm 17:31
- 11:59 am 11:59, 11:59 pm 23:59

Note: 00:00 = midnight. If the time is documented as $00:00 \ 11-24- 20XX$, review supporting documentation to determine if the Arrival Date should remain 11-24- 20XX or if it should be converted to 11-25- 20XX.

When converting Midnight or 24:00 to 00:00 do not forget to change the Arrival Date.

Example: Midnight or 24:00 on 11-24- 20XX = 00:00 on 11-25- 20XX

Notes for Abstraction (Date)

- If the date of arrival is unable to be determined from medical record documentation, select "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the
 date documented is obviously in error (not a valid format/range or outside of the
 parameters of care [after the Discharge Date]) and no other documentation is found that
 provides this information, the abstractor should select "UTD."
- Examples:
 - Documentation indicates the Arrival Date was 03- 42 -20 XX. No other documentation in the list of ONLY Acceptable Sources provides a valid date. Since the Arrival Date is outside of the range listed in the Allowable Values for "Day", it is not a valid date and the abstractor should select "UTD."
 - Patient expires on 02-12-20 XX and all documentation within the ONLY Acceptable Sources indicates the Arrival Date was 03-12-20 XX. Other documentation in the medical record supports the date of death as being accurate. Since the Arrival Date is after the Discharge Date (death), it is outside of the parameter of care and the abstractor should select "UTD."
- Note:
- Transmission of a case with an invalid date as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for Arrival Date allows the case to be accepted into the warehouse.
- Review only the acceptable sources to determine the earliest date the patient arrived at the hospital. This may differ from the admission date.
- Note :
- Medical record documentation from all of the "only acceptable sources" should be carefully examined in determining the most correct date of arrival. Arrival date should NOT be abstracted simply as the earliest date in the acceptable sources, without regard

to other (i.e., ancillary services) substantiating documentation. If documentation suggests that the earliest date in the acceptable sources does not reflect the date the patient arrived at the hospital, this date should not be used.

- When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports or ECGs) obtained prior to arrival. The intent is to utilize any documentation, which reflects processes that occurred in the ED or hospital.
- If the patient is in an outpatient setting of the hospital, except for observation status, (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for inpatient care as arrival date.
- If the patient is in an observation status and is subsequently admitted to the hospital:
 - If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient presents to the ED or arrived on the floor for observation care as the arrival date.
 - If the patient was admitted to observation from the ED of the hospital, use the date the patient presented to the ED as the arrival date.
 - If the patient was a direct admit to observation, use the earliest date the patient arrived at the hospital.
- If the patient is a "Direct Admit" to the cath lab, as a transfer from another ED or acute care hospital, use the date the patient presents to the cath lab as the arrival date.
- For "Direct Admits" to acute inpatient, use the earliest date the patient arrives at the hospital.
- The source "Any ED documentation" includes ED vital sign record, ED/Outpatient Registration form, triage record and ECG reports, laboratory reports, x-ray reports, etc., if these ancillary services were rendered while the patient was an ED patient.
- The source "Procedure notes" refers to formal documents that describe a procedure that was done (e.g., endoscopy, cardiac cath). ECG and x-ray reports should NOT be considered procedures notes.

Notes for Abstraction (Time)

- For times that include "seconds", remove the seconds and record the time as is.
- Example:
 - o 15:00:35 would be recorded as 15:00
- If the time of arrival is unable to be determined from medical record documentation, select "UTD."
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obviously in error (not a valid format/range) and no other documentation is found that provides this information, the abstractor should select "UTD."
- Example:
 - Documentation indicates the Arrival Time was 3300. No other documentation in the list of ONLY Acceptable Sources provides a valid time. Since the Arrival Time is outside of the range in the Allowable Values for "Hour," it is not a valid time and the abstractor should select "UTD."
- Note:
- Transmission of a case with an invalid time as described above will be rejected from the QIO Clinical Warehouse and the Joint Commission's Data Warehouse. Use of "UTD" for Arrival Time allows the case to be accepted into the warehouse.
- Review only the acceptable sources to determine the earliest time the patient arrived at the hospital. This may differ from the admission time.
- Note:

- Medical record documentation from all of the "only acceptable sources" should be carefully examined in determining the most correct time of arrival. Arrival time should NOT be abstracted simply as the earliest time in the acceptable sources, without regard to other (i.e., ancillary services) substantiating documentation. If documentation suggests that the earliest time in the acceptable sources does not reflect the time the patient arrived at the hospital, this time should not be used.
- When reviewing ED records do NOT include any documentation from external sources (e.g., ambulance records, physician/advanced practice nurse/physician assistant [physician/APN/PA] office record, laboratory reports, or ECGs) obtained prior to arrival. The intent is to utilize any documentation which reflects processes that occurred in the ED or hospital.
- If the patient is in an outpatient setting of the hospital, except for observation status, (e.g., undergoing dialysis, chemotherapy, cardiac cath) and is subsequently admitted to
- acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time.
- If the patient is in an observation status and is subsequently admitted to the hospital:
 - If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient presents to the ED or arrived on the floor for observation care as the arrival time.
 - If the patient was admitted to observation from the ED of the hospital, use the time the patient presented to the ED as the arrival time.
 - If the patient was a direct admit to observation, use the earliest time the patient arrived at the hospital.
- If the patient is a "Direct Admit" to the cath lab, as a transfer from another ED or acute care hospital, use the time the patient presents to the cath lab as the arrival time.
- For "Direct Admits" to acute inpatient, use the earliest time the patient arrives at the hospital.
- The source "Any ED documentation" includes ED vital sign record, ED/Outpatient Registration form, triage record and ECG reports, laboratory reports, x-ray reports, etc., if these ancillary services were rendered while the patient was an ED patient.
- The source "Procedure notes" refers to formal documents that describe a procedure that was done (e.g., endoscopy, cardiac cath). ECG and x-ray reports should NOT be considered procedure notes.

Suggested Data Sources:

ONLY ACCEPTABLE SOURCES:

- Any ED documentation
- Nursing admission assessment/admitting note
- Observation record
- Procedure notes
- Vital signs graphic record
- For "Direct Admits," in addition to the above suggested data sources, the following may also be utilized:
 - o Face sheet

Guidelines for Abstraction:

Inclusion - None

Exclusion - Addressographs/stamps

SAdmission Data

Demographics

Age

This is the age on the day of admission, calculated from date of birth in medical record. Because this data element is critical in determining the population for all measures, the abstractor should NOT assume the UB-92/UB-04 claim information for the birth date is correct. If the abstractor determines through chart review that the UB-92/UB-04 day is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct birth date through chart review, she/he should default to the UB-92/UB-04 date of birth.

SAdmission Data, UB-92/UB-04, Field Location: 14.

Gender

The patient's documented sex on arrival at the hospital.

- Male
- Female
- Unknown

Collect the documented patient's sex at admission or the first documentation after arrival.

- Consider the sex to be unable to be determined and select "Unknown" if:
 - The patient refuses to provide their sex.
 - Documentation is contradictory.
 - o Documentation indicates the patient is a Transexual.
 - o Documentation indicates the patient is a Hermaphrodite

SAdmission Data, UB-92 Field Location 15.

Hispanic Ethnicity

Documentation that the patient is of Hispanic ethnicity or Latino.

- o Yes
- No/UTD (Unable to determine)

The data element, Race, is required in addition to this data element.

Example: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

Examples:

- Black-Hispanic
- Chicano
- H
- Hispanic
- Latin American
- Latino/Latina
- Mexican-American
- Spanish
- White-Hispanic

SAdmission Data

Race

The patient's self-assessed race/ethnicity, or if not available, the physician or institution's assessment. Assumptions should not be made based on physical characteristics. This data allows for analysis of racerelated patterns of care. If patient is multi-racial, select each race they designate. Select all that apply from the list provided. Hold down the "Ctrl" key on the keyboard to select multiple options or to deselect an option. Options include:

- White implies White or origins in Europe, Middle East or North Africa (e.g., Caucasian, Iranian, White)
- Black or African American would also include Haitian.
- Asian includes those from the Far East, southeast Asia, or the Indian subcontinent, including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippines, Hmong, Thailand, and Vietnam.
- American Indian/Alaska Native A person having origins in any of the original peoples of North and South American (including Central America) and who maintains tribal affiliation or community attachment (e.g., any recognized tribal entity in North and South America [including Central America], Native American).
- Native Hawaiian/Pacific Islander includes persons having origins in any of the other original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- Other
- UTD (Unable to determine)

The data element Hispanic Ethnicity is required in addition to this data element.

(For The Joint Commission, both Other and Unknown are equivalent to UTD or Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).)

Examples:

- Based on physical characteristics, the Patient 050a appears to be of Asian descent. When asked, the patient clarifies that she is both African American and Fijian. Check both the Black or African American AND the Pacific Islander boxes.
- When asked, Patient 050b states that she is African American and Filipino. Check boxes for Black or African-American AND Asian.
- Patient 050c reports he is Afro-Caribbean. Check Black or African American, and note the appropriate ethnicity (Hispanic Yes or No).

• Patient 050d is aphasic and the race indicated on the Admission sheet is different than on the history and on the ED triage sheet. Check Unknown.

SAdmission Data

Diagnosis and Evaluation

Final clinical diagnosis related to stroke

This is the Stroke or TIA diagnosis defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

Select one of the 6 diagnosis options based on the clinical information found in the medical record. This assignment of clinical diagnosis should be done independently of the ICD-9-CM code assigned. In particular, patients admitted with ischemic stroke who are treated with IV tPA or other medications and develop the complication of intracerebral hemorrage should be coded as ischemic stroke, even if the ICD-9-CM code is assigned as a hemorragic stroke classification.

Ideally the diagnosis selected here should be equivalent to the final ICD-9-CM code. However, in some circumstances another ICD-9-CM code may be chosen. When there is a discrepancy, please consult your local Stroke Champion or Stroke Team lead and/or the hospital administrator responsible for assigning ICD-9 codes. Note for Coverdell users, this may be different from the presumptive hospital admission diagnosis.

This field is used to define patient populations in the Get With The Guidelines® Stroke Achievement Measures.

- Ischemic stroke
- Transient ischemic attack
- Subarachnoid hemorrhage
- Intracerebral hemorrhage
- Stroke not otherwise specified
- No stroke related diagnosis

Notes for Abstraction:

- Patients with transient symptoms upon ED arrival whose symptoms resolve but then return later during the hospitalization (symptoms > 24hrs or infarction on brain imaging while an inpatient) should be entered as inpatient strokes ischemic strokes and not as TIAs (Patient location when stroke symptoms discovered = stroke occurred while patient was an inpatient in your hospital; Final clinical diagnosis related to stroke = lschemic stroke)
- Patients who arrive with symptoms of stroke and have complete resolution after IV tPA should be diagnosed with "aborted stroke" (434.91) and not as TIA (435), and should be classified as "ischemic stroke" in the PMT (Patient Management Tool) (Final clinical diagnosis related to stroke = ischemic stroke).
- Patients with transient symptoms but infarction on the brain imaging are routinely diagnosed as ischemic stroke (not TIA) by treating physicians. You should enter the final clinical diagnosis related to stroke as documented by the physician, even if the ICD-9 code assigned to these patients is one of ischemic stroke.

- Patients admitted for non-stroke related illness but who have inpatient strokes should have a Final clinical Diagnosis Related to Stroke that is in alignment with their inpatient stroke type.
- Patients who present with neurological symptoms, but after work-up are determined not to have suffered from a stroke or TIA, should not be entered into the tool.
- Patients who are documented as having "CVA" or "Stroke" in their medical record, without any additional documentation around stroke type, and who have no evidence of hemorrhage (spelling) on initial brain imaging should be classified as Ischemic Stroke.
- Patients who do not have brain imaging, or in whom the interpretation of brain imaging is uncertain between ischemic and hemorrhagic stroke, should be categorized as "Stroke not otherwise specified." For example, a patient in whom there is evidence of both ischemic injury and brain hemorrhagic on initial imaging would be classified as "stroke not otherwise specified."
- Patients who present with symptoms that are not recognized as having been caused by stroke while in the initial phase of their hospital care should still be assigned a Final Clinical Diagnosis of stroke, TIA, etc. as appropriate.

Example: Patient 060a was admitted with pneumonia. On hospital day 2 he developed right sided weakness and was diagnosed with an ischemic stroke. Data entry should be "Ischemic Stroke."

SAdmission Data

Symptom Timeline

Date/Time patient last known to be well? [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/TIA? (To within 15 minutes of exact time is acceptable.)]

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

- Date:MM/DD/YYYY
- Time: HH:MM
- 24-hour clock (military time)

Notes for Abstraction:

The purpose of this data element is to identify the earliest possible time that stroke symptoms began. This is sometimes known as "Onset Time" although the use of this term has been confusing to many in the past. If a patient experiences the onset of their symptoms in the company of another individual who can verify that the patient was functioning normally up until the time of start of symptoms, then in this patient the time "last known well" is also the time of symptom discovery. In many cases, however, no one is present at the exact start of symptoms. In this situation, we need to document the time that the patient was last known to be well or at their baseline (time last known well), and record both of these. The time last known well should be the time closest to the time of discovery for which we have clear evidence that the patient was at their previous baseline. Depending on the type of stroke symptoms, this might be established by a telephone or in person conversation. Family members, EMS personnel, and others, often mistakenly record the time of symptom discovery as the time the patient was last known

well. It is imperative to distinguish these two times to avoid inappropriate use of IV t-PA (Intravenous Tissue Plasminogen Activator) in patients who are recently discovered to have symptoms but are many hours (>3 hrs) from their time of last being well.

- If a stroke "onset time" is listed in the medical record, without reference to the circumstances preceding its detection, then it should be assumed to be the time "last known well". Enter this time in the specified format. If there is a specific reference to the patient having been discovered with symptoms already present, then this "onset time" should be treated as a "time of symptom discovery" rather than a time of "last known well". If no time of "last known well" can be determined, then "Unknown" should be selected for time "last known well".
- When a time of discovery is documented, but the start of stroke symptoms is not witnessed and no time "last known well" is documented, then "Unknown" should be selected for time "last known well".
- When the start of stroke 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 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 hospital or ED arrival (e.g., "2 3 hours ago"), assume the maximum time from the range (e.g., 3 hours), and subtract that number of hours from the time of arrival to compute the time "last known well".
- If there are multiple times of "last known well" documented, either because subsequent more accurate information became available or because of different levels of expertise in sorting out the actual time 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
- The purpose of 'last known well' is to conservatively identify/estimate time of symptom onset. Use "last known well" to identify when the patient was either last seen or last known to be well (well means at the patient's baseline or usual state of health). This may change with various observers. If the last known well time cannot be identified, then indicate that last known well time and/or date is not known.
- In certain selected cases, patients may have transient symptoms which resolve and are later followed by symptoms that do not resolve and result in presentation to the hospital. If in the opinion of the physician, the patient had several symptomatic episodes between which he/she returns completely to baseline, then use the onset time of the most recent episode.

Examples:

- 1. Patient 140a arrived in ED via EMS on 12/10/2007 2:43 pm accompanied by her daughter. Her daughter states that patient was found at 2:00 pm "in her chair slumped over, I couldn't understand what she was saying and she was drooling from her mouth and her face didn't look right." On further questioning by the neurologist, the daughter says her mother ate lunch at 12:30 pm and then went to sit in her chair where she was later found as noted above.
 - Time and date of last known well are known as 12/10/2007 12:30, and time and date of discovery are known as 12/10/2007 14:00.
- 2. Patient 140b arrived in the ED with his son on 11/10/2007 8:09 am. His son states that he last saw his father last night at 8:30 pm. His father lives alone. His father woke up this morning about 6:30 am and noticed that his right arm was weak. It did not get better, so

patient called his son at 7:00 am, who came over right away and was concerned that his father was having a stroke, but his father could walk and talk OK. Daughter arrives and states that she had talked to her father on the phone last night around 9:30 pm and that he didn't mention anything about a problem with his arm.

- Time and date of last known well are known as 11/09/2007 21:30, and time and date of discovery are known as 11/10/2007 06:30.
- 3. Patient 140c was eating dinner with his wife tonight after they finished watching the nightly news on TV "when his arm began shaking and he couldn't hold onto his fork or his water glass or anything. He has never done this before." Their nightly news show is on from 6:00 to 6:30 pm. She called the ambulance right away. ED arrival date and time is 11/29/2007 7:53 pm.
 - Time and date of last known well are known as 11/29/2007 18:30, and date of discovery is known as 11/29/2007 with an unknown time. There is no reference to time of discovery in this scenario, so it remains unknown to the abstractor. Above the Date/Time field, select "MM/DD/YYYY" and just enter 11/29/2007.
- 4. Patient 140d states she has been having numbness come and go in her left arm for the past week, but it always went away. Today the numbness started about 4 hours before she came to the ED and didn't go away so she decided to get it checked. She thinks her arm isn't completely numb, but it feels heavy, and she can't hold a pen tightly. ED arrival time is 5:15 pm on 09/09/2007.
 - Time and date of last known well are known as 09/09/2007 13:15, and time and date of discovery are known as 09/09/2007 13:15.
- 5. Patient 140e was found on the floor beside the commode by the charge nurse at Starlight Nursing Home on her night rounds at 12:45 am on 12/01/2007. He wasn't able to talk or move, but his left leg was shaking. He is normally quite alert and normally walks with his walker. She called 911 right away after conferring with another nurse on duty. According to the evening charge nurse, there were no problems reported with Patient at change of shift. They think that the evening nurse would have seen him between 9 and 10 pm on her rounds. Information was provided by sheet sent from the nursing home. A phone call to the charge nurse does not reveal any further information from the patient's medical medical record. ED arrival date and time is 12/01/2007 1:37 am.
 - Time and date of last known well are known as 11/30/2007 21:00, and time and date of discovery are known as 12/01/2007 00:45.
- 6. A 58 y/o woman was last known normal at 7:00 pm and was found at 7:30 pm with right hemiparesis and aphasia. She is transferred to your hospital from another hospital having IV t-PA initiated on 06/10/2007 at 9:30 pm and arrived at your hospital at 10:15 pm.
 - Time and date of last known well are known as 06/10/2007 19:00, and time and date of discovery are known as 06/10/2007 19:30.
- 7. A 55 year old male had a brief episode of slurred speech at 6am on 5/10/2007. The episode resolved quickly and he returned completely to normal. At Noon on that same day (5/10/2007) he developed one sided weakness and slurred speech which persisted when he arrived to your hospital.
 - Time and date of last known well are known as 5/10/2007 12:00.

S Admission Data, Hospitalization Data

Date/Time of discovery of stroke symptoms? [When was the patient first discovered to have the current stroke symptoms? (To within 15 minutes of exact time of discovery is acceptable).]

Indicate the date and time of discovery of patient's symptoms (i.e., when the patient was found with symptoms). This should be the earliest time that patient was known to have symptoms. This date and time should not vary. If the event was witnessed, then the last known well date and time and the

discovery date and time will be identical. Record both, even if identical (checking the box for Time of Discovery same as Last Known Well will automatically set the discovery Date/Time with the same Date/Time as "last known well".)

- Date:MM/DD/YYYY
- Time: HH:MM
- 24-hour clock (military time)

See examples from Last Known Well

SAdmission Data, Hospitalization Data

Time of Discovery same as 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 this is the case, check this box to automatically fill-in discovery Date/Time with the same Date/Time as "last known well".

Brain Imaging

Brain imaging completed at your hospital for this episode of care? (Was Brain Imaging Performed at your hospital after arrival as part of the initial evaluation for this episode of care or this event?)

This question applies to the initial brain image for this event. If patient did not receive any brain imaging at this hospital/facility or an outside hospital, then select No/ND. If a patient had outside brain imaging prior to transfer from another hospital, and results for that imaging are recorded in the record, please select NC and record these findings under the subsequent data element, "Interpretation of first brain image after symptom onset, done at any facility."

- Yes
- No/ND
- NC

This data element is looking to capture information around the initial brain image (regardless if it is done at your facility or not). If a second brain image is completed at your hospital, after an initial imaging has been completed at an outside hospital, you would still select NC here and would record the findings of the initial brain image that was performed at the outside facility under Interpretation of first brain image after symptom onset, done at any facility.

Example: Patient 150a presented to the ED with a brief episode of slurred speech. The patient had a CT and lab tests completed. Symptoms completely resolved while in the ED and the patient was discharged from the ED with complete recovery of neurological symptoms. The patient returned to the ED 3 hours later and no repeat CT or lab tests were completed, but the previous CT and labs are used to determine course of treatment. Select NC for Brain Imaging Completed at this hospital.

SAdmission Data, Hospitalization Data, especially Radiology notes

Date/Time Brain Imaging Completed

Enter date and time stamped on the initial CT/MRI of the head performed at your institution. Record only CT/MRI date/time if the first study was performed at your hospital. Please note. If the first brain image is done at an outside hospital, "Outside brain imaging prior to transfer" is selected, and "Date/Time Initial Brain Imaging Completed" should not be filled in. Use the time stamp on the radiology report only if it clearly indicates the time of study completion and NOT time of scheduling, dictation or reporting. If an exact time is not available, see appropriate response categories for estimates and information not available below.

- Date:MM/DD/YYYY
- Time: HH:MM
- 24-hour clock (military time)

Example: If the ED nurses notes document that the head imaging study was done at 10:30 in the morning of November 23, 2004, the data entry would be: 11/23/04 10:30.

SAdmission Data, Hospitalization Data, especially Radiology notes

IV Thrombolytic Therapy

IV thrombolytic therapy initiated at this hospital?

Indicate whether IV tPA (Intravenous Tissue Plasminogen Activator) was initiated at your hospital.

- o Yes
- o **No**

Select Yes if IV tPA was given for acute ischemic stroke.

Select No If IV tPA is not initiated at your hospital, even if there are documented contraindications or warnings to IV tPA. In the case that tPA is contraindicated, select No for IV tPA initiated at your hospital and select Yes for Documented Contraindications or Warnings for not initiating IV thrombolytic in either the 0-3 hour or 3-4.5 hour treatment window. Please note the previous use of the NC choice has been replaced by separate Yes/No questions for documented contraindications and warnings.

It is essential that documented contraindications or warnings for non-treatment be selected when applicable for both the 0-3 and the 3-4.5 hour windows since the actual contraindications and warnings may differ between the two windows.

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 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, select Yes here and select Yes for "Not Admitted, Transferred from your ED to another acute care hospital?" This will allow you to capture the "drip and

ship" patient and disable non-relevant questions. See instructions for "<u>Not Admitted, Transferred from</u> your ED to another acute care hospital?"

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

If a patient begins treatment with IV tPA, but does not get the full dose due to a medical reason like an elevated INR or a newly discovered history element, select "Yes".

Note: IV tPA is not FDA approved for use in the 3-4.5 hour window, but there is now a Class 1A level guideline from the AHA regarding this treatment: <u>Expansion of the Time Window for Treatment of Acute</u> <u>Ischemic Stroke With Intravenous Tissue Plasminogen Activator.</u> (link is http://stroke.ahajournals.org/cgi/reprint/STROKEAHA.109.192535) There is a new Quality report available to assist tracking performance on this new measure.

SAdmission Data, Hospitalization Data

Date/Time IV tPA initiated (at this hospital or ED)

If IV tPA was initiated at this hospital or ED, record the date and time that IV tPA was initiated (time of bolus administration). If there are discrepancies in the documentation of bolus administration, the nursing documentation on the medication administration sheets should be treated as the most reliable source, followed by the stroke physician's documented time or ED note.

Please note, this time of treatment is used to control skip logic related to contraindications, warnings, etc related to non-treatment, so it is critical to enter the correct date/time here. If the data elements are not appearing as expected, please check that the date/time is abstracted accurately.

- Date:MM/DD/YYYY
- Time: HH:MM
- 24-hour clock (military time)

Notes for Abstraction:

- This data element applies only to patients for whom IV thrombolytic therapy was initiated at this hospital. Do not abstract this data element if IV thrombolytic therapy was initiated at another hospital and patient was subsequently transferred to this hospital.
- IV t-PA is the only FDA-approved IV thrombolytic therapy.

Example : For Patient 170a, a bolus of IV tPA occurred at 4:00 pm, and there was a 10 minute delay in finding a infusion pump, so infusion started at 4:10 pm. Record the Date and Time of IV tPA Initiated as 4:00 pm.

SAdmission Data, Hospitalization Data

Documented Contraindications or Warnings for not initiating IV thrombolytic in the 0-3hr treatment window?

o Yes

o **No**

Select Yes if there is a documented contraindication or warning for not initiating IV tPA in the 0 - 3 hour treatment window.

Select No if there are no specific reasons documented in the medical record why tPA was not administered or if a hospital-related factor or other reason was present which may or may not be documented but was apparent to the abstractor. This is the only section where it may be proper to infer reasons for non-treatment and is provided to assist in quality improvement activities.

It is not expected that in routine situations the physician will explicitly identify which contraindications or warnings were relevant to the 0-3 or 3-4.5 hour window. Most likely, this will only be documented when different reasons were relevant to the decision for the two time windows. See examples under Documented Reasons in the medical record for no IV t-PA started at your hospital.

TJC definition for this field from the Specifications Manual for National Hospital Inpatient Quality Measures:

The month, date, and year that IV thrombolytic therapy was initiated to a patient with ischemic stroke at this hospital. IV thr plasminogen to plasmin, which in turn breaks down fibrin and fibrinogen, thereby dissolving thrombus.

The time (military time) for which IV thrombolytic therapy was initiated at this hospital. IV thrombolytics convert plasminoge breaks down fibrin and fibrinogen, thereby dissolving thrombus.

- MM = Month (01 12)
- DD = Day (01 31)
- YYYY = Year (2001 Current Year)
- UTD = Unable to Determine
- HH = Hour (00-23)
- MM = Minutes (00-59)

Time must be recorded in military time format. With the exception of midnight and Noon:

- If the time is in the a.m., conversion is not required
- If the time is in the p.m., add 12 to the clock time hour

Examples:

- Midnight 00:00 Noon 12:00
- 5:31 am 05:31 5:31 pm 17:31
- 11:59 am 11:59 11:59 p.m. 23:59

Note:

00:00 = midnight. If the time is documented as 00:00 11-24- 20XX, review supporting documentation to determine if the *IV Date* should remain 11-24-20XX or if it should be converted to 11-25-20XX.

When converting Midnight or 24:00 to 00:00 do not forget to change the *IV Thrombolytic Initiation Date*.

Example: Midnight or 24:00 on 11-24- 20XX = 00:00 on 11-25- 20XX .

Notes for Abstraction:

- Use the date/time at which initiation of the IV thrombolytic was first documented. If a discrepancy exists in date does sources, choose the earliest date/time.. If there are two or more different IV thrombolytic initiation dates (either different episodes or corresponding with the same episode), enter the earliest date/time.
- If the date/time IV thrombolytic therapy was initiated is unable to be determined from medical record documentatio
- The medical record must be abstracted as documented (taken at "face value"). When the date/time documented is valid date/format) **and** no other documentation is found that provides this information, the abstractor should select
- Example:
 - Documentation indicates the IV thrombolytic initiation date was 03- 42 -20XX. No other documentation in t a valid date. Since the IV thrombolytic initiation date is outside of the range listed in the Allowable Values f date and the abstractor should select "UTD
 - 15:00:35 would be recorded as 15:00
 - Documentation indicates the IV thrombolytic initiation time was 3300. No other documentation in the media time. Since the IV thrombolytic initiation time is outside of the range listed in the Allowable Values for "Hou the abstractor should select "UTD."
- The use of "hang time" or "infusion time" is acceptable as IV thrombolytic initiation time when other documentation
- IV thrombolytic initiation time refers to the time the thrombolytic bolus/infusion was started.
- Do not use physician orders as they do not demonstrate initiation of the IV thrombolytic (in the ED this may be use nurse).
- The medical record must be abstracted as documented (taken at "face value"). When the time documented is obvi time) and no other documentation is found that provides this information, the abstractor should select "UTD."
- Note: Transmission of a case with an invalid date as described above will be rejected from the Joint Commission's "UTD" for IV thrombolytic initiation date allows the case to be accepted into the warehouse.

Suggested Data Sources

- Emergency department record
- IV flow sheets
- Medication administration record
- Nursing flow sheets
- Progress Notes

SAdmission Data, Hospitalization Data

Was other thrombolytic/reperfusion therapy administered?

IV tPA at an outside hospital

Indicate if IV tPA was initiated at an outside hospital.

- Yes
- No

SAdmission Data, Hospitalization Data

IA catheter-based reperfusion at this hospital?

Indicate if IA catheter-based reperfusion was initiated at this hospital. IA catheter-based reperfusion therapy includes all uses of IA thrombolytic therapy, as well as mechanical devices such as "Clot retrieval devices". Mechanical devices may be used alone or in conjunction with IA thrombolytic therapy.

- Yes
- No

SAdmission Data, Hospitalization Data

Date/Time of IA catheter-based reperfusion at this hospital

If IA catheter-based reperfusion was initiated at this hospital or ED, record the date and time initiated.

- Date:MM/DD/YYYY
- Time: HH:MM
- 24-hour clock (military time)

The start time for IA catheter-based reperfusion therapy should be either the date and time on the angio showing evidence of treatment, or the start time of the infusion if the angio time is not available.

SAdmission Data, Hospitalization Data

IA catheter-based reperfusion at outside hospital?

Indicate if IA catheter-based reperfusion was initiated at an outside hospital.

- Yes
- No

SAdmission Data, Hospitalization Data

In-Hospital Treatment and Complications

Complications of thrombolytic therapy (Check all that apply)

Indicate if there were any complications from the thrombolytic therapy.

- Symptomatic intracranial hemorrhage <36 hours
- Life threatening, serious systemic hemorrhage <36 hours
- Other serious complications

- No serious complications
- UTD

Notes for Abstraction:

- Definition for symptomatic intracranial hemorrhage: 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.
- 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.
- 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
- Serious complications are those that require additional medical interventions or prolonged length of stay. If complications do not require additional medical interventions or prolong the length of stay, select "No serious complications".
- Select UTD if worsening stroke symptoms or in-hospital death without confirmed hemorrhage.

Example: Patient 190a received intravenous tPA in the ED on 07/01/04. The following day the patient developed a sudden headache and decreased level of consciousness. A head CT was performed which showed a large intracerebral hemorrhage. Select "Symptomatic intracranial hemorrhage < 36 hours."

SAdmission Data, Hospitalization Data, Radiology notes, Discharge Data

If bleeding complications occur in patient transferred after IV t-PA

Indicate if hemorrhagic complications of tPA within 36 hours from the time of tPA bolus, as defined above, occurred in a patient transferred to another healthcare facility after IV tPA administration.

- Symptomatic hemorrhage detected prior to patient transfer
- Symptomatic hemorrhage detected only after patient transfer
- Unable to determine
- N/A

Notes for Abstraction:

- If symptomatic brain or systemic hemorrhage was detected or strongly suspected prior to transfer, select "symptomatic hemorrhage detected prior to patient transfer". Select this option if the patient has hemodynamic instability suggesting systemic hemorrhage, or a deterioration in the neurologic exam suggesting intracerebral hemorrhage while still at the initial treating hospital, even if the testing which confirms the finding doesn't occur until after transfer.
- If symptomatic brain or systemic hemorrhage is not detected or strongly suspected prior to transfer, and occurs only after the patient has left the initial treating facility, select "symptomatic hemorrhage detected only after patient transfer".
- If it is not possible to obtain information from the hospital at which the patient received IV tPA prior to transfer (if you are the receiving hospital), or to which you transferred the patient after starting IV tPA (if you are the initial treating hospital), select "unable to determine". Note that the Federal Privacy Rule (HIPAA) does not restrict the

communication of protected health information when performed for quality assurance purposes. To avoid interfering with an individual's access to quality health care or the efficient payment for such health care, the Privacy Rule permits a covered entity to use and disclose protected health information, with certain limits and protections, for treatment, payment, and health care operations activities. [These health care operations activities include] conducting quality assessment and improvement activities, population based activities relating to improving health or reducing health care costs, and case management and care coordination; Reviewing the competence or qualifications of health care professionals, evaluating provider and health plan performance, training health care and non-health care professionals, accreditation, certification, licensing, or credentialing activities [from The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, enacted on August 21, 1996.]

- Also select "Unable to determine" in case of patient death without confirmed hemorrhage.
- If no tPA given, then this element is not applicable, select N/A.
- Patient 200a received intravenous tPA in the ED at TMC on 07/01/04 at 11:00 and was transferred to GMC at 13:00. The following day at GMC the patient developed a sudden headache and decreased level of consciousness. A head CT was performed which showed a large intracerebral hemorrhage. Select "symptomatic hemorrhage detected only after patient transfer". If the symptoms began in the ambulance after leaving TMC, you would still select "symptomatic hemorrhage detected only after patient transfer".
- Patient 200b received intravenous tPA in the ED at TMC on 07/01/04 at 11:00 and developed a sudden headache and decreased level of consciousness prior to transfer to GMC at 13:00. Upon arrival at GMC, a head CT was performed which showed a large intracerebral hemorrhage. Select "symptomatic hemorrhage detected prior to patient transfer".
- Patient 200c received intravenous tPA in the ED at TMC on 07/01/04 at 11:00 and was transferred to GMC at 13:00. Despite a request by the staff at TMC to the Stroke Center director at GMC, no further information can be obtained about the patient after transfer. Select "unable to determine".

SAdmission Data, Hospitalization Data, Radiology notes, Discharge Data

Discharge Information

Discharge Date (Date of discharge from hospital)

The discharge date is the day that the patient is discharged from your institution's acute care unit OR the date of the patient's expiration OR the date of the patient's discharge OR date patient left against medical advice (AMA) OR date of transfer to, a rehabilitating, skilled nursing, or hospice unit in your institution OR transfer to an acute in-patient unit outside of your own institution, even if that hospital is affiliated with your own OR expired.

• Date:MM/DD/YYYY

Because this data element is critical in determining the population for all measures, the abstractor should NOT assume the UB-92/UB-04 claim information for the discharge date is correct. If the abstractor determines through chart review that the UB-92/UB-04 day is incorrect, she/he should correct and override the downloaded value. If the abstractor is unable to determine the correct discharge date through chart review, she/he should default to the UB-92/UB-04 date.

Example: Patient 023 is admitted to your in-patient neurology floor from your ED, with a diagnosis of acute ischemic stroke, on January 10, 2004 (01/10/2004). Due to extension of the infarct, need for jejunosotmy and placement, the patient is still on the in-patient unit on January 30, 2004 (01/30/2004). The patient has been on the in-patient unit for 16 days. The patient expires from complications of aspiration pneumonia on February 12, 2004 (02/12/2004). Data entry is 02/12/2004 (MM/DD/YYYY).

SDischarge Data, UB-04, (previously UB-92)

Discharge Status

The patient's discharge destination from acute care is the location where the patient is going for post-acute stay.

- o 01 Discharged to home or self care (routine discharge)
- o 02 Discharged/transferred to another short term general hospital for inpatient care
- o 03 Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification
- o 04 Discharged /transferred to an intermediate care facility
- o 05 Discharged/transferred to a Designated Cancer Center or Children's Hospital
- 06 Discharged/transferred to home under care of organized home health service organization
- o 07 Left against medical advice or discontinued care
- 20 Expired
- 43 Discharged/transferred to a federal health care facility Usage note: Discharged and transfers to a government operated health care facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient resides there or not.
- 50 Hospice home
- o 51 Hospice medical facility (certified) providing hospice level of care
- 61 Discharged/transferred to hospital-based Medicare approved swing bed Usage note: Medicare-used for reporting patients discharged/transferred to a SNF level of care within a hospital's approved swing bed arrangement.
- 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
- o 63 Discharge/transferred to a Medicare certified long term care hospital (LTCH)
- 64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- o 66 Discharged/transferred to a Critical Access Hospital (CAH)
- 70 Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List (See Code 05)

Notes for Abstraction:

- The values for Discharge Destination are taken from the National Uniform Billing Committee Manual (NUBC) manual which is used by the billing/HIM to complete the UB-92/UB-04.
- Because this data element is critical in determining the population for many measures, the abstractor should NOT assume that he UB-92/UB-04 value is what is reflected in the medical record. For abstraction purposes, it is important that the medical record reflect the appropriate discharge status. If the abstractor determines through medical record

review that the UB-92/UB-04 discharge status is not what is reflected in the medical record, she/he should correct and override the downloaded value.

- It would be appropriate to work with your billing office to develop processes that can be incorporated to improve medical record documentation to support the appropriate discharge status and to ensure consistency between the UB-92/UB-04 discharge status and the medical record.
- If state assigned codes are used, it is the organization's responsibility to ensure that one of the allowable values listed is used.
- While there are additional UB-92/UB-04 values for this data element, they are used for these measures at this time.
- Selection of Discharge codes 02, 07, 20, 50, or 51 will either set the discharge treatments below to NC or disable those fields accordingly.
- **Example1:** Patient 024 was admitted to your institution for new onset stroke symptoms from a local shelter. The patient had partial resolution of symptoms leaving only minor neurologic deficits. The patient was scheduled to be discharged to a shelter on Friday, December 21, 2004 (12/21/2004) with a written care plan for home care services, however patient left the unit prior to discharge and did not return. Check the box for left AMA (07). If the patient had been d/c to shelter with home health, data entry would be to select "06 Discharged/transferred to home under organized home care".
- **Example 2:** Patient 024 could have been discharged to another local acute care hospital for inpatient care, or to a freestanding rehabilitation facility).

"Did not recover" is specific to the Christian Science religion. They use this term rather than referring to death.

SDischarge Data, UB-04, (previously UB-92)