

Suggested Sources to use in data abstraction³

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, medication 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, Consultation progress notes, Diagnostic report, Physician progress notes, Progress notes)

Inpatient documentation (including physician notes, history and physical, medication 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

Diet or nutrition services consultation or progress notes

Discharge face sheet

Discharge form

Discharge instruction sheet

Discharge orders

Discharge summary

Flow sheets

Multidisciplinary progress notes

Nursing discharge notes

Physical or occupational therapy consultation or progress notes

Physician summary

Referral notes

Teaching sheets

Transfer note

Transfer record

Inclusion Criteria for Stroke Abstraction^{1,3}

Final clinical diagnosis related to stroke and age greater than or equal to 18years^{1,3}

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." This assignment of clinical diagnosis should be done independently of the ICD-9-CM code assigned.

Inclusion Criteria- Primary Discharge ICD-9 Code

Ischemic Stroke	433.01	OCL BSLR ART W INFRCT
Ischemic Stroke	433.10	OCL CRTD ART WO INFRCT
Ischemic Stroke	433.11	OCL CRTD ART W INFRCT
Ischemic Stroke	433.21	OCL VRTB ART W INFRCT
Ischemic Stroke	433.31	OCL MLT BI ART W INFRCT
Ischemic Stroke	433.81	OCL SPCF ART W INFRCT
Ischemic Stroke	433.91	OCL ART NOS W INFRCT
Ischemic Stroke	434.00	CRBL THRMBS WO INFRCT
Ischemic Stroke	434.01	CRBL THRMBS W INFRCT
Ischemic Stroke	434.11	CRBL EMBLSM W INFRCT
Ischemic Stroke	434.91	CRBL ART OCL NOS W INFRC
Ischemic Stroke	436	CVA
Hemorrhagic Stroke	430	SUBARACHNOID HEMORRAGE
Hemorrhagic Stroke	431	INTRACEREBRAL HEMORRAGE
TIA (optional WA State decision) ⁴	435.9	TRANSIENT ISCHEMIC ATTACK

Sampling Methodology^{1,2,4}

Sampling is a process of selecting a representative part of a population to estimate the hospital's performance without collecting data for the entire population. Using a statistically significant valid sample can be a way to measure performance, if volume requirements are met after review of the number of cases that meet the stroke inclusion criteria.

To obtain a statistically valid sample data, the sample size should be carefully determined, and the sample cases should be randomly selected in such a way that individual cases in the population have an equal chance of being selected. Only when the sample data truly represent the whole population can the sample-based performance measure data be meaningful and useful.

Sample size count is based on the **quarterly volumes of cases** identified by the Inclusion Criteria- Primary Discharge ICD-9 Code and age.

Per Washington State Cardiac Stroke Technical Advisory Committee if initial patient population is 1-44 **100%** of initial population should be abstracted (**no sampling**).

Average Quarterly Initial Patient population	Minimum Required Sample
Size "N"	Size "n"
≥900	180
226-899	20% of Initial Patient Population size
45-225	45
1-44* per WA State	No sampling; 100% Initial Population required

Second Draft submitted by K Kiesz 9-14-12. This document is a working draft for use at this time of the WA State Stroke Work Group.

Timetable for Data Submission^{1,4}

Hospital data submission is due on a quarterly basis to ensure the most complete and up to date information is included in regional and state data reports. The following is the time table for submission. If the due date falls on a weekend or holiday, it is due on the next business day. If you are unable to complete the data by the deadline please contact the WA State Department of Health Cardiac/Stroke Systems Coordinator, Practice Improvement Section.

Timetable for Data Submission		
Quarter	Time Period	Submission Due Date
Q1	January 1 through March 31	May 15
Q2	April 1 through June 30	August 15
Q3	July 1 through September 30	November 15
Q4	October 1 through December 31	February 15

General notation³

- **Y**=Yes
- **N**=No
- **ND** = Not Documented. Select ND when there is no documentation in the medical record to explain why a treatment or intervention is not performed.
- **NC** = None-Contraindicated. Select NC when a reason for non-treatment was documented in the medical record (e.g. not indicated, contraindicated, patient/family refused).
- **UTD** = Unable to determine

The following set of data elements were reviewed by the Stroke Data Work Group on 7-10-12.

1. Patient ID³

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. Does 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 Data Reporting Tool with actual identifiers.

2. Final Diagnosis related to stroke³

This field is used to define patient population by type of stroke

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

Notes for Abstraction:

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- 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.
- 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 ischemic strokes and not as TIAs
- 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" (**Final clinical diagnosis related to stroke = ischemic stroke**).
- Patients admitted with ischemic stroke who are treated with IV tPA or other medications and develop the complication of intracerebral hemorrhage should be entered as ischemic stroke, even if the ICD-9-CM code is assigned as a hemorrhagic stroke classification.
- 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, are not required to be entered into the tool. You can choose to enter patients with no stroke related diagnosis if:
 - The patient presents with stroke mimic or a stroke-like clinical picture and IV tPA is initiated, but the final clinical diagnosis is later determined not to be stroke related. For these patients select "No Stroke Related Diagnosis" and complete the subsequent data element "If No Stroke Related Diagnosis." This will allow hospitals to track outcomes of the relatively small number of patients who appeared to be having a stroke and were treated with IV tPA, but later turned out to have a stroke mimic.
 - The patient presents with stroke mimic or a stroke-like clinical presentation and the stroke code is activated and/or the patient is followed by the stroke service until the stroke diagnosis is ruled out. For these patients, Select "No Stroke Related Diagnosis" and complete the subsequent data element "If No Stroke Related Diagnosis".
- 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 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 hemorrhage 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."

3. Mode of arrival³

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

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

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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 is from home or scene includes cab, bus, car, walk-in, etc.

4. Arrival time³

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)
- 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

Notes for Abstraction (Date/Time)

- If the date/time of arrival is unable to be determined from medical record documentation, select "UTD."
- For times that include "seconds", remove the seconds and record the time as is.
 - Example: 15:00:35 would be recorded as 15:00
- The medical record must be abstracted as documented (taken at "face value"). When the date/time 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." .
- Direct Admits:
 - If the patient is a "Direct Admit" to the neuro/cath lab, use the earliest date/time the patient arrived at the neuro/cath lab (or neuro/cath lab staging/holding area) as the arrival date/time.
 - For "Direct Admits" to acute inpatient or observation, use the earliest date/time the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival date/time.
- If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival date/time at the first facility.

5. Advanced notification by EMS³

Whether EMS notified the receiving hospital prior to arrival of possible stroke patient.

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- **Yes:** EMS notified the receiving hospital prior to arrival
 - **No/ND:** EMS either did not pre-notify the receiving hospital or this was not documented
 - **N/A:** the patient did not arrive via EMS
-
- In order to select "yes" there must be explicit documentation that advanced notification by EMS included that the patient was a suspected stroke. The following language is sufficient to identify patients with suspected stroke; any use of the word "stroke" or any documentation of signs & symptoms consistent with stroke:
 - * Sudden numbness or weakness of 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.

Example: Patient 010a was picked up by the EMTs at 0810. On their departure to the hospital at 0820, they call the ED to inform them they are bringing in a potential stroke patient. They arrive at the ED at 0830. The hospital was therefore pre-notified that a potential stroke patient was arriving

6. 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 baseline³

- Date: MM/DD/YYYY and Time: HH:MM
 - 24-hour clock (military time)
-
- 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 when symptoms were first discovered (time of symptom discovery) as well as 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.

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- 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.

7. IV thrombolytic therapy initiated at this hospital? ³

- **Yes:** IV tPA was given for acute ischemic stroke.
- **No:** IV tPA was not initiated at your hospital, even if there are documented contraindications or warnings to IV tPA.

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

- 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".
- 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"
- In the case that tPA is contraindicated, select "No" for IV tPA initiated at your hospital.
- Do not include thrombolytic therapy for indications other than ischemic stroke. That is, do not include intracerebral 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 question #7 is YES: continue to questions 8 & 9- then to question 12

If question #7 is NO: continue to questions 10 & 11- then to question 12

8. Date and time at which the patient was treated with IV thrombolytic therapy³

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

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

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.

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

9. Door to Needle time for IV thrombolytic therapy⁴

- Arrival time and date minus time and date IV thrombolytic therapy initiated
- See previous definitions for each element
- Record time in HH:MM

This should be reflected as a calculation in the data collection spreadsheet

10. Documented Contraindications or Warnings for not initiating IV thrombolytic in the 0-3hr treatment window? ^{3,5}

- **Yes:** There is a documented contraindication or warning for not initiating IV tPA in the 0 - 3 hour treatment window. For a list, refer to abstraction notes for questions 10 and 11^{3,5,6}.
- **No:** There are no specific reasons documented in the medical record why tPA was not administered or a hospital-related factor or other reason was present.

11. Documented Contraindications or Warnings for not initiating IV thrombolytic in the 3-4.5hr treatment window? ^{3,6}

- **Yes:** There is a documented contraindication or warning for not initiating IV tPA in the 3 - 4.5 hour treatment window. For a list, refer to abstraction notes for questions 10 and 11^{3,5,6}.
- **No:** There are no specific reasons documented in the medical record why tPA was not administered or a hospital-related factor or other reason was present.

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Abstraction notes for questions 10 and 11^{3,5,6}.

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

Contraindications (0-3 hr and 3-4.5 hr treatment windows):

- Active internal bleeding (<22 days)
- CT findings (ICH, SAH, or major infarct signs)
- History of intracranial hemorrhage or brain aneurysm or vascular malformation or brain tumor
- Platelets <100,000, PTT> 40 sec after heparin use, or PT > 15 or INR > 1.7, or known bleeding diathesis
- Recent intracranial or spinal surgery, head trauma, or stroke (<3 mo.)
- Recent surgery/trauma (<15 days)
- SBP > 185 or DBP > 110 mmHg despite treatment
- Seizure at onset
- Suspicion of subarachnoid hemorrhage

Warnings (0-3 hr and 3-4.5 hr treatment windows):

- Advanced age
- Care-team unable to determine eligibility
- Glucose < 50 or > 400 mg/dl
- Increased risk of bleeding due to comorbid conditions , e.g., currently receiving oral anticoagulants (Warfarin, therapeutic dose of dabigatran (Pradaxa))
- IV or IA tPA given at outside hospital
- Left heart thrombus
- Life expectancy < 1 year or severe co-morbid illness or CMO on admission
- Myocardial infarction in the previous 3 months
- Pregnancy
- Pt./Family refused
- Rapid improvement
- Stroke severity too mild
- Stroke severity - Too severe (e.g., NIHSS >22)

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- MI in previous 3 months

Additional warnings specific reason(s) for not administering IV tPA at this hospital for patients considered for treatment with IV tPA in the 3-4.5 hour treatment window:

- Age > 80
- Prior Stroke and Diabetes
- Any anticoagulant use prior to admission (even if INR < 1.7)
- NIHSS > 25
- CT findings of >1/3 MCA
-

12. Was patient evaluated in the ED for acute Stroke or TIA and never admitted as an inpatient to your hospital? ³

Yes, not admitted: Patient was evaluated in the Emergency Department (ED), found to have a diagnosis of Ischemic Stroke, Subarachnoid Hemorrhage, Intracerebral Hemorrhage, or Transient Ischemic Attack, and was never admitted to your hospital as an inpatient. Include here patients that are transferred from the ED to another acute care hospital, those that are discharged directly from the ED to home or other location, those that leave against medical advice (AMA) from the ED, those that die in the ED, and those that are discharged from observation status without ever being admitted as an inpatient.

No, patient admitted as inpatient: Patient was admitted to your hospital.

13. What was the patient's discharge disposition from the facility? ^{2,4}

- 1 Home
- 2 Hospice - Home
- 3 Hospice – Health Care Facility
- 4 Acute Care Facility
- 5 Other Health Care Facility(Select one of the below)
 - Skilled Nursing Facility (SNF)
 - Inpatient Rehabilitation Facility (IRF)
 - Long Term Care Hospital (LTCH)
 - Intermediate Care facility (ICF)
 - Other: Psychiatric Hospital or Psychiatric Unit of a Hospital
- 6 Expired
- 7 Left Against Medical Advice/AMA
- 8 Not Documented or Unable to Determine (UTD)

Definition: The final place or setting to which the patient was discharged from the facility.

If Other Health Care Facility is selected for Discharge Disposition, select the specific facility to which the patient was discharged.

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- **Skilled Nursing Facility (SNF)** : Patient was discharged or transferred to a skilled nursing facility (SNF) This would include patients discharged to:
 - skilled nursing facility (SNF),
 - SNF rehabilitation unit (a unit within the SNF),
 - Sub-Acute Care,
 - Transitional Care Unit (TCU),
 - Swing Bed (patients discharged/ transferred to a SNF level of care within the hospital's approved swing bed arrangement), or
 - Skilled nursing facility with hospice referral only (has not accepted hospice care by a hospice organization).
- **Inpatient Rehabilitation Facility (IRF)**: Patient was discharged or transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
- **Long Term Care Hospital (LTCH)**: Patient was discharged or transferred to a Medicare certified long term care hospital (LTCH or LTACH) or a nursing facility certified under Medicaid but not certified under Medicare. For hospitals that meet the Medicare criteria for LTCH certification, a long-term care hospital or long-term care facilities provide acute inpatient care with an average length of stay greater than 25 days.
- **Intermediate Care facility (ICF)**: Patient was discharged or transferred to an intermediate care facility (ICF) This would include patients discharged to:
 - ECF (Extended Care Facility),
 - ICF (Intermediate Care Facility),
 - Nursing Home,
 - Nursing facility for non-skilled/custodial/residential level of care,
 - Veteran's Administration Nursing Facility,
 - Nursing facility with neither Medicare nor Medicaid certification
 - Nursing facility with hospice referral only (has not accepted hospice care by a hospice organization).
- **Other**: The patient was discharged or transferred to a Psychiatric Hospital or Psychiatric Unit of a Hospital or other healthcare facility not defined in above options.

Suggestions for WA State Customized Tab additional per Stroke Data Work Group 9-13-12

Custom element(s) for Washington State Stroke System

The hospital index number is used in reference to identify patients transferred from another facility for stroke care. Hospital Index number is a unique number hospital⁷

Central Region

014 = Children's Hospital & Medical Center (Seattle)
 029 = Harborview Medical Center (HMC) (Seattle)
 035 = Enumclaw Community Hospital (Enumclaw)
 126 = Highline Community Hospital (Burien)
 130 = Northwest Hospital & Medical Center (Seattle)
 131 = Overlake Hospital Medical Center (Bellevue)
 155 = Valley Medical Center (Renton)
 164 = Evergreen Hospital Medical Center (Kirkland)
 183 = Auburn Regional Medical Center (Auburn)
 201 = St. Francis Community Hospital (Federal Way)

East Region

021 = Newport Community Hospital (Newport)
 030 = Mount Carmel Hospital (Colville)
 037 = Deaconess Medical Center (Spokane)
 042 = Deer Park Hospital (Spokane)
 080 = Odessa Memorial Healthcare (Odessa)
 082 = Garfield County Hospital District (Pomeroy)
 108 = Tri-State Memorial Hospital (Clarkston)
 111 = East Adams Rural Hospital (Ritzville)
 125 = Othello Community Hospital (Othello)

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137 = Lincoln Hospital (Davenport)
139 = Holy Family Hospital (Spokane)
153 = Whitman Hospital and Medical Center (Colfax)
157 = St Luke's Rehabilitation Institute (Spokane)
162 = Sacred Heart Medical Center (Spokane)
167 = Ferry County Memorial Hospital (Republic)
172 = Pullman Regional Hospital (Pullman)
180 = Valley Hospital & Medical Center (Spokane)
194 = St. Joseph Hospital (Chewelah)
950 = St. Joseph Regional Medical Center (Lewiston, ID)

North Region

027 = Providence Everett Medical Center (Everett)
073 = Skagit Valley Hospital (Mt. Vernon)
104 = Valley General Hospital (Monroe)
106 = Cascade Valley Hospital (Arlington)
138 = Stevens Hospital (Edmonds)
145 = St. Joseph Hospital (Bellingham)
156 = Whidbey General Hospital (Coupeville)
163 = Island Hospital (Anacortes)
961 = Inter-Island Medical Center (Friday Harbor)
965 = Darrington Clinic (Darrington)
967 = United General Hospital (Sedro-Woolley)

North Central Region

023 = Okanogan-Douglas County Hospital (Brewster)
045 = Columbia Basin Hospital (Ephrata)
078 = Samaritan Hospital (Moses Lake)
107 = North Valley Hospital (Tonasket)
129 = Quincy Valley Medical Center (Quincy)
147 = Mid-Valley Hospital (Omak)
150 = Coulee Community Hospital (Grand Coulee)
158 = Cascade Medical Center (Leavenworth)
165 = Lake Chelan Community Hospital (Chelan)
168 = Central Washington Hospital (Wenatchee)

Northwest Region

038 = Olympic Medical Center (Port Angeles)
054 = Forks Community Hospital (Forks)
085 = Jefferson General Hospital (Port Townsend)
142 = Harrison Memorial Hospital (Bremerton)
152 = Mason General Hospital (Shelton)

South Central Region

022 = Lourdes Medical Center (Pasco)
039 = Kennewick General Hospital (Kennewick)
044 = Walla Walla General Hospital (Walla Walla)
046 = Prosser Memorial Hospital
050 = Providence St. Mary Medical Center
058 = Yakima Valley Memorial Hospital
102 = Yakima Regional Medical Center
140 = Kittitas Valley Community Hospital (Ellensburg)
141 = Dayton General Hospital (Dayton)
161 = Kadlec Medical Center (Richland)
198 = Sunnyside Community Hospital (Sunnyside)
199 = Toppenish Community Hospital (Toppenish)

Southwest Region

08 = Klickitat Valley Hospital (Goldendale)
026 = St. John Medical Center (Longview)
079 = Ocean Beach Hospital (Ilwaco)
096 = Skyline Hospital (White Salmon)
170 = Southwest Washington Medical Center (Vancouver)

West Region

032 = St. Joseph Medical Center (Tacoma)
056 = Willapa Harbor Hospital (South Bend)
063 = Grays Harbor Community Hospital (Aberdeen)

Second Draft submitted by K Kiesz 9-14-12. This document is a working draft for use at this time of the WA State Stroke Work Group.

081 = Good Samaritan Community Healthcare (Puyallup)
132 = St. Clare Hospital (Lakewood)
159 = Providence St. Peter Hospital (Olympia)
173 = Morton General Hospital (Morton)
175 = Mary Bridge Children's Hospital (Tacoma)
176 = Tacoma General Hospital (Tacoma)
186 = Mark Reed Hospital (McCleary)
191 = Providence Centralia Hospital (Centralia)
197 = Capital Medical Center (Olympia)
209 = St. Anthony Hospital (Gig Harbor)
720 = Madigan Army Medical Center (Fort Lewis)

References:

1. 2012 Disease-Specific Care Certification Manual. The Joint Commission.
<http://www.jointcommission.org/certification/>
2. Specifications Manual for National Hospital Inpatient Quality Measures Discharges 07-01-2012 (3Q12) through 12-31-12 (4Q12). Version 4.1. www.qualitynet.org
3. Get With the Guidelines® - Stroke PMT® Coding Instructions Updated July 2012.
https://osstatic.outcome.com/online_doc_qi/StrokePMT/coding_instruction/stroke_help.htm#noiv03
4. WA State DOH Stroke Data Work Group Recommendations (Subcommittee of the WA State Cardiac Stroke Technical Advisory Committee).
5. ["Guidelines for the Early Management of Adults With Ischemic Stroke: A Guideline From the American Heart Association/ American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research Interdisciplinary Working Groups"](#).
6. Expansion of the Time Window for Treatment of Acute Ischemic Stroke With Intravenous Tissue Plasminogen Activator. (link is <http://stroke.ahajournals.org/cgi/reprint/STROKEAHA.109.192535>)
7. Washington State Hospital Data Dictionary Version CVW4
<http://www.doh.wa.gov/Portals/1/Documents/Pubs/530124.pdf>