Hospital Outpatient Instrument

VHA EPRP

FY2019Q4

Purpose of Training

- Review Hospital Outpatient (HOP) instrument prior to beginning abstraction
  - Questions
  - Abstraction guidelines
- Identify HOP measures including population

Hospital Outpatient (HOP) Quality Reporting

- Hospital Outpatient measures were developed by Centers for Medicare & Medicaid Services (CMS) to provide a uniform set of quality measures to be implemented in hospital outpatient settings.
- The Joint Commission (TJC) recognizes select HOP measures to complement its core measure sets and assist facilities to meet measurement requirements.

VHA HOP Measures

hop2	Fibrinolytic Therapy Received within 30 Minutes of ED Arrival
hop3a	Median Time to Transfer to Another Facility for Acute Coronary Intervention – overall rate
hop3b	Median Time to Transfer to Another Facility for Acute Coronary Intervention – reporting measure
hop3c	Median Time to Transfer to Another Facility for Acute Coronary Intervention - quality improvement measure
hop5	Median Time to ECG
hop18a	Median Time from ED Arrival to ED Departure for Discharged ED Patients – overall rate
hop18b	Median Time from ED Arrival to ED Departure for Discharged ED Patients – reporting measure
hop18c	Median Time from ED Arrival to ED Departure for Discharged ED Patients – psychiatric/mental health patients
hop18d	Median Time from ED Arrival to ED Departure for Discharged ED Patients – transfer patients
hop23	Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation within 45 Minutes of ED Arrival

HOP2 - Fibrinolytic Therapy Received within 30 Minutes of Emergency Department (ED) Arrival

Population

- E/M code for ED encounter (Appendix A, OP Table 1.0)
- Patients (Pts) DC/Transfer to short-term general hospital or federal healthcare facility
- ICD-10-CM Principal Dx Code for AMI (Appendix A, OP Table 1.1)
- ST-segment elevation on ECG closest to ED arrival
- Fibrinolytic Administration

Excluded

- Pts < 18 yrs
- Pts who did not receive fibrinolytic within 30 minutes AND had a Reason for Delay in Fibrinolytic Therapy

HOP2 - Fibrinolytic Therapy Received within 30 Minutes of ED Arrival

Numerator

- ED AMI pts whose time from ED arrival to fibrinolysis is 30 minutes or less

Denominator

- ED AMI pts with ST-segment elevation on ECG who received fibrinolytic therapy

HOP 3a, 3b, 3c Median Time to Transfer to Another Facility for Acute Coronary Intervention

Population

- Same as first 4 in HOP2 plus
- Patients with Transfer for Acute Coronary Intervention

Excluded

- Pts < 18 yrs
- Pts receiving fibrinolytic administration

HOP5 Median Time to ECG

Description

- Time (in minutes) from emergency department arrival to ECG (performed in the ED prior to transfer) for AMI or Chest Pain patients (with *Probable Cardiac Chest Pain*)

Population

- Same as first 4 in HOP2 plus
- Pts receiving an ECG

Excluded

- Pts < 18 years

HOP18 Median Time from ED Arrival to ED Departure for Discharged ED Patients

Description

- Time (in minutes) from ED arrival to ED departure for patients discharged from the ED

Population

- Patients seen in a Hospital Emergency Department (E/M Code in Appendix A OP Table 1.0)

Excluded

- Patients who expired in the ED

HOP23 Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation Within 45 Minutes of ED Arrival

Population

- **E/M code for ED encounter (Appendix A, OP Table 1.0)**
- **Age ≥ 18 years**
- **An *ICD-10-CM Principal Diagnosis Code* for Acute Ischemic or Hemorrhagic Stroke as defined in Appendix A, OP Table 8.0**

HOP23

Numerator:

- **ED Acute Ischemic Stroke or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the *Time Last Known Well*, with an order for a head CT or MRI scan whose time from ED arrival to interpretation of the Head CT or MRI scan is within 45 minutes of arrival**

Denominator:

- **ED Acute Ischemic Stroke or Hemorrhagic Stroke patients arriving at the ED within 2 hours of the *Time Last Known Well* with an order for a head CT or MRI scan**

HOP23

Excluded Populations:

- **Patients less than 18 years of age**
- **Patients who expired**
- **Patients who left the ED against medical advice, [discontinued care, or for whom *Discharge Code* is not documented or unable to be determined (UTD).]**

Case Selection by VHA

- Patients seen in a Hospital Emergency Department (**E/M code on OP Table 1.0, Appendix A**):

Code	E/M Code Description
99281	Emergency department visit, new or established patient
99282	Emergency department visit, new or established patient
99283	Emergency department visit, new or established patient
99284	Emergency department visit, new or established patient
99285	Emergency department visit, new or established patient
99291	Critical care, evaluation and management

Sub-populations

TJC	VHA	Population
OP-2, OP-3	HOP2 HOP3	ICD-10-CM Principal Diagnosis Code for AMI defined in Appendix A, OP Table 1.1.
OP-5	HOP5	AMI Population as described above OR Chest Pain Population: ICD-10-CM Principal or Other Diagnosis Codes for Angina, Acute Coronary Syndrome, or Chest Pain as defined in Appendix A, OP Table 1.1a with Probable Cardiac Chest Pain
OP-18	HOP18	E/M code on OP Table 1.0, Appendix A
OP-23	HOP23	ICD-10-CM Principal Diagnosis Code for Acute Ischemic or Hemorrhagic Stroke as defined in Appendix A, OP Table 8.0.

VAMCs

Facility#	Name	Facility#	Name
508	ATLANTA	558	DURHAM
509	AUGUSTA	573	N FL/S GA HCS
516	BAY PINES	578	HINES
521	BIRMINGHAM	580	HOUSTON
523	BOSTON	583	INDIANAPOLIS-10TH ST
534	CHARLESTON	598	LITTLE ROCK
541	LOUIS STOKES CLEVELAND	600	VA LONG BEACH HCS CA
546	MIAMI	614	MEMPHIS
549	DALLAS	618	MINNEAPOLIS
554	DENVER	626	VA MID TENN HCS NASH TN

VAMCs

Facility#	Name	Facility#	Name
630	N.Y. HARBOR HCS	671	SAN ANTONIO
640	PALO ALTO-PALO ALTO	672	SAN JUAN PR
646	PITTSBURGH-UNIV DR	673	TAMPA
648	PORTLAND	674	VA CENTRAL TEXAS HCS
652	RICHMOND	678	SOUTHERN ARIZONA HCS
657	VA HEARTLAND-E VH MO	688	WASHINGTON
660	SALT LAKE CITY HTHCARE	689	WEST HAVEN
662	SAN FRANCISCO	691	GREATER LA HCS
663	PUGET SOUND HCS	695	MILWAUKEE
664	VA SAN DIEGO HCS CA		

Data Elements

- Several data elements are familiar
  - Arrival date and time
  - Principal and other diagnosis codes
  - Emergency Department questions
  - Electrocardiogram questions
  - Fibrinolytic therapy
- Please read definition and decision rules carefully

Acute Care Arrival Date and Time

- Please note these questions specify earliest arrival at the emergency department (ED) at this VAMC.
- Q1 arrvdate will be auto-filled and can be modified if date is incorrect.
- Q2 arrvtime definition/decision rules are similar to other instruments with exception of limitation to ED.
- Default 99:99 can be entered if arrival time is unable to be determined.
- ONLY ACCEPTABLE DATA SOURCE: ED Record

Code Questions

- Q3 emcode - autofilled. Can be modified. Do NOT change unless E/M code documented in the record is not the code displayed in the software.
- Q4 princode - autofilled. Can be modified. Do NOT change unless the Principal Dx code documented in the record is not the code displayed in the software.
- Q5 othrcode - autofilled (up to 24 codes). CANNOT be modified. If no codes pre-filled, verify codes in record and enter.

Discharge Disposition (dccode)

- Q6 dccode - What was the patient's discharge disposition from the *outpatient setting*?

dccode options

1. Home
- Assisted Living Facilities (ALFs) – includes assisted living care at nursing home/facility
- Court/Law Enforcement – includes detention facilities, jails, and prison
- Home – includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, and homeless shelters
- Home with Home Health Services
- Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization

dccode options

2. Hospice – Home (or other home setting as listed in #1 above)

3. Hospice – Health Care Facility
- General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities

dccode options

- Value 4 differs from Inpatient options

4a. Non-VA Acute Care Facility – General Inpatient Care

4b. Acute Care Facility – Critical Access Hospital

4c. Acute Care Facility - Cancer or Children's Hospitals

4d. Acute Care Facility - Department of Defense or Veteran's Administration Hospitals

dccode options

5. Other Health Care Facility
- Extended or Immediate Care Facility (ECF/ICF)
- Long Term Acute Care Hospital (LTACH)
- Nursing Home or Facility including Veteran's Administration Nursing Facility
- Psychiatric Hospital or Psychiatric Unit of a Hospital
- Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed
- Transitional Care Unit (TCU)
- Veteran's Home

dccode options

6. Expired
7. Left Against Medical Advice/AMA
99. Not documented or unable to determine

ED, AMI, and Chest Pain Population

- Next series of questions (7 – 21)
- Q7 edcdt asks for entry of the date the patient departed from the ED.
- Only Acceptable Source is ED record.
- If the date of departure from the ED is not documented, but the date of departure can be determined from other documentation, (e.g., you are able to identify from documentation the patient arrived and was transferred to medical unit on the same day), enter this date.

ED Departure Date cont'd

- For patients who are placed into observation services, enter the date of the physician/APN/PA order for observation services as ED Departure Date.
- A discharge date listed on an ED disposition sheet may be used.
- If there is documentation the patient left against medical advice (AMA) and it cannot be determined what date the patient left AMA, enter 99/99/9999.
- After careful review if date is unable to be determined, 99/99/9999 may be entered.

ED Departure Time (q8 edctm)

- ***ED Departure Time*** is the documented time the patient physically left the Emergency Department. The intent is to capture the latest time at which the patient was receiving care in the ED, under the care of ED services, or awaiting transport to services/care.
- When more than one acceptable *ED Departure Time* is documented, abstract the **latest** time.
  Example: Two departure times found in ED nursing notes: 12:03 via WC and 12:20 via wheelchair. Enter the latest time 12:20 for *ED Departure Time*.
- If the patient expired in the ED, use the time of death as the *ED Departure Time*.
- For patients who are placed into observation services, use the time of the physician/APN/PA order for observation services as *ED Departure Time*.
- Review others in D/D rules

ED Departure Date and Time

- The medical record must be abstracted as documented (i.e., face value). If date documented is obviously in error (e.g. 11/42/20xx) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.
- If time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99

Cardiac Chest Pain (q9 cardpain)

- Was there physician/APN/PA or RN documentation that the patient's chest pain was presumed to be cardiac in origin?
- Review qualifier guidelines in D/D rules

Probable Cardiac Chest Pain Inclusion Guidelines	
Acute coronary syndrome	Chest tightness
Angina	Ischemia
Cardiac	Unstable angina
Cardiac Chest Pain	

Cardiac Chest Pain cont'd

- If there is documentation of a differential/working diagnosis of acute myocardial infarction select "Yes."
  - The term "rule out" indicates a differential/working diagnosis
- Disregard documentation of inclusions/exclusions described with terms indicating the condition is not acute, such as "history of."
- If there is documentation by the nurse or physician of an exclusion term, select "No." If there is nurse or physician documentation of an exclusion term and an inclusion term, select "No."

Definitive Terms Indicating AMI

- Acute myocardial infarction
- Non-ST elevation myocardial infarction, NSTEMI
- Non-STEMI MI, non-STEMI AMI
- Transmural myocardial infarction
- Myocardial infarction, MI
- Heart Attack
- ST-elevation myocardial infarction, STEMI
- Nontransmural myocardial infarction

Cardiac Chest Pain Exclusion Guidelines

- Atypical Chest Pain
- Chest Pain musculoskeletal
- Chest Pain qualified by a non-cardiac cause
- Chest wall pain
- Non Cardiac Chest Pain
- Non-specific Chest Pain
  (R07.9 Chest Pain, Unspecified)
- Traumatic Chest Pain
- Trauma
- MVA (Motor Vehicle Accident)

- Excluded data sources:
  - Chest X-Ray reports, radiology reports

Electrocardiogram (ECG)

- Questions 10 – 13
- Q10 ecg: Was an ECG performed within one hour prior to ED arrival or in the ED prior to transfer?

- If there is an ECG performed within one hour prior to arrival select "Yes."
- If there are multiple ECGs performed within one hour prior to emergency department arrival and/or in the ED prior to transfer, select "Yes."

ECG Date and Time

- Ecgdt – Enter the date the **earliest** ECG was performed.
- Ecgtm – Enter the time the **earliest** ECG was performed.
- **In the event the patient had an ECG performed within 60 minutes prior to arrival at the emergency department, enter the date and time the patient arrived at this emergency department.**
- If there are 2 ECGs performed (one prior to arrival and one after arrival) abstract the ECG performed prior to arrival.
- If no ECGs were performed within 60 minutes prior to arrival, and multiple ECGs were performed after arrival, abstract the ECG performed closest to arrival.
- **ONLY accept date and time printed on the ECG tracing for ECGs performed in the ED**

ECG Interpretation (q13 ecginter)

- Is there documentation of ST-segment elevation on the ECG performed closest to ED arrival?
  1. Yes
  2. No
- ST-SEGMENT ELEVATION: new or presumed new ST-segment elevation >/= .10mV in more than one lead.
- Review inclusion and exclusion guidelines.
- Review Qualifiers/Modifiers

ST-segment Elevation Inclusion Guidelines

- Myocardial infarction (MI) with any mention of location or combinations of locations (e.g., anterior, apical, basal, inferior, lateral, posterior, or combination) IF DESCRIBED AS ACUTE/EVOLVING (e.g., "posterior AMI")
- Q wave MI, IF DESCRIBED AS ACUTE/EVOLVING
- ST ↑
- ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI
- ST-elevation (STE)
- ST-elevation myocardial infarction (STEMI)
- ST-segment noted as >/= .10mV
- ST-segment noted as >/= 1mm
- STEMI or equivalent
- Transmural MI, IF DESCRIBED AS ACUTE/EVOLVING

ECG interpretation cont'd

- **ECG Interpretation is defined as:**
  - 12-lead tracing with name/initials of the physician/APN/PA who reviewed the ECG signed or typed on the report, **OR**
  - Physician/APN/PA documentation of ECG findings in another source (e.g., ED notes, progress notes).
  - Do not measure ST-segments or attempt to determine if there is ST elevation from the tracing itself.
  - **Identify the ECG performed closest to arrival, either before or after emergency department arrival, but not more than 1 hour prior to arrival. Must be prior to any procedures (cardiac cath or PCI).**
  - **Exception:** If the pre-arrival ECG and the first ECG performed after arrival are exactly the same amount of time away from hospital arrival (e.g., both ECGs are 10 minutes away from Arrival Time), use the first ECG performed after hospital arrival.

Hierarchy ECG Interpretation

1. If there is a cardiologist's note that refers to interpretation of the ECG, performed closest to ED arrival, use this interpretation. **If the ECG interpretation differs between the cardiologist and another physician, use the cardiologist interpretation.**
2. **If there is discrepancy in interpretation between two physicians and neither is a cardiologist, use the interpretation done closest to the ACS event.**
3. A 12-lead ECG report in which the name or initials of the physician/APN/PA who reviewed the ECG is signed or typed on the report. An electronic ECG "reading" must also be" signed off" by the physician/APN/PA.
4. Any physician interpretation of ECG findings. Interpretations may be taken from documentation of ECG findings in ED notes, admission note, or progress note.

Fibrinolytic Therapy (q14 – 18)

- **Fibrintx question: Did the patient receive fibrinolytic therapy at this ED?**

Classes of fibrinolytic drugs and examples:	
Tissue Plasminogen Activators (tPA) -Alteplase (Activase; rtPA) -Retaplase (Retavase) -Tenecteplase (TNK-tPA) -Streptokinase -Natural streptokinase (Kabikinase, Streptase, SK)	**Combination** -Anisoylated plasminogen streptokinase activator complex (APSAC)

Fibrinolytic therapy cont'd

- **In the event:**
  - The patient was brought to the hospital via ambulance and fibrinolytic therapy was infusing at the time of arrival, select "Yes."
  - The patient was brought to the emergency department via ambulance and fibrinolytic therapy was infused during transport **but was completed** at the time of emergency department arrival, select "No."
- If the first dose of reteplase (Retavase) is given in the ambulance and the second dose is given in the emergency department, select "Yes."
- **Exclude fibrinolytic therapy given during or after a PCI**.

Fibrinolytic Date and Time

- **Fibtxdt - Enter the date primary fibrinolytic therapy was administered at this facility.**
- Check emergency department notes, medication administration record, and nursing notes for specific date fibrinolytic therapy was administered.
- If there are two or more different fibrinolytic administration dates (either different fibrinolytic episodes or corresponding with the same episode), enter the date the earliest fibrinolytic agent was initiated.
- If the patient was brought to the hospital via ambulance and fibrinolytic therapy was infusing at the time of hospital arrival, enter the date the patient arrived at the hospital.

- **Fibtxtm - Enter the time primary fibrinolytic therapy was administered at this facility.**
- **If fibrinolytic therapy was initiated in the ambulance and was infusing at the time of arrival, use the hospital arrival time.**
- If there are two or more different fibrinolytic administration times (either different fibrinolytic episodes or corresponding with the same episode), enter the earliest time the fibrinolytic agent was initiated.

Reason for Delay - Fibrinolytic (q17 fibdelay)

- **Is there a reason documented by a physician, APN, or PA for a delay in initiating fibrinolytic therapy after hospital arrival?**
- **Reasons for delay in fibrinolytic therapy should be collected regardless of how soon after arrival it was ultimately initiated or how minimal the delay.**
- **Many guidelines to consider!**

Fibrinolytic Delay cont'd

- **Physician/APN/PA documentation must be clear in the record that:**

  (1) a "hold," "delay," "deferral", or "wait" in initiating fibrinolysis/reperfusion actually occurred, AND

  (2) the underlying reason for that delay was non-system in nature.
- **Do NOT make inferences from documentation of a sequence of events alone.**

System Reasons are NOT acceptable

Examples of system reasons include but are not limited to:

- Equipment-related (e.g., IV pump malfunction)
- Staff related issues (e.g., waiting for medication to be sent from pharmacy)

Fibrinolytic Delay cont'd

- **EXCEPTIONS that do NOT require documentation that a delay in initiating fibrinolytic therapy occurred:**
  1. Physician/APN/PA documentation that cardiopulmonary arrest, mechanical circulatory assist device placement, or intubation occurred within 30 minutes after arrival.
  2. Physician/APN/PA documentation of initial patient/family refusal of fibrinolysis/reperfusion

Reason for Not Administering Fibrinolytic

- **Q18 nofibtx: Is there physician/APN/PA or pharmacist documentation of a contraindication or reason for not administering fibrinolytic therapy?**

  1. Yes, physician/APN/PA or pharmacist documented reason for not administering fibrinolytic therapy

  2. Yes, physician/APN/PA documented the patient has a diagnosis of cardiogenic shock

  95. Not applicable

  98. Patient/caregiver refused fibrinolytic therapy

  99. No documentation of reason for not administering fibrinolytic therapy or unable to determine

Reason for Not Administering Fibrinolytic (cont'd)

- **When conflicting information is documented in a medical record, a positive finding (fibrinolytic allergy) should take precedence over a negative finding (no known allergy).**
- **Only use reasons/contraindications listed in the data element.**
- **In situations where there is documentation that would support more than one of the allowable values, 1, 2, 98, or 99, select the lowest value. Example: Patient has a documented contraindication from the inclusion list and a diagnosis of cardiogenic shock, select value "1."**

Inclusion Guidelines

- Extensive list of contraindications
- **NOTE: Current use of any of the following anticoagulants prior to arrival is a contraindication to fibrinolytic therapy:** apixaban (Eliquis), warfarin (Coumadin, Jantoven), dabigatran (Pradaxa), rivaroxaban (Xarelto)

Transfer to Another Facility (q19 tranaci)

- **Was there documentation the patient was transferred from this facility's emergency department to another facility for acute coronary intervention?**
  1. There was documentation the patient was transferred from this facility's emergency department to another facility specifically for acute coronary intervention
  2. There was documentation the patient was admitted to observation status prior to transfer
  3. There was documentation the patient was transferred from this facility's emergency department to another facility for reasons other than acute coronary intervention or unable to determine reason for transfer from medical record

Transfer Guidelines

- **To select value "1," documentation must include a specifically defined reason for transfer such as "Percutaneous Coronary Intervention," "Angioplasty," or "for cardiac cath."**
- **To select value "2," there must be documentation of a physician/APN/PA order to admit to observation status.**
- **Review inclusion guidelines for Acute Coronary Intervention (e.g., acute angiogram, acute cardiac intervention, angioplasty, cath lab)**

Imaging Studies for Stroke Patients

- **The last set of questions (20 – 25) focuses on imaging studies (CT or MRI of the head) for patients seen in the ED with stroke diagnosis (identified by ICD-10 principal diagnosis code on OP Table 8.0, Appendix A).**
- **Includes ischemic and hemorrhagic stroke**

CT or MRI (ctmriord)

- **Was a computerized tomography (CT) or Magnetic Resonance Imaging (MRI) scan of the head ordered by the physician/APN/PA during the emergency department visit?**
  1. Yes
  2. No
- If there is documentation a Head CT or MRI Scan is ordered during the ED visit but is cancelled, and there are no other Head CT or MRI Scans ordered during the emergency department visit, abstract "No".
- **Priority data sources:** Nurses notes, physician notes/orders, radiology notes

Head CT / MRI Scan Date and Time

- **Ctmridt: Enter the date the earliest Head CT or MRI Scan interpretation was completed/reported.**
- The date the earliest Head CT or MRI scan interpretation was completed/reported is the date the results are available to the physician/APN/PA.
- If multiple Head CT or MRI Scans are documented, abstract the date of the earliest interpretation.

- **Ctmritm: Enter the time the earliest Head CT or MRI Scan interpretation was completed/reported.**
- The time the earliest Head CT or MRI scan interpretation was completed/reported is the time the results are available to the physician/APN/PA.
- If multiple Head CT or MRI Scans are documented, abstract the time of the earliest interpretation.

Last Known Well (lastwell)

- **Is there documentation that the date and time of last known well was witnessed or reported?**
  1. Yes
  2. No
- **Last Known Well: The date and time prior to hospital arrival at which it was witnessed or reported that the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.**

Lastwell Guidelines

- **Select "Yes," if BOTH a *Date Last Known Well* and a *Time Last Known Well* are documented.**
- **For patients with a documented date and time of witnessed onset of stroke signs and symptoms, select "Yes".**
  - **Example: Wife reported that while eating dinner with patient, right corner of mouth started to droop and speech slurred about 6:00 PM this evening."**

Lastwell Guidelines

- **Select "No" if:**
  - **There is any physician/APN/PA documentation that *Time Last Known Well* is unknown/uncertain.**
  - **Time Last Known Well is clearly greater than 2 hours prior to hospital arrival AND no specific time is documented. Example: "Patient OK last night." Select "No" because no other documentation of a specific time/time range/time reference was present in the medical record and the time is required for *Time Last Known Well*.**
  - **Documentation of Last Known Well or stroke symptoms occurred following hospital arrival (e.g., in-house stroke).**

Last Known Well Date (lastwelldt)

- ***Date Last Known Well* is the date prior to hospital arrival at which the patient was last known to be well without the signs and symptoms of the current stroke or at his or her baseline of health.**
- Date last known well documented as a specific date and entered as *Date Last Known Well* on a "Code Stroke" form or stroke-specific electronic template, enter that date.
- *Date Last Known Well* documented on a stroke-specific form or template should be selected regardless of other dates last known well documented elsewhere in the medical record. **Exception: Physician/APN/PA documentation that last known well/ onset of signs/symptoms is unknown/uncertain takes precedence over specific time on Code Stroke Form.**

Stroke Specific Forms

Inclusions:

- Code Stroke Form
- Stroke Activation Form
- Stroke Alert Form
- Stroke Assessment Form, etc.

Exclusions:

- Stroke Education Form
- Core Measure Form

Last Known Well Date (lastwelldt)

- **References related to *Arrival Date* are acceptable (e.g., today, tonight, this evening, and this morning). The *Date Last Known Well* and the *Arrival Date* may be the same date or a different date.**

  Example: "Wife reports patient normal this evening until approximately 9 PM." Hospital arrival is 0030 on 12-10-20xx. *Date Last Known Well* is 12-09-20xx.

Last Known Well Date cont'd

- If a reference to date last known well is documented without a specific date [e.g., "patient last known well today (arrival date)"], enter that date. If multiple dates are documented, select the earliest date.
  - Example: "Patient normal yesterday" (day before arrival) documented in ED note and consult note documents that patient was last known to be well on Monday (two days prior to arrival). Select Monday's date for *Date Last Known Well.*
- Review Inclusion/Exclusion Guidelines for Code Stroke Form

Time Last Known Well (lastwelltm)

- ***Time Last Known Well*** is the time prior to hospital arrival at which the patient was last known to be well without the signs and symptoms of the current stroke or at his or her baseline of health.
- Guidelines similar to ***Date Last Known Well***
- ***If Time Last Known Well* is:**
  - Documented as specific number of hours prior to arrival, subtract that number from ED arrival time and enter that time as *Time Last Known Well.*

Time Last Known Well cont'd

- Noted to be a range of time prior to ED arrival (e.g., felt left side go numb 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*.
- Both the *Time Last Known Well* and symptom onset are documented, select the *Time Last Known Well.*

Example: "Patient was doing well at 4:30 PM – noticed difficulty speaking around 6 pm." *Time Last Known Well* is 1630.

Time Last Known Well cont'd

- The only time documented is time of symptom onset without mention of when the patient was last known well, use the time of symptom onset for *Time Last Known Well.*

- If there are multiple times of last known well documented in the absence of the *Time Last Known Well* explicitly documented on a "Code Stroke" form, use physician documentation first before other sources, e.g., nursing, EMS.
- If multiple times of last known well are documented by different physicians or the same provider, use the earliest time documented.

Questions

For VHA field staff:

Eva.Sowinski@va.gov

For EPRP abstractors:

Sharon (shmiller@qualityinsights.org)

Anna (asites@qualityinsights.org)

Alice (aullum@qualityinsights.org)

Quality Insights