

#	Section	Element	MSR#	Page	Type of Modification	Description
1	Patient	Arrival date and time	1.4, 1.5	1	Notes addition	Added: <i>6. This is the time that is used to compute both of the hospital day two performance measures.</i>
2	Patient	Age	1.10	2	Notes deletion	Deleted: UB-92 Replaced with: UB-04
3	Patient	Gender	1.11	2	Notes addition	Added: <i>2. Determined by the ER admissions document or the intake/face sheet/hospital admissions database consultation notes, history and physical, nursing admission notes, progress notes, or UB-04. Use the gender written in the medical record. If there is a conflict as to gender in the medical record, use self-identified gender.</i>
4*	Demographics	Health Insurance	2.1	4	Options clarification	Added: <ul style="list-style-type: none"> • Medicare/<i>Medicare Advantage</i> • Medicaid • Private/VA/Champus • Self Pay/No Insurance • Not Documented • Other
5	Demographics	Race	2.2	4	Examples addition, Suggested Data Sources addition	<u>Examples</u> Added: <ol style="list-style-type: none"> <i>1. Based on physical characteristics, the patient appears to be of Asian descent. When asked, the patient clarifies that she is both African American and Fijian. Check both the "Black or African American" AND the "Native Hawaiian or Pacific Islander" boxes.</i> <i>2. When asked, patient states that she is African American and Filipino. Check boxes for "Black or African-American" AND "Asian". Patient reports he is Afro-Caribbean. Check "Black or African American", and note the appropriate ethnicity.</i> <i>3. Patient is aphasic and the race indicated on the Admission sheet is different than on the history and on the ED triage sheet. Check "Unknown".</i> Suggested Data Sources:

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						<i>ER admissions document or the intake/face sheet/hospital admissions database</i>
6*	Demographics	Ethnicity	2.3	5	Options replacement	<p>Deleted:</p> <ul style="list-style-type: none"> • Yes • No • UTD <p>Replaced with:</p> <ul style="list-style-type: none"> • <i>Hispanic or Latino</i> • <i>Not Hispanic or Latino</i> • <i>Unknown</i>
7*	Pre-Hospital/ EMS	Place of Occurrence	3.1	6	Question clarification, Options addition, Moving points from Notes to Examples	<p><u>Question</u></p> <p>Clarified: Where was the patient when stroke was detected or when symptoms were discovered? <i>In the case of a patient was transferred to your hospital where they were an inpatient, ED patient, or NH/long-term care resident, from where was the patient transferred from?</i></p> <hr/> <p><u>Options</u></p> <p>Added:</p> <ul style="list-style-type: none"> • Not in a healthcare setting • Another acute care facility • Chronic health care facility • Stroke occurred while patient was an inpatient in your hospital • <i>Outpatient healthcare setting</i> • Cannot be determined <hr/> <p><u>Notes for Abstraction:</u></p> <p>What is left:</p> <ol style="list-style-type: none"> 1. <i>A chronic care facility would include nursing home, long-term care facility, inpatient rehab facility, or an assisted-living facility.</i> 2. <i>Do not confuse this question with TJC's Point of Origin question (see MN 3.2 below).</i> <p><u>Examples</u></p> <p>Added:</p> <ol style="list-style-type: none"> 1. <i>If the patient was admitted to an ED of another hospital or was an inpatient of another hospital and was transferred to your hospital but</i>

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						<p><i>was outside of a healthcare setting when the stroke occurred – choose, “Not in a healthcare setting”.</i></p> <p>2. <i>If the patient was an inpatient of another acute care hospital when the stroke occurred and was subsequently transferred to your hospital – choose, “Another acute care facility”.</i></p> <p>3. <i>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.”</i></p> <p>4. <i>If the patient was a resident of a nursing home and the stroke occurred at the NH, and the patient came from the NH to your hospital, choose, “Chronic health care facility”.</i></p> <p>5. <i>If the patient was an inpatient in your hospital choose option 4, “Stroke occurred while patient was an inpatient in your hospital”. 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”.</i></p> <p>6. <i>If the patient was a visitor in your hospital, choose, “Not in a healthcare setting”.</i></p> <p>7. <i>If the patient is at a clinic or physician office visit, or at your hospital but receiving outpatient procedure or service and was not an inpatient, choose, “Outpatient healthcare setting”.</i></p> <p>8. <i>If the patient was an inpatient in your hospital choose “Stroke occurred 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 can be considered either as a TIA or inpatient strokes. These patients should all be entered as inpatient strokes.</i></p>
8*	Pre-Hospital/EMS	Arrival Mode	3.3	8	Options addition, notes addition	<p><u>Options</u></p> <p>Addition:</p> <ul style="list-style-type: none"> • EMS • Private transportation/taxi/other • <i>Transfer from another hospital</i> • Not Documented or unknown

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						Notes for Abstraction: <i>3. If a patient is transferred to your hospital from another hospital by EMS, choose "Transfer from another hospital"</i>
9	Pre-Hospital/EMS	Date and time call received by EMS	3.5, 3.6	8	Description addition, Notes addition, Examples addition	<p><u>Description</u></p> <p>Deleted: As recorded on the EMS trip sheet or other similar documentation</p> <p>Replaced with: <i>Date and time that the first call was received by the EMS dispatcher OR the date and time of EMS vehicle dispatch as recorded on the EMS Trip sheet or other similar documentation.</i> (Point from notes)</p> <p><u>Notes for Abstraction</u></p> <p>Added: 1. <i>This data element is looking to capture the date and time that EMS was first called to the scene of the stroke (and not meant to capture those patients that are transferred between hospitals via EMS).</i></p> <p>Deleted: This should be on a 24-hour time or military time</p> <p><u>Examples</u></p> <p>Added: 1. <i>If a patient is transported by EMS from the scene of the stroke to an outside hospital and is then transferred by EMS to your hospital, enter the time when the first call was received by the EMS dispatcher from the scene.</i></p>
10*	Pre-Hospital/EMS	EMS Pre-Notification	3.7	9	Options clarification, Notes addition	<p><u>Options</u></p> <p>Clarified:</p> <ul style="list-style-type: none"> • Yes • No/Cannot Determine/Unknown <p><u>Notes for Abstraction</u></p> <p>Added: 1. <i>"Yes" means EMS notified the receiving hospital prior to arrival of an incoming possible stroke patient.</i> 2. <i>No/Cannot Determine/Unknown: EMS did not pre-notify the receiving hospital that this was a suspected stroke; or this was not documented</i></p>

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						4. <i>There should be documentation that the pre-notification included possible stroke.</i>
11	Pre-Hospital/EMS	Glasgow Coma Scale	3.8	9	Notes clarification, addition	<p>Clarified/Added:</p> <ol style="list-style-type: none"> GCS has been shown to be a predictor of outcome from the bleed <i>and consequently</i> the GCS should be collected on all patients who present with an intracerebral hemorrhage. Record the first GCS documented. This can either be the one completed by EMS, or if not completed by EMS then the first one done in the hospital. <i>Record GCS scores for eye, motor and voice response.</i> <i>If patient has endotracheal tube in place at the time GCS measured, check "intubated" and leave the voice score blank.</i> <i>If only a total score is documented, only fill in "Total GCS" score.</i>
12*	Hospital	Patient transferred from ED to another acute care hospital	4.8	11	New data element	<p>Element: <i>Patient Transferred from your ED to another acute care hospital (MN 4.8)</i></p> <p><i>Patient was transferred from your ED to another acute care hospital without being admitted to your hospital.</i></p> <p>Options:</p> <ul style="list-style-type: none"> Yes No/ND <p>Notes for Abstraction:</p> <ol style="list-style-type: none"> Select "Yes" for patients who are evaluated in the Emergency Department, found to have a diagnosis of Ischemic Stroke, Subarachnoid Hemorrhage, Intracerebral Hemorrhage or Transient Ischemic Attack, and are subsequently transferred to another acute care hospital rather than being admitted to your hospital. Select "No/ND" for patients who are admitted or are not transferred to another acute hospital. If selection is "Yes", then specific post admission fields will be skipped automatically within these sections: Pre-Hospital/EMS, Hospital, Thrombolytics, History, Procedures, Complications, Discharge, and Discharge Services.
13	Hospital	Admission and Discharge dates	4.2	11	Notes deletion, Suggested Data Sources addition	<p><u>Notes for Abstraction</u></p> <p>Deleted:</p> <ol style="list-style-type: none"> Hospital arrival date and admission date are usually the same for direct admissions.

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						<p><u>Suggested Data Sources</u></p> <p>Added: Admission sheet, discharge summary, ED nurses notes, history and physical notes, progress notes, or UB-04 claim information as a last resort. Do NOT assume that the UB-92/UB-04 claim information for the admission date is correct. If determined through medical record review that the UB-92/UB-04 date is incorrect, correct and override the downloaded value.</p>
14	Hospital	Ambulation status prior to the current event	4.5	13	Notes addition/clarification, Examples addition	<p><u>Notes for Abstraction</u></p> <p>Added/Clarified:</p> <ol style="list-style-type: none"> 1. Ambulatory: <ol style="list-style-type: none"> a. <i>This means patient is able to ambulate without help from another person. The use of a device, such as a cane, still meets this definition.</i> b. Patient ambulating throughout the day with assistance of another person or assistive device - <i>Select option "With assistance (from person)".</i> c. Patients ambulating to and from the bathroom unassisted are considered to meet the definition of ambulation. Even though actual ambulation is not documented in the medical record, privileges to walk to and from the bathroom and evidence of the patient getting out of bed unassisted are also considered to meet the definition of ambulation. 2. Non-ambulatory: <ol style="list-style-type: none"> a. Patient is on bed rest b. Patient is only getting out of bed to the bedside commode (or up in chair) and is primarily in the bed (or immobile) c. <i>Patient is bedridden</i> <hr/> <p><u>Examples</u></p> <p>Added:</p> <ol style="list-style-type: none"> 1. <i>Patient walks around the home but rides a motorized scooter when outdoors. Select "Ambulating without assistance".</i> 2. <i>Patient has severe arthritis and is sedentary throughout most of the day. She requires a full person assistance to transfer from bed to chair. Select "Unable to ambulate."</i>
15	Hospital	CMO	4.6	14	Notes clarification	<p>Clarified:</p> <ol style="list-style-type: none"> 2. Select Yes if there is physician/<i>advanced practice nurse</i>/physician assistant documentation that the patient was receiving comfort measures only. Commonly referred to as "palliative care" in the medical community and "comfort care" by the general public. Palliative care includes attention to the psychological and spiritual needs of the patient and support for the dying

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						patient and the patient's family. Usual interventions are not received because a medical decision was made to limit care to comfort measures only. Comfort Measures Only are <u>not</u> equivalent to the following: Do Not Resuscitate (DNR), living will, no code, no heroic measure.
16	Hospital	CMO, end of day 2	4.7	14	Notes addition	<p>Added:</p> <p>3. <i>Hospital day one is day of ARRIVAL, which may be prior to the day of admission.</i></p> <p>4. <i>If there is documentation that the patient was made 'Comfort Measures only' on or before 23:59 on the day after arrival, answer "Yes" to MN 4.7 as well as MN 4.6.</i></p>
17	Imaging	Brain Imaging Performed	5.1	16	Description addition, Options clarification, Notes addition/deletion, Examples addition	<p><u>Description</u></p> <p>Added: Brain imaging performed at this hospital <i>after arrival as part of the initial evaluation for episode of care or event.</i></p> <p>Options:</p> <ul style="list-style-type: none"> • Yes • No/Not Documented • NC <hr/> <p><u>Notes for Abstraction</u></p> <p>Added:</p> <p>1. This question applies to the initial brain image for this event. If patient did not receive any brain imaging at this hospital/facility, then select No/Not Documented. If a patient had outside brain imaging prior to transfer from another hospital, <i>select "NC" and record the results for that imaging please record Image Results in MN 5.4</i></p> <p>2. <i>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.</i></p> <p>3. "NC": if outside imaging prior to transfer or patient is <i>DNR/CMO</i></p> <p>Deleted: Was brain imaging performed at your hospital after arrival as part of the initial evaluation for this episode of care or this event?</p>

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						<p><u>Examples</u></p> <p>Added:</p> <ol style="list-style-type: none"> 1. Patient 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 three 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.
18	Imaging	Brain Imaging date and time	5.2, 5.3	16	Notes addition	<p>Added:</p> <ol style="list-style-type: none"> 2. Time and date are only <i>documented</i> if the initial imaging was done at your hospital. You do not need to record time and date of in the case of outside brain imaging 3. <i>Enter date and time of the initial CT/MRI of the head performed at your institution from the DICOM header information. This is the date and time printed on the hard copy of the film or available when reviewing the image digitally.</i> 4. <i>Record only CT/MRI date/time if the first study was performed at your hospital.</i> 5. <i>Please note, use the time indicated on the radiology report only if it clearly indicates the time of study initiation or completion and NOT time of scheduling, dictation or reporting.</i>
19	Imaging	Initial Brain Imaging Findings	5.4	17	Notes re-wording	<p>Re-worded:</p> <ol style="list-style-type: none"> 1. Hemorrhage <i>is taken to mean any</i> intracranial hemorrhage.
20	Onset	Last known well, Discovery Date and Time	6.1, 6.2, 6.3, 6.4	18	Data element re-organization, Notes additions/clarifications, Examples addition	<p>Merging of the Notes and Examples sections for 6.1-6.2 and 6.3-6.4</p> <p><u>Last Known Well</u> 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.</p> <ul style="list-style-type: none"> ➤ Date: MM/DD/YYYY (MN 6.1) ➤ Time: HH:MM [24-hour clock (military time)] (MN 6.2) <p><u>Discovery Date and Time</u> Indicate the date and time of discovery of patient's symptoms (i.e., when the patient was found with symptoms).</p> <ul style="list-style-type: none"> ➤ Date: MM/DD/YYYY (MN 6.3) ➤ Time: HH:MM [24-hour clock (military time)] (MN 6.4)

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						<p>Notes for Abstraction:</p> <ol style="list-style-type: none"> 1. The purpose of 'Last Known Well' is to conservatively identify/estimate time (To within 15 minutes of exact time is acceptable) 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. 2. 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." 3. 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". 4. 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". 5. 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: <ol style="list-style-type: none"> a. Stroke team/neurology b. Admitting physician c. Emergency department physician d. ED nursing notes e. EMS 6. 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 as the "Last Known Well" time. 7. 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

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						<p>there is a specific reference to the patient having been discovered with symptoms already present, then this time should be treated as a "time of symptom discovery" rather than a time of "last known well". If no time of "last known well" can be determined, then "Unknown" should be selected for time "last known well".</p> <p>8. The purpose of "Discovery Date and Time" is to identify the earliest possible time that stroke symptoms began (To within 15 minutes of exact time of discovery is acceptable.).</p> <p>9. The "Discovery Date and Time" should be the earliest time that patient was known to have symptoms. The 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".)</p> <p>10. "Onset Time" may be different than "Discovery Date and Time".</p> <p>11. 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 in patients who are recently discovered to have symptoms but are many hours (>3 hrs) from their time of last being well.</p> <p>Examples:</p> <p>1. Patient 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 12:30pm 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.</p> <p>2. Patient 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</p>

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						<p>11/09/2007 21:30, and time and date of discovery are known as 11/10/2007 06:30.</p> <p>3. Patient was eating dinner with his wife tonight after they finished watching the nightly news on TV "when his arm began shaking and he couldn't hold onto his fork or his water glass or anything. He has never done this before." Their nightly news show is on from 6:00 to 6:30 pm. She called the ambulance right away. ED arrival 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.</p> <p>4. Patient states she has been having numbness come and go in her left arm for the past week, but it always went away. Today the numbness started about 4 hours 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.</p> <p>5. Patient was found on the floor beside the commode by the charge nurse at Starlight Nursing Home on her night rounds at 12:45 am 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 chart. ED arrival date and time is 12/01/2007 1:37am. 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.</p> <p>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 tPA 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.</p> <p>7. A 55-year-old male had a brief episode of slurred speech of 6 am on 5/10/2007. The episode resolved quickly and he returned completely to normal. At noon on that same day, he developed one-sided weakness and slurred speech, which persisted when he arrived to your hospital.</p>

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						<p>Time and date of last known well are known at 5/10/2007 12:00.</p> <p><i>Suggested Data Sources:</i> ED records, intake/face sheet/hospital admissions records, progress notes, acute physician notes</p>
21*	Onset	Stroke Symptoms Resolved	6.7	20	New Data Element	<p><u>Element:</u> Stroke Symptoms Resolved (MN 6.7)</p> <p><i>Had stroke symptoms resolved at the time of presentation?</i></p> <p>Options:</p> <ul style="list-style-type: none"> • Yes • No • ND <p>Notes for Abstraction:</p> <ol style="list-style-type: none"> 1. If record describes new findings present on clinical exam, then select "No".
22	Onset	NIH Stroke Scale Performed	6.5	20	Notes clarification, addition	<p><u>Notes for Abstraction:</u></p> <p>Clarified/Added:</p> <ol style="list-style-type: none"> 1. Select 'Yes' if complete NIH stroke scale has been performed 2. Select 'No' if other stroke scale was performed which includes Modified NIH stroke scale 3. Answer "Yes" if an NIH stroke scale was performed as part of the initial evaluation. 4. You should be looking for the first NIHSS that is performed as part of the patient's work-up (whether done in the ED or not).
23*	Onset	Initial Exam Findings – Weakness or Paresis	6.8	21	New data element	<p><u>Element:</u> Initial Exam Findings: Weakness or paresis (MN 6.8)</p> <p>Identify from the record the patient's initial exam findings concerning weakness of paresis present at the time of hospital arrival.</p> <p>Options:</p> <ul style="list-style-type: none"> • Yes • No <p>Notes for Abstraction:</p> <ol style="list-style-type: none"> 1. Definition of weakness/paresis: weakness or paresis of an arm, leg, side of the face, or any part of the body.

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24*	Onset	Initial Exam Findings – Altered level of consciousness	6.9	21	New data element	<p>Element: Initial Exam Findings: Altered level of consciousness (MN 6.9)</p> <p>Identify from the record the patient's initial exam findings concerning level of consciousness present at the time of hospital arrival.</p> <p>Options:</p> <ul style="list-style-type: none"> • Yes • No <p>Notes for Abstraction:</p> <ol style="list-style-type: none"> 1. This includes any mention of decreased alertness, sleepiness, drowsiness, stupor, coma, difficulty to arouse, need for painful stimulation to gain the patients attention, and documentation of a Glasgow Coma Score (GCS) that includes: "No eye opening", "Eye opening to pain", "Eye opening to verbal command" .
25*	Onset	Initial Exam Findings – Aphasia	6.10	22	New data element	<p>Element: Initial Exam Findings: Aphasia (MN 6.10)</p> <p>Identify from the record the patient's initial exam findings concerning aphasia present at the time of hospital arrival.</p> <p>Options:</p> <ul style="list-style-type: none"> • Yes • No <p>Notes for Abstraction:</p> <ol style="list-style-type: none"> 1. Definition of aphasia: loss of the ability to communicate. This item refers to disturbances of language and communication. 2. This can be documented as difficulty with producing speech (including the terms non-fluent, Broca's, Wernicke's, paraphasia, dysphasia, mutism), following commands, naming objects, repeating phrases, speaking fluently, or answering questions appropriately 3. Documentation of a Glasgow Coma Score (GCS) that includes "No verbal response", "Incomprehensible sounds" or "Inappropriate

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						<p>words" would qualify.</p> <p>4. It does NOT include patients whose only language difficulty is slurring of speech or dysarthria.</p>
26	Thrombolytics	IV tPA	7.1	23	Examples addition	<p>Added:</p> <p>1. <i>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".</i></p>
27	Thrombolytics	IV tPA date and time	7.2, 7.3	23	Notes addition	<p>Added:</p> <p>2. <i>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.</i></p> <p>4. <i>"NC": Documented reason exists for not giving IV thrombolytic.</i></p>
28	Thrombolytics	Complications	7.11, 7.12	25	Options clarification, notes addition	<p><u>Options</u></p> <p>Clarified:</p> <ul style="list-style-type: none"> • Yes – within 36 hours (≤ 36 hours) of t-PA • No • Unknown/Unable to Determine <hr/> <p><u>Notes for Abstraction</u></p> <p>Added:</p> <p>6. Select "No" to indicate that patient did not experience either symptomatic intracranial hemorrhage or life threatening, serious systemic hemorrhage as complications of thrombolytic therapy.</p> <p>7. If you administered or prescribed tPA at your hospital or emergency room, and then shipped the patient to another hospital, you are to follow up on the patient with the hospital that you referred the patient to, and you are required to answer these questions regarding hemorrhagic complications of thrombolytic therapy.</p> <p>8. 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 "Unknown/Unable to determine".</p>

#	Section	Element	MSR#	Page	Type of Modification	Description
						<p>9. 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.]</p> <p>10. Also select "Unknown/Unable to determine" in case of patient death without confirmed hemorrhage.</p> <hr/> <p><u>Example</u></p> <p>Addition:</p> <p>2. Patient 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".</p>
29*	Thrombolytics Non-Treatment	Thrombolytics non-treatment	8.1-8.15	27	Question clarification, definition clarification	<p><u>Question</u></p> <p>Clarified: Were one or more of the following reasons for not administering IV thrombolytic therapy at this hospital explicitly documented by a physician, advance practice nurse, or physician assistant's notes in the chart?</p> <p><u>Definition</u></p> <p>Clarified:</p> <ul style="list-style-type: none"> ➤ Warnings: (MN 8.3) <ul style="list-style-type: none"> • Stroke severity – Too severe (e.g., NIHSS >22) • Glucose < 50 or > 400 mg/dl • Left heart thrombus

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						<ul style="list-style-type: none"> • Increased risk of bleeding due to: <ul style="list-style-type: none"> ○ Pregnancy ○ Acute (<i>or recent</i>) pericarditis ○ SBE ○ Hemostatic defects ○ Diabetic hemorrhagic retinopathy ○ Septic thrombophlebitis or occluded AV cannula ○ Currently receiving oral anticoagulants (e.g., Warfarin) <p>➤ Unable to diagnose or did not diagnose in 3 hour time frame (MN 8.10)</p>
30	Thrombolytics Non-Treatment	Thrombolytics non-treatment	8.1-8.15 (cont.)	27, 28	Notes additions	<p>Added:</p> <p>4. If the medical record documents concern that the symptoms may be due to subarachnoid hemorrhage and this is the reason for withholding tPA, then select "Suspicion of subarachnoid hemorrhage" (MN 8.1). Do not select this option simply because headache, nausea, or vomiting was described in the medical record.</p> <p>5. "Care team unable to determine eligibility" (MN 8.8) means that the diagnosis of stroke was made but that eligibility for thrombolytic therapy could not be established or the clinician could not verify the patient's eligibility for treatment. This might be that the time of onset could not be clearly established at the time of patient assessment in the ED, or that the timing of a recent procedure or surgery could not be definitively established, or time of "Last Known Well" (MN 6.1) is unknown. Also select "Care-team unable to determine eligibility" (MN 8.8) when a lack of an accurate history or concern about the presence of a prior medical condition raise concern about eligibility of tPA therapy. Also select this option when patients have experience multiple episodes of transient neurologic function, or TIAs, which have fully resolved clinically, but imaging or other features of the history make it uncertain as to when the stroke actually started.</p> <p>8. Select "IV or IA tPA given at outside hospital" (MN 8.9) when a patient was transferred from another hospital where IV tPA was started, even if the infusion continues after the patient arrives at your facility.</p> <p>9. Select "Life expectancy < 1 year or sever co-morbid illness or CMO on admission" (MN 8.6) if the patient has an order for Comfort Measures Only in the ED and this restriction of care preceded evaluation for tPA. This option is also appropriate when patients are not treated due to coexisting terminal cancer, advanced dementia, severe cardiopulmonary disease or other conditions which severely limit quality of life or life expectancy. These co-morbid conditions need to be explicitly documented as the reason for no tPA.</p> <p>10. It is permissible to abstract reasons for non-treatment from the medical</p>

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						<p>record that are entered after the tPA decision has occurred. This should be done only when the documentation is written by someone who was involved in the tPA decision, but was unable to document it at the time. This documentation needs to be made prior to patient discharge. An example of this would be if the neurologist who was called by telephone puts a note in the medical record the next day that documents the reason for non-treatment.</p> <p>15. If record documents that the reason is "NIHSS low" (for example "NIHSS = 3"), then this would appropriately be categorized as stroke severity too mild. Select "Rapid improvement or stroke severity too mild" (MN 8.5) when symptoms are rapidly improving or there is minimal to no disability associated with the stroke symptoms (e.g. numbness, mild weakness, lack of gait impairment). Note that there is no lower limit to NIHSS score that prohibits the use of IV tPA.</p> <p>16. Select "Stroke severity - Too severe (e.g., NIHSS >22)" (MN 8.2) when the physician notes "document tPA was withheld due to the severity of the stroke symptoms". Note there is no upper limit in terms of NIHSS score that prohibits the use of IV tPA and many centers would still treat a patient with an NIHSS score of 25.</p> <p>18. If the diagnosis is unclear during the ED evaluation or at the time of admission, select "Unable to diagnose in the 3 hour time frame" (MN 8.10). This may be an admitting diagnosis such as "rule out migraine", etc.</p> <p><i>Hospital-Related or Other Factors</i></p> <p>23. If "IV tPA at this hospital" (MN 7.1) is "No", "Hospital-Related or Other Factors" (MN 8.10-8.15) can be selected. The use of inference is only acceptable in selecting data elements MN 8.10-MN 8.15.</p> <p>24. If the diagnosis is unclear, select "No" for "IV tPA at this hospital" (MN 7.1) and select "Unable to diagnose or did not diagnose in 3 hour time frame" (8.10) under "Hospital-related or Other Factors".</p> <p>25. If there is a delay in getting the CT done or read, or a delay in patient evaluation, then select "In-hospital Time Delay" (8.11).</p> <p>26. If patients decline IV t-PA and instead select an investigational protocol, select "Pt./Family refused" (MN 8.7). If there is no evidence that the patient/family was offered IV t-PA, then select "No" for "IV tPA at this hospital" (MN 7.1) rather than "NC" since there are no documented reasons for not treating with IV t-PA.</p>

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#	Section	Element	MSR#	Page	Type of Modification	Description
31	History	History of Stroke	9.2	31	Definition change	<p>Deleted: Stroke/TIA/VBI</p> <p>Replaced with: Stroke</p>
32*	History	History of TIA/VBI	9.25	31	New data element	<p><u>Element:</u> History of TIA/VBI</p> <p><i>Is there a history of TIA/VBI?</i></p> <p>Options:</p> <ul style="list-style-type: none"> • Yes • No <p>NOTE: MN 9.2 (History of Stroke/TIA/VBI) was split apart into two data elements: History of Stroke (MN 9.2) and History of TIA/VBI (MN 9.25)</p>
33	History	Dyslipidemia	9.6	31	Notes clarification	<p>Clarified:</p> <p>6. <i>Dyslipidemia:</i> <i>The intent of the question is to identify patients with a documented history of hyperlipidemia. Dyslipidemia is taken to mean high cholesterol, hyperlipidemia or hypercholesterolemia is present based on physician diagnosis, treatment with a lipid lowering agent, total cholesterol greater than 200, LDL greater than 130, HDL less than 40, or elevated triglycerides greater than 200. Patients on lipid lowering therapy are included in this category even if their LDL levels are in range. See Adult Treatment Protocol (ATP) III Clinical Guidelines for further clarification and methods of calculating goal based on Framingham risk data (www.nhlbi.nih.gov).</i></p>
34	History	Atrial-fibrillation/flutter	9.12	31	Notes clarification	<p>11. Atrial Fib/Flutter: The patient has any <i>prior</i> history of atrial fibrillation OR atrial flutter (i.e., remote, paroxysmal or persistent.) <i>Do not record a history of Atrial Fib/Flutter if the episode was transient AND entirely reversible due to thyrotoxicosis or within 8 weeks of CABG (these are the only two circumstances in which you would not record a history of Atrial fib/flutter). Any patient with a history of Atrial Fib/Flutter who has undergone a procedure for atrial fib/flutter such as such as pacemaker placement or ablation or who is under medical therapy for rhythm control is still considered as having a history of Atrial Fib/Flutter and you should select atrial fib/flutter under medical history.</i></p>
35*	History	Medications prior to admission-cholesterol reducing	9.13	32	Example clarification, Data Entry System Enhancement	<p>Examples</p> <p>Clarified:</p> <p>1. Patient is admitted to the in-patient unit with right hemiparesis and dysarthria. His preadmission medications were lisinopril, aspirin,</p>

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						<p>metformin and furosemide. His metformin is held but all other medications are continued. LDL is noted to be 180 and he has a recent non-q wave MI. He is discharged on day 5 on his original pre-admission medications and pravastatin plus a low cholesterol diet. Select "No, Not Documented". Additionally, select "Yes" for "Cholesterol - reducing/controlling medication prescribed at discharge" (MN 12.6) and "Statin" for "Prescribed Lipid Medication Class" (MN 12.7).</p> <hr/> <p>Data Entry System Changes:</p> <p>a. MN 9.13 moved to top of list under Medications tab</p> <p>b. Check-boxes for MN 9.13 have changed to radio buttons with options: Yes, No/Not Documented</p>
36	History	Medications prior to admission-antithrombotic	9.15	33	Notes clarification, addition	<p>Added: Only the following are considered acceptable antithrombotic <i>medications</i>:</p> <ol style="list-style-type: none"> 1. <i>Antiplatelet:</i> <ol style="list-style-type: none"> a. Aspirin (ASA) b. ASA/dipyridamole (Aggrenox) BID c. Clopidogrel (Plavix) d. Ticlopidine (Ticlid) 2. <i>Anticoagulant:</i> <ol style="list-style-type: none"> e. Warfarin (Coumadin) f. Unfractionated heparin IV g. Full dose LMW heparin (Enoxaparin, others) h. Fondaparinux (Arixtra) i. Other anticoagulant
37	History	Lipid Profile and HgbA1	9.16-9.20	34	Notes clarification, addition	<p>Clarified/Added:</p> <ol style="list-style-type: none"> 2. If there is more than one lipid profile, select the one performed closest to hospital admission date <i>that is drawn within 48 hours of admission</i>, which could be a fasting level reported within the preceding 30 days, or the first one drawn <i>after admission</i>, or drawn at initial evaluation. 4. <i>If triglycerides are < 400 mg/dL, LDL can be calculated from the following formula:</i> $LDL = Total\ Cholesterol - (HDL + (Triglycerides / 5))$ <i>However, if triglycerides are >= 400 mg/dL, this formula cannot be used to compute LDL.</i>
38*	History	Evidence of Atherosclerosis	9.26	34	New data element	<p><u>Element: Evidence of Atherosclerosis</u></p> <p><i>Is there documentation in the record that the patient has evidence of atherosclerosis or is the stroke/TIA of atherosclerotic origin?</i></p>

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						<p>Options:</p> <ul style="list-style-type: none"> • Yes • No • <i>Not Documented</i> <p>Notes for Abstraction:</p> <ol style="list-style-type: none"> 1. <i>Select "Yes" if there is evidence of atherosclerotic origin of the stroke or if the patient has evidence of atherosclerosis, which includes any mention of this in the record, or the presence of any one or more of the following:</i> <ol style="list-style-type: none"> a. <i>Carotid stenosis or plaque</i> b. <i>Vertebral artery stenosis or plaque</i> c. <i>Intracranial atherosclerosis</i> d. <i>Small vessel disease</i> e. <i>Lacunar infarction</i> f. <i>Artery-to-artery embolism</i> g. <i>Aortic arch atheroma or plaque</i> h. <i>Coronary artery / coronary heart disease (CAD / CHD)</i> i. <i>Peripheral artery / peripheral vascular disease (PAD / PVD)</i> j. <i>Other documentation indicating the presence of atherosclerosis.</i> 2. <i>Select "ND" if there is insufficient evidence in the record to determine if atherosclerotic disease is present.</i>
39	Procedures	Where patient care occurred	10.1-10.3	36	Options clarification, Examples addition	<p><u>Options</u></p> <p>Clarified:</p> <ul style="list-style-type: none"> ➤ Admittance Type (MN 10.1) Options: <ul style="list-style-type: none"> • <i>Neuro Admit</i> • Other <i>Service Admit</i> • Unable to determine ➤ Consult Type (MN 10.2) Options: <ul style="list-style-type: none"> • Stroke Consult • No Stroke Consult • Unable to determine ➤ Unit Type (MN 10.3) Options: <ul style="list-style-type: none"> • <i>In</i> Stroke Unit • <i>Not in</i> Stroke Unit

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						<ul style="list-style-type: none"> • Unable to determine <p><u>Examples</u></p> <p>Added:</p> <ol style="list-style-type: none"> 2. <i>Patient arrived in the ED and was seen by the neurology resident (or neurologist) and admitted to the neurology service. Patient was admitted to the stroke unit. Select "Neuro Admit" and "In Stroke Unit".</i> 3. <i>Patient admitted to stroke unit by internist. There is no neurologist at this hospital, which dedicates two telemetry beds specifically for stroke patients. Select "Other Service Admit", "No Stroke Consult", and "In Stroke Unit".</i>
40	Procedures	Antithrombotic therapy by end of day 2	10.4	37	Notes addition	<p>Added:</p> <ol style="list-style-type: none"> 3. <i>Anticoagulants at doses (low dose) designed to prevent deep vein thrombosis are insufficient as antithrombotic therapy to prevent recurrent ischemic stroke or TIA. Conversely, antiplatelet agents at doses to prevent recurrent ischemic stroke or TIA are insufficient therapy to prevent deep vein thrombosis. However, anticoagulants at full therapeutic doses (full dose LMW heparin, Unfractionated heparin IV, or warfarin) are considered acceptable treatment options for both DVT prophylaxis and antithrombotic medication.</i> 5. Reasons for not prescribing antithrombotic medication must be documented by a physician, <i>advanced practice nurse</i>, or physician assistant. If reasons are not mentioned in the context of antithrombotics, do not make inferences (e.g., do not assume that antithrombotic medication is not being prescribed because of a bleeding disorder unless documentation explicitly states so). 6. Acceptable reasons for not giving antithrombotic medication by the end of the 2nd hospital day include: <ol style="list-style-type: none"> a. Risk for bleeding or discontinued due to bleeding b. Patient receiving terminal care or comfort care only c. Patient <i>or family</i> refused d. Allergy to or complication r/t aspirin, ticlopidine, clopidogrel, dipyridamole and warfarin (hx or current) e. <i>Patient or family refused</i> f. <i>Serious side effect to medication</i> g. <i>tPA administered within 24 hours of the end of hospital day 2</i> 7. <i>If antithrombotic held for 24 hours due to status post IV tPA, select "NC".</i> 8. <i>"NC": Documented reason for not giving antithrombotic therapy exists in the medical record</i>

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						<p><u>Example</u></p> <p>Added:</p> <ol style="list-style-type: none"> 1. <i>Patient arrives at ED on Monday at 05:00 with an ischemic stroke. Because beds are full, patient waits in ED holding bed, and patient is not delivered to the stroke unit until 15:00 on Tuesday. Hospital day 1 is Monday (day of arrival at hospital), hospital day two is Tuesday. Patient should receive antithrombotic therapy by 23:59 on Tuesday in order to answer "Yes".</i>
41	Procedures	Ambulatory at end of hospital day two	10.5	38	Notes clarification, example addition	<p><u>Notes for Abstraction</u></p> <p>Clarified:</p> <ol style="list-style-type: none"> 1. Ambulating: <ol style="list-style-type: none"> a. Patient ambulating without assistance (no help from another person), <i>not bedridden or confined to bed, able to walk about</i> b. Patient ambulating with <i>or without the</i> assistance of another person or assistive device throughout the day c. Patient ambulating to and from the bathroom <i>throughout the day with or without the assistance of another person or device is considered to meet the definition of ambulation. Even though ambulation is not documented in the medical record, privileges to walk to and from the bathroom and evidence of the patient getting out of bed unassisted are considered to meet the definition of ambulation.</i> 2. Non-ambulating: <ol style="list-style-type: none"> a. Patient is on bed rest b. Patient is only <i>transferred</i>/getting out of bed to the bedside commode (or up in chair) and is primarily in the bed (or immobile) on the 2nd hospital day c. If unable to determine from documentation consider this patient non-ambulatory <p><u>Examples</u></p> <p>Added:</p> <ol style="list-style-type: none"> 1. Patient is only getting out of bed to the bedside commode and is primarily in the bed on the hospital day two. This patient is considered non-ambulatory. Select "No".

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						<p>2. Patient has privileges to walk to and from the bathroom unassisted but there is no further evidence of ambulation by hospital day two, choose "Yes" as this patient would be considered ambulatory.</p> <p>3. Patient has orders written for "bathroom with assist." There is no other documentation in the medical record to indicate that the patient is in fact ambulating by hospital day two. Choose "No" as this patient would be considered non-ambulatory. An order of "bathroom with assist" without additional evidence of ambulation would not be considered ambulatory.</p> <p>4. Patient is ambulating with assistance from nursing. There is documented evidence of the patient walking around the unit with assistance from his nurses. Choose "Yes" as this patient is considered ambulatory.</p>
42	Procedures	DVT prophylaxis at end of hospital day two	10.6	39	Definition clarification, Inclusion addition/clarification, notes addition, examples addition	<p><u>Definition</u></p> <p>Clarified:</p> <p>Determination if medication and/or devices were ordered and initiated by the end of hospital day two for prophylaxis against the formation of deep venous thrombosis. <i>Day one is arrival day – this may differ from admit day.</i></p> <p><u>Inclusion</u></p> <p>Added/Clarified:</p> <ol style="list-style-type: none"> 1. Low-dose, sub-Q, subcutaneous, unfractionated ("regular") heparin, Low Molecular Weight (LMW) heparin (enoxaparin, dalteparin, nadroparin, danaparoid, hirudin, bivalirudin, heparinoids), <i>fondaparinux</i>, or trial based antithrombin agent or other agent not listed above 3. Pneumatic Compression Stockings, compression socks, Intermittent compression devices, ICDs (<i>such as Venodynes and Pneumoboots</i>), (TED Hose do NOT apply) <p><u>Notes for Abstraction</u></p> <p>Added:</p> <ol style="list-style-type: none"> 1. In general, "medication and/or devices" include heparins, heparinoids, other anticoagulants, pneumatic compression devices.

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						<p>6. Reasons for not prescribing DVT prophylaxis must be documented by a physician, <i>advanced practice nurse</i>, or physician assistant. If reasons are not mentioned in the context of DVT prophylaxis, do not make inferences.</p> <p>9. <i>Please note that anticoagulants at doses (low dose) designed to prevent deep vein thrombosis are insufficient as antithrombotic therapy to prevent recurrent ischemic stroke or TIA. Conversely, antiplatelet agents at doses to prevent recurrent ischemic stroke or TIA are insufficient therapy to prevent deep vein thrombosis. However, anticoagulants at full therapeutic doses (full dose LMW heparin, Unfractionated heparin IV, or warfarin) are considered acceptable treatment options for both DVT prophylaxis and antithrombotic medication.</i></p> <p>10. <i>“NC”: Documented reason for not administering DVD prophylaxis was present in the medical record.</i></p> <hr/> <p><u>Examples</u></p> <p>Added:</p> <p>3. Patient was prescribed DVT prophylaxis on admission to hospital for ischemic stroke. There is no documentation about imaging studies performed to identify DVT. Select “No/Not Documented.”</p>
43	Procedures	NPO	10.7	40	Question clarification	<p>Clarified:</p> <p>Indicate if the patient was NPO (nothing by mouth), including food, fluids, or medications, for the entire hospital stay <i>including any medications delivered in the Emergency Room phase of care.</i></p>
44	Procedures	Screened for dysphagia	10.8	41	Notes clarification	<p>Added:</p> <p>2. Reasons for not performing a dysphagia screen must be explicitly documented or clearly implied by a physician, <i>advanced practice nurse</i>, or physician assistant. If reasons are not mentioned in the context of dysphagia screening, do not make inferences unless documentation explicitly states so. Acceptable reasons for not performing dysphagia screening include the presence of a previously placed gastrostomy tube, and complete recovery of all symptoms and neurological deficits.</p> <p>6. <i>“NC”: Documented reason for screening not required exists in the medical record.</i></p>
45*	Procedures	Results of screening for dysphagia	10.9	42	New data element	<p><u>Element:</u> Results of the Dysphagia screening (MN 10.9)</p> <p><i>If patient was screened for dysphagia, what were the results of the screen?</i></p> <p><u>Options:</u></p>

#	Section	Element	MSR#	Page	Type of Modification	Description
						<ul style="list-style-type: none"> • <i>Pass</i> • <i>Fail</i> • <i>Not Documented</i> <p>Notes for Abstraction:</p> <ol style="list-style-type: none"> 1. <i>Select "Pass" if there is documentation that the screen is passed, or that the patient successfully demonstrates safe swallowing on the initial bedside screening evaluation. Documentation might include evidence that oral intake of food or medication without modification of consistency or other swallowing related features is permitted unsupervised. Restrictions on type of diet such as amounts of calories, protein, etc are not relevant to this item.</i> 2. <i>Select "Fail" if there is documentation that the screen is failed, or that the patient did not demonstrate safe swallowing on dysphagia screening protocol. Restrictions in oral intake generally follow as a result of failure in screen.</i> 3. <i>Select "Not Documented" if there was a screen performed but there is no documentation as to the results of the dysphagia screen.</i>
46*	Complications	DVT or PE	11.1	43	Options clarification, Example clarification	<p><u>Options:</u></p> <p>Clarified:</p> <ul style="list-style-type: none"> • Yes • <i>No/Not Documented</i> <p>(No and Not Documented combined)</p> <p><u>Examples</u></p> <p>Clarified:</p> <ol style="list-style-type: none"> 2. Patient was prescribed DVT prophylaxis on admission to hospital for ischemic stroke. On day 4 of admission the patient had a tender calf, ultrasound was negative for DVT. Answer would be "<i>No/Not Documented</i>". 3. Patient was prescribed DVT prophylaxis on admission to hospital for ischemic stroke. On the day of admission, the patient complained of a tender calf for the previous 3 days. Ultrasound revealed a DVT of the left calf. Answer would be "<i>No/Not Documented</i>". 4. Patient was prescribed DVT prophylaxis on admission to hospital for ischemic stroke. There is no documentation about imaging studies performed to identify DVT. Answer would be "<i>No/Not Documented</i>".

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47*	Complications	Pneumonia	11.2	43	Question clarification, options clarification	<p><u>Definition</u></p> <p>Clarified: Indicate if patient was treated for nosocomial (<i>hospital-acquired</i>) pneumonia after 48 hours of admission</p> <p>Options</p> <p>Clarified:</p> <ul style="list-style-type: none"> • Yes • No • <i>Pneumonia</i> Not Documented
48*	Complications	UTI	11.3	44	Option clarification	<p>Added: Options:</p> <ul style="list-style-type: none"> • Yes • No • <i>UTI</i> Not Documented <hr/> <p><u>Notes for Abstraction</u></p> <p>Added:</p> <ol style="list-style-type: none"> 1. <i>This does not apply to UTIs present on admission or detected on admission evaluation.</i>
49	Complications	Atrial or paroxysmal fibrillation/Flutter	11.5	45	Notes addition	<p>Added:</p> <ol style="list-style-type: none"> 2. <i>The medical record should contain documentation by a physician or other provider which describes the episode or EKG/monitor of atrial fibrillation or flutter. This includes persistent or paroxysmal fibrillation/flutter.</i>
50	Discharge	ICD-9-CM discharge diagnosis related to stroke	12.1	46	Notes addition	<p>Added: <i>997.02 IATROGEN CV INFARC/HMRHG</i></p>
51*	Discharge	Principal ICD-9 discharge diagnosis	12.2	47	Data Entry System Enhancement	<p>Twofold change: First, MN 12.2 appears first - switched order with "ICD-9 discharge diagnosis related to stroke" (MN 12.1). Second, added a selection box if Principal diagnosis is a stroke diagnosis. Checking this box automatically fills the MN 12.1 field with the same value.</p>
52	Discharge	Clinical hospital diagnosis related to stroke	12.3	47	Question deletion/addition, notes addition, example addition	<p><u>Definition</u></p> <p>Deleted: This is the clinical admission diagnosis after completion of all diagnostic procedures, examinations and consultations that was ultimately responsible for this admission</p>

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						<p>Replaced with: 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."</p> <p><u>Notes for Abstraction</u></p> <p>Added:</p> <ol style="list-style-type: none"> <i>Ideally this diagnosis code should be equivalent to the final ICD-9-CM code.</i> <i>However, in some circumstances another ICD-9-CM code may be chosen.</i> <i>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 that this may be different from the presumptive hospital admission diagnosis.</i> <i>For patients who have transient symptoms that are present on arrival to the ED but resolve, and then those symptoms later return during the hospitalization and subsequently meet criteria for ischemic stroke (symptoms > 24hrs or infarction on brain imaging) should be entered as inpatient ischemic strokes.</i> <i>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.</i> <i>Patients with transient symptoms but infarction on the brain imaging should also be classified as ischemic stroke (not TIA).</i> <i>Patients admitted for non-stroke related illness but who have inpatient strokes should have a selection for MN 12.3 that is in alignment with their inpatient stroke type.</i> <i>Patients who present with neurological symptoms but are determined not to have a stroke or TIA should not be entered into the tool.</i> <p><u>Example</u></p> <p>Added:</p> <ol style="list-style-type: none"> <i>Patient was admitted with pneumonia. On hospital day two he developed right sided weakness and was diagnosed with an ischemic stroke. Select "Ischemic Stroke."</i>
53*	Discharge	Discharge Destination	12.4	48	Options addition/deletion, notes addition	<p><u>Options</u></p> <p>Added: <i>08 Reserved for National Assignment</i></p>

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						<p>Deleted: 41 Expired in medical facility, such as hospital, SNF, ICF, or freestanding hospice.</p> <p>Deleted: 20 - Did not recover" is specific to the Christian Science religion. They use this term rather than referring to death. Non-hospice patients who die should be coded as "20".</p> <hr/> <p><u>Notes for Abstraction</u></p> <p>Added:</p> <p>2. <i>Code 43 usage note: Discharges and transfers to a government operated health care facility such as a Department of Defense hospital, a Veterans Administration (VA) hospital or VA hospital or a VA nursing facility. To be used whenever the destination at discharge is a federal health care facility, whether the patient lives there or not.</i></p>
54*	Discharge	Ambulation status	12.5	49	Question re-wording, notes clarification, example addition; Data Entry System Enhancement	<p><u>Question</u></p> <p>Re-worded: Indicate the patient's ambulation status at discharge</p> <p><u>Notes for Abstraction</u></p> <p>Clarified:</p> <ol style="list-style-type: none"> 1. Ambulatory: <ol style="list-style-type: none"> a. Patient ambulating without assistance (no help from another person). <i>This means patient is able to ambulate without help from another person. The use of a device, such as a cane, still meets this definition.</i> b. Patient ambulating throughout the day with assistance of another person or assistive device - <i>Select "With assistance (from person)".</i> c. <i>Patients ambulating to and from the bathroom unassisted are considered to meet the definition of ambulation. Even though actual ambulation is not documented in the medical record, privileges to walk to and from the bathroom and evidence of the patient getting out of bed unassisted are considered also to meet the definition of ambulation.</i> 2. Non-ambulatory: <ol style="list-style-type: none"> a. Patient is on bed rest b. Patient is only getting out of bed to the bedside commode (or up in chair) and is primarily in the bed (or immobile) c. <i>Patient is bedridden</i>

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						<p><u>Examples</u></p> <p>Added:</p> <ol style="list-style-type: none"> 1. <i>Patient has privileges to walk to and from the bathroom unassisted but there is no further evidence of ambulation by at discharge, choose "Able to ambulate independently with or without a device" as this patient would be considered ambulatory.</i> 2. <i>Patient has orders written for "bathroom with assist." There is no other documentation in the medical record to indicate that the patient is in fact ambulating at discharge. Choose " With assistance (from person)" as this patient would be considered non-ambulatory. An order of "bathroom with assist" without additional evidence of ambulation would not count as ambulatory.</i> 3. <i>Patient is ambulating with assistance from nursing. There is documented evidence of the patient walking around the unit with assistance from his nurses. Choose "Able to ambulate independently with or without a device" as this patient is considered ambulatory.</i> <hr/> <p>Data Entry System Enhancement - Skip Logic: When selecting one of the "patient expired" options for Discharge Destination (12.4), the web-entry system will skip the "Ambulation status at discharge" element (12.5).</p>
55	Discharge	Cholesterol Reducing/ Controlling medication prescribed at discharge	12.6	50	Notes addition	<p><u>Notes for Abstraction</u></p> <p>Added:</p> <ol style="list-style-type: none"> 3. <i>In determining whether cholesterol reducing therapy was prescribed at discharge, it is not uncommon to see conflicting documentation among different medical record sources. For example, the discharge summary may list a drug that is not included in any of the other discharge medication sources (e.g., discharge orders). All discharge medication documentation available in the medical record should be reviewed and taken into account by the abstractor.</i> 4. <i>In cases where there is a cholesterol reducing drug noted in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (select "Yes") unless documentation elsewhere in the medical records suggest that it was NOT prescribed at discharge – Consider it a discharge medication in the absence of contradictory documentation.</i> 5. <i>If documentation is contradictory (e.g., MD noted discontinuation of</i>

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						<p><i>the cholesterol reducing therapy in the discharge medication orders, but it is listed in the discharge summary's discharge medication list), or after careful examination of circumstances, context, timing, etc., documentation raises enough questions, the case should be deemed "unable to determine" (select "No").</i></p> <p>6. <i>When there is a documented plan to delay initiation/restarting of a cholesterol reducing therapy for a time period after discharge, select "No".</i></p> <p>7. <i>Patients who meet Adult Treatment Panel (ATP) III criteria* should receive lipid-lowering therapy. The conditions that reflect systemic atherosclerosis and therefore meet ATP III criteria include: Clinical coronary heart disease; symptomatic carotid artery disease; peripheral arterial disease; abdominal aortic aneurysm and diabetes mellitus. Patient may also meet ATP III criteria based on their Framingham Risk score.</i></p> <p><i>*Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report, Circulation 106: 3143.</i></p> <p>10. <i>Reasons must be documented by a physician, advanced practice nurse or physician assistant. If reasons are not mentioned in the context of cholesterol reducing drugs, do not make inferences (e.g., do not assume that cholesterol reducing drugs are not being prescribed because of a particular condition unless documentation explicitly states so).</i></p> <p>12. <i>If documentation by a physician, nurse practitioner, or physician assistant is present in the chart that indicates that the stroke was not of an atherosclerotic origin or that the patient does not meet NCEP ATP III criteria for lipid lowering therapy, select "NC".</i></p>
56*	Discharge	Contraindications to statins	12.11	51	New data element	<p><i>Element: Contraindications to statins</i> <i>If statin not prescribed, was there a documented contraindication to statins?</i></p> <p><i>Options:</i></p> <ul style="list-style-type: none"> <i>• Yes</i> <i>• No/Not Documented</i>
57	Discharge	Antihypertensive medication prescribed at discharge	12.8	52	Examples additions	<p><i>Examples</i></p> <p><i>Added:</i></p> <ol style="list-style-type: none"> <i>1. Patient is admitted to the in-patient unit with right hemiparesis and</i>

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						<p><i>dysarthria. His pre-admission medications were lisinopril, aspirin, metformin and furosemide. His metformin is held but all other medications are continued. He is discharged on day 5 on his original pre-admission medications and the DASH diet. Data entry will be to select "Yes".</i></p> <p>2. <i>The notes for patient document critical intracranial stenosis. At discharge his blood pressure is 100/60 and his lisinopril and furosemide were held with a plan to restart if BP increases. Data entry would be to select "No/Not Documented".</i></p>
58	Discharge	Antithrombotic medication prescribed at discharge	12.9	52	Notes addition, example addition	<p><u>Notes for Abstraction</u></p> <p>Added:</p> <p>1. Only the following are considered acceptable antithrombotic medications:</p> <p><i>Antiplatelet:</i></p> <ul style="list-style-type: none"> a. <i>Aspirin (ASA)</i> b. <i>ASA/dipyridamole (Aggrenox) BID</i> c. <i>Clopidogrel (Plavix)</i> d. <i>Ticlopidine (Ticlid)</i> <p><i>Anticoagulant:</i></p> <ul style="list-style-type: none"> e. <i>Warfarin (Coumadin)</i> f. <i>Unfractionated heparin IV</i> g. <i>Full dose LMW heparin (Enoxaparin, others)</i> h. <i>Fondaparinux (Arixtra)</i> i. <i>Other anticoagulant</i> <p>3. Reasons for not prescribing antithrombotic therapy must be documented by a physician, <i>advanced practice nurse</i>, or physician assistant. If reasons are not mentioned in the context of antithrombotics, do not make inferences (e.g., do not assume that antithrombotics are not being prescribed because of a bleeding disorder unless documentation explicitly states so.) Acceptable reasons for not giving antithrombotic therapy include:</p> <ul style="list-style-type: none"> a. Risk of bleeding or discontinued due to bleeding b. Allergy to or complication <i>r/t aspirin, Ticlopidine, Clopidogrel, dipyridamole and Warfarin or heparins (hx or current)</i> c. Patient receiving terminal or comfort care only d. Patient/family refused e. <i>Serious side effect to medication</i> <p>4. <i>Anticoagulants at doses (low dose) designed to prevent deep vein</i></p>

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						<p><i>thrombosis are insufficient as antithrombotic therapy to prevent recurrent ischemic stroke or TIA.</i></p> <p>5. <i>Conversely, antiplatelet agents at doses to prevent recurrent ischemic stroke or TIA are insufficient therapy to prevent deep vein thrombosis. However, anticoagulants at full therapeutic doses (such as full dose LMW heparin, unfractionated heparin IV, or warfarin) are considered acceptable treatment options for both DVT prophylaxis and antithrombotic medication.</i></p> <p>6. "NC": Documented reason for not administering exists in the record</p> <p><u>Examples</u></p> <p>Added:</p> <p>2. Patient is admitted with new onset atrial fibrillation and a minor stroke. He is discharged on dalteparin 100 IU/kg sq twice a day (full dose LMW heparin) along with a plan to start warfarin in 7 days. Data entry will be to check "Yes".</p> <p>3. Patient is admitted with new onset atrial fibrillation and a minor stroke. He is discharged on enoxaparin 40 mg sq daily for DVT prophylaxis. Data entry will be to check "No".</p>
59	Discharge	Anticoagulation medication prescribed	12.10	53	Notes addition	<p><u>Notes for Abstraction</u></p> <p>Added:</p> <p>5. Examples of anticoagulation therapy include:</p> <ol style="list-style-type: none"> Warfarin (Coumadin) <i>Full dose unfractionated heparin IV</i> <i>Full dose LMW heparin</i> <i>Other anticoagulants (e.g., Lepirudin)</i> <p>7. <i>If reasons are not mentioned in the context of anticoagulation therapy, do not make inferences.</i></p> <p>8. "NC": Documented reason for not prescribing anticoagulation medication exists in the record</p>
60	Discharge Services	Past medical history of smoking	13.1	55	Notes-Examples clarification	<p><u>Notes for Abstraction/ Examples</u></p> <p>Added/Clarification:</p> <p>1. When to select YES (Smoker):</p> <ol style="list-style-type: none"> <i>In cases where conflicting information about the patient's smoking history is documented and there is no specific documentation that</i>

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						<p><i>the patient has not smoked during the year prior to hospital arrival, select "Yes".</i></p> <p>b. <i>If there is documentation of current smoking or tobacco use, or a history of smoking or tobacco use, and the type of product is not specified, assume this refers to cigarette smoking.</i></p> <p>c. <i>If there is a history of smoking and documentation that the patient quit "several months ago," infer the patient smoked within one year prior to arrival, and select "Yes".</i></p> <p>Examples:</p> <ol style="list-style-type: none"> 1. <i>Current smoker" per H&P, but ED note states "Non-smoker" – select "Yes".</i> 2. <i>"Cigarette Smoking: Yes, 1-2 cigarettes a day" on nursing admission note, but "Smoking – Quit" on H&P – select Smoker.</i> 3. <i>"Recent smoker" in H&P, but progress note states "Smokes – No" – select "Yes".</i> <p>More examples for selecting YES (Smoker):</p> <ol style="list-style-type: none"> 4. <i>+ Smoker, type of product not identified</i> 5. <i>+ Tobacco use, type of product not identified</i> 6. <i>History of cigarette use without mention of a time frame, if no indication that patient quit</i> 7. <i>History of smoking (type of product not identified), without mention of a time frame, if no indication that patient quit</i> 8. <i>History of smoking and documentation that the patient quit "several months ago"</i> 9. <i>History of smoking within one year prior to arrival, type of product not identified</i> 10. <i>History of tobacco use (type of product not identified), without mention of a time frame, if no indication that patient quit</i> 11. <i>History of tobacco use within one year</i> 12. <i>Indication that patient quit</i> 13. <i>History of smoking and documentation that the patient quit "several months ago"</i> 14. <i>History of smoking within one year prior to arrival, type of product not identified</i> 15. <i>History of tobacco use (type of product not identified), without mention of a time frame, if no indication that patient quit</i> 16. <i>History of tobacco use within one year prior to arrival, type of product not identified</i> 17. <i>Recent smoker</i> <p>2. When to select "No/Not Documented":</p> <ol style="list-style-type: none"> a. <i>In some cases smoking history documentation in one medical record source may further clarify the patient's smoking history</i>

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						<p><i>documented in another medical record source.</i></p> <p>b. <i>Do not include documentation of smoking history referenced as a "risk factor" (e.g., "risk factor: tobacco", "risk factor: smoking", "risk factor: smoker"), where current smoking status is indeterminable.</i></p> <p>c. <i>If there is a history of smoking and documentation indicates the patient quit, but the timeframe in which the patient quit is not clear, select "No/Not Documented".</i></p> <p>Examples:</p> <ol style="list-style-type: none"> <i>Progress note states "history of smoking" and the nursing admission assessment notes "quit 2 years ago" – select "No/Not Documented".</i> <i>Discharge summary states smoker without specifying the type of tobacco and the ED record specifies the type of tobacco as cigar – select "No/Not Documented".</i> <i>In cases where at least one source has specific documentation that the patient has not smoked anytime during the year prior to hospital arrival – select "No/Not Documented".</i> <i>"Current smoker" per H&P, but consultation note states patient "quit 2 years ago" – select "No/Not Documented".</i> <i>" + tobacco use" per ED note, "Smoker – Yes" per nursing admission note, but H&P states, "Quit smoking in 2002" – select "No/Not Documented".</i> <i>Progress note states "Still smokes occasionally" but nursing admission assessment has "No" circled next to "Tobacco use within past year" – select "No/Not Documented".</i> <i>Nursing admission assessment documents patient as "ex- smoker" or "former smoker," or simply notes pt. "quit smoking" – select "No/Not Documented".</i> <i>History of tobacco abuse" per H&P, and consultation note states "nonsmoker" – select "No/Not Documented" (not a case of conflicting information).</i> <p>More examples for selecting "No/Not Documented".</p> <ol style="list-style-type: none"> <i>Chewing tobacco use only</i> <i>Cigar smoking only</i> <i>Cigarette smoking within one year prior to arrival or any of the other inclusion terms described using one of the following qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect or suspicious</i> <i>Illegal drug use only (e.g., marijuana)</i> <i>Oral tobacco use only</i> <i>Pipe smoking only</i> <i>Remote smoker (smoked in the past, but greater than one year ago)</i>

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61*	Discharge Services	Education	13.3-13.7	-	Data Entry System Enhancement	Reports: User can analyze patient education elements separately in addition to the aggregate measure report.
62*	Discharge Services		13.7	58	Label re-wording, notes addition	<p><u>Label</u></p> <p>Deleted: Their prescribed medication</p> <p>Replaced with: Medications prescribed at discharge</p> <p><u>Notes for Abstraction</u></p> <p>Added: 2. <i>Electronically formatted media such as videos, CDs, and DVDs are acceptable for educational materials. Documentation must clearly convey that (1) personal risk factors for stroke are included in the material, and (2) the patient was given a copy to take home. Referral to web-based materials or help-lines would qualify.</i></p>
63	Discharge Services		13.8	59	Notes addition	<p>Added: 5. <i>If nursing note documents that symptoms fully resolved prior to discharge and therefore the patient does not need rehabilitation, this qualifies as a "Yes". If progress note states that symptoms resolved but this is not mentioned with respect to rehabilitation, then select "No/Not Documented."</i></p>