Get With The Guidelines ®- Stroke PMT ®
Special Initiatives Tab for Ohio – Coverdell Stroke Program
CODING INSTRUCTIONS

Effective 10-24-15

Date and time first seen by ED MD:

- The time entered should be the earliest documented date and time the patient was seen by the ED physician or the first physician the patient sees upon arrival at the hospital (i.e. neurologist, etc.)
- The time is entered in military time

Admit from:

Notes for Abstraction

- The purpose of this section is to gain a better understanding of the level of care patients were receiving when they had their stroke. This is a more "global" snapshot of a patient's residence/care setting. It differs from the "Where was the patient when the stroke symptoms were discovered" which specifically defines the actual physical location of the patient when the stroke was discovered.

O **Home**

- Home or primary community-based residence (i.e., assisted living facility or retirement community)

O **Nursing Home** (long-term care, patient residence)

- Nursing home or dedicated residential stay unit of a continuing care facility
- Nursing facility certified under Medicaid but not certified under Medicare
- Nursing facility for non-skilled/custodial/residential level of care
- Veteran's Administration Nursing Facility

O **Skilled Nursing Facility** or **Inpatient Rehabilitation Facility**

Skilled Nursing Facility

- Skilled nursing facility (SNF) for short-term care (and not the patient's residence)
- SNF rehabilitation unit (a unit within the SNF)
- Sub-Acute Care
- Transitional Care Unit (TCU)
- Swing Bed (patients admitted from a SNF level of care within the hospital's approved swing bed arrangement)

- Skilled nursing facility with hospice (has not accepted hospice care by a hospice organization)

Inpatient Rehabilitation Facility (IRF)

- Free standing inpatient rehabilitation facility (and not a part of a nursing home)
- Acute inpatient rehabilitation unit in a hospital

O **Another acute care hospital (inpatient)**

- Transferred from another acute care facility, critical access hospital, or short-term general hospital where he or she was an inpatient
- Transferred from a long-term acute care hospital

O **Other**

- Admitted from another facility not listed above

O **ND**

- The patient's residence/last care setting is not documented in the medical record
- The patient's residence/last care setting is unknown

Zip Code:

- Enter zip code of patient's residence from "Admit From" section
- Enter 5 digits at a minimum; enter 9 digits if that information is documented in the chart

Date of Birth:

- This should prepopulate from the Admissions Tab
- If not prepopulated, enter in MM/DD/YYYY format

Coding Instructions for Follow-up Data Elements Section

Notes for Abstraction:

- The goal of these questions is to facilitate quality improvement efforts surrounding "Transitions of Care" and to address follow-up appointment processes to decrease avoidable re-admissions. These questions are a mechanism to track follow-up appointment processes for patients with stroke and TIA in order to develop best practices and improve patient continuity.

- Data for these questions may be found in the following locations (these are suggestions from Coverdell participants and may or may not apply to your organization – please use your own discretion). See Suggested Data Sources for specific questions as indicated.
    - Physician progress note
    - Discharge summary

- Discharge instruction sheet
- Case management notes
- Patient education notes or documentation
- Progress notes

- Skip logic is built into these questions, so some questions and answer choices grey out based on the answer to a previous question.

Follow-up with Primary Care Provider

Notes for Abstraction:

- **Primary Care:** This may include an appointment with a primary care physician, nurse practitioner or physician's assistant.
- **Primary Care Provider Inclusion:** For the purposes of these questions, include all patients with a final clinical diagnosis related to stroke (including ICH, SAH, TIA, Ischemic Stroke and Stroke Not Otherwise Specified) and are discharged to (1)-Home. This includes patients transferred to your facility for treatment that will return to their home community post discharge.

  (1)-Home includes:
  - Assisted Living Facility
  - Court/Law Enforcement (detention facilities, jails and prison)
  - Home
  - Home with Home Health Service
  - Outpatient Services including outpatient procedures at another hospital, Outpatient Chemical Dependency Programs and Partial Hospitalization

  (1)-Home excludes:
  - Hospice in the Home

- **Primary Care Provider Exclusion:**
  - Patients who have Comfort Measures Only documented
  - Patients discharged or transferred to:
    - Hospice
    - Another acute care facility
    - Other healthcare facility
    - Left AMA
    - Expired
    - Had no documentation of discharge disposition or unable to determine discharge disposition
  - Patients who were not admitted
  - Patients < 18 years old

1. Was a follow-up appointment made prior to discharge for the patient to see their pre-admission Primary Care Provider (PCP)?

O Yes- Evidence that appointment was made

Answer "Yes" if:

- There is documentation that the patient has an appointment scheduled with PCP.
    - This could include documentation that the patient states he/she already has an appointment made with their PCP after discharge – including the date and time of the appointment.
- Name, date and time are provided to patient at time of discharge.
- Documentation that a follow-up appointment was not needed.
- Documentation that the patient/family refused having the follow-up appointment made by the hospital prior to discharge.
    - May be documented in Nursing Notes.
- Documentation that the patient has an appointment scheduled with a practitioner that would serve as an alternate to the PCP (i.e. another appropriate primary care provider – such as PCP nurse practitioner, cardiologist, internist, etc.).

O No- Patient has a PCP but no evidence that appointment was made

Answer "No" if:

- No documentation exists that an appointment was scheduled; for example if documentation only states "call for appointment in 2 weeks".

O NA- Patient did not have a PCP prior to hospitalization

Answer "NA" if:

- Documentation that patient did not have a PCP or any provider acting as a PCP prior to admission.

2. If the patient was not being followed by a PCP prior to admission, was a PCP assigned prior to discharge?

O Yes- Patient was assigned a PCP

Answer "Yes" if:

- Documentation exists that the patient was provided with the name and contact information of a PCP (which includes a medical practice and a specific medical clinic) at time of discharge.
- Documentation that patient/family refused assignment of a new PCP.
    - May be documented in Nursing Notes.

O **No- Patient was not assigned a new PCP**

Answer "No" if:

- No documentation of PCP name or contact information being provided to the patient at the time of discharge.

3. If a new PCP was assigned to the patient, was a follow-up appointment with the new PCP made prior to discharge?

O **Yes- Evidence that appointment was made**

Answer "Yes" if:

- There is documentation that the patient has an appointment scheduled with PCP.
- Name, date and time are provided to patient at time of discharge.
- Documentation that a follow-up appointment was not needed.
- Documentation that the patient/family refused having the follow-up appointment made by the hospital prior to discharge.
- Documentation that the patient has an appointment scheduled with a practitioner that would serve as an alternate to the PCP (i.e. another appropriate primary care provider – such as PCP nurse practitioner, cardiologist, internist, etc.).

O **No- No evidence that appointment was made**

Answer "No" if:

- No documentation exists that an appointment was scheduled; for example if documentation only states "call for appointment in 2 weeks".

Follow-up with Neurology/Neurosurgery Provider:

Notes for Abstraction

- **Neurological follow-up** may not always be with a physician. If a referral is made for the patient to be seen, for example, by the nurse practitioner in the stroke clinic, this meets the definition of neurological follow-up.
- **Neurology/Neurosurgery Provider Follow-up Inclusion:** For the purposes of these questions, include all patients with a final clinical diagnosis related to stroke (including ICH, SAH, TIA, Ischemic Stroke, and Stroke Not Otherwise Specified) and discharged to (1)-Home or (5)-Other Healthcare Facility. This includes patients transferred to your facility for treatment that will return to their home community post discharge.

(5) - Other Healthcare Facilities includes:

- 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 Rehabilitation Unit of a Hospital
- Skilled Nursing Facility (SNF), SNF Rehab Unit, Sub-Acute Care or Swing Bed
- Transitional Care Unit (TCU)
- Veteran's Home

- **Neurology/Neurosurgery Provider Follow-up Exclusion:**
  - Patients who have Comfort Measures Only documented
  - Patients discharged or transferred to:
    - Hospice
    - Another acute care facility
    - Left AMA
    - Expired
    - Had no documentation of discharge disposition or unable to determine discharge disposition from the documentation
  - Patients who were not admitted
  - Patients < 18 years old

1. Was a referral ordered or recommended for a follow-up appointment after discharge with either a Neurologist, Neurosurgeon or Neurology Provider?

O Yes- A referral was ordered or recommended

Answer "Yes" if:

- There is an order for neurology follow-up visit to a Neurologist, Neurosurgeon or Neurology Provider after discharge.
- There is documentation that the patient was referred for a follow-up visit to a Neurologist, Neurosurgeon or Neurology Provider.

O No- No evidence of a referral ordered or recommended

Answer "No" if:

- No documentation of the patient being referred to follow-up with a Neurologist, Neurosurgeon or Neurology Provider exists.

O NA– Referral to Neurology Provider was not appropriate

Answer "NA" if:

- There is documentation that a Neurology follow-up appointment is not needed or not clinically appropriate.
- There is documentation that the patient is not eligible for a Neurology follow-up appointment.

Suggested Data Sources:

- Physician Orders
- Discharge Summary
- Discharge Instruction Sheet
- Case Management Notes
- Discharge Planning Notes
- Progress Notes

2. Was a follow-up appointment made prior to discharge for the patient to see a Neurologist, Neurosurgeon or Neurology Provider?

O Yes- Evidence that appointment was made

Answer "Yes" if:

- There is documentation that the patient has an appointment scheduled with a Neurologist, Neurosurgeon or Neurology Provider.
- Documentation that the patient has an appointment scheduled with a practitioner that would serve as an alternate to the Neurology Provider (i.e. a stroke clinic including neurology, group neurology appointments, etc.).
- Name, date and time are provided to patient at time of discharge.
- Documentation that the patient/family refused having the follow-up appointment made by the hospital prior to discharge.
  - May be documented in Nursing Notes.
- The patient had an appointment scheduled with a Neurologist, Neurosurgeon or Neurology Provider prior to this hospital admission.

O No- No evidence that an appointment was made

Answer "No" if:

- No appointment scheduled; for example, if documentation only states "call for appointment in 2 weeks".