

**Instructions for Paul Coverdell National Acute Stroke Program (PCNASP) Post-Hospital Data Elements**

Public reporting of this collection of information is estimated to average 30 minutes – 1 hour per response, including the time for reviewing instructions and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a current valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-1108)

Item	Variable name	Text Prompt	Field Type	Legal Values	Required/Optional
HOSPITAL DISCHARGE DATE	<DscDateD>	Patient's date of hospital discharge:	__/__/____	Date MMDDYYYY	Required
HOSPITAL ADMISSION DATE	<HospadD>	Hospital Admission Date (part of in-hospital dataset):	__/__/____	Date MMDDYYYY	Optional
FOLLOW-UP	<FLMTHD>	Follow up Conducted (check all that apply):	Numeric # = 1-digit	1 = Phone; 2 = Patient's home (in-person); 3 = Chart review; 4 = At a health facility; 5 = EHR/chart abstraction; 6 = Other; 7 = Unable to reach	Required
	<FLPhone>	If phone call conducted, date:	__/__/____	Date MMDDYYYY	Required
	<FLHOME>	If in home follow up conducted, date:			
	<FLChart>	If chart review conducted, date:			
LOCATION OF PATIENT	<FLHealth>	If follow up conducted at a health facility, date:	Numeric # = 1-digit	1 = Home with services; 2 = Home without services; 3=Hospital or Acute care facility; 4=long term care facility; 5=Acute Rehabilitation; 6=Skilled nursing facility;7= Unknown/ND	Required
	<CurrLoc>	Where is the patient at the time of follow-up?			
INFORMANT	<CurLoc30>	Where is the patient 30 days after discharge?	Numeric # = 1-digit	1 = Home; 2 = Hospital or Acute care facility; 3=long term care; 4=Acute Rehab; 5=Skilled nursing facility;6= Unknown/ND	Required
	<Informnt>	Who provided responses to this follow-up?	Numeric # = 1-digit	1 = Patient; 2 = Family Member; 3 = Other Lay Caregiver; 4 = Home Health Aide; 5= EMS; 6 = Other	Optional
REHAB	<Rehab>	Which rehab services were provided at discharge?	Numeric # = 1-digit	1 = Patient received rehabilitation services during hospitalization; 2 = Patient transferred to rehabilitation facility; 3 = Patient referred to rehabilitation services following discharge; 4 = Patient ordered rehab, but declined services; 5 = Patient ineligible to receive rehabilitation services due to impairment; 6 = Patient not assessed for rehabilitation during their previous inpatient visit	Required

Item	Variable name	Text Prompt	Field Type	Legal Values	Required/Optional
RANKIN	<RehabOff>	What type of rehab was ordered?	Numeric # = 1-digit	1 = Occupational Therapy; 2 = Physical Therapy; 3 = Speech Therapy	Optional
	<RehabT>	Select the period of time at which rehab was ordered.	Numeric # = 1-digit	1 = Within 30 days post-discharge; 2 = Within 60 days post-discharge; 3 = Within 90 days post-discharge	Optional
	<RehabSt>	Current Therapy Status: (check all fields that apply)	Numeric # = 1-digit	1 = Home Therapy; 2 = Home with outpatient Therapy; 3 = Home with no therapy; 4 = Rehabilitation facility; 5 = Unknown/ND	Optional
	<mRS30Day>	What is the level of the patient's disability at 30 days? This is the 30-day modified Rankin Scale score.	Numeric # = 1-digit	<b>0 = No symptoms; 1 = Some symptoms but able to carry out all usual duties and activities; 2 = Some disability, unable to carry out all previous activities, but able to look after own affairs without assistance; 3 = Moderate disability; requiring some help, but able to walk without assistance; 4 = Moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance; 5 = Severe disability; bedridden, incontinent, and requiring constant nursing care and attention</b>	<b>Required</b>
TOBACCO	<TobacUse>	Was patient identified as a tobacco user at time of stroke? (Tobacco use includes: cigarettes, cigars/cigarillos, little cigars, pipes, smokeless tobacco (chew, dip, snuff, and snus), hookah/water pipe, and electronic vapor products (e-cigarettes, e-hookah, vape pens).	Numeric # = 1-digit	1 = Yes; 0 = No; 2 = Unknown/ND	<b>Required</b>

Item	Variable name	Text Prompt	Field Type	Legal Values	Required/Optional
	<CurTobac>	If patient was identified as a tobacco user at the time of their stroke, have they used tobacco (cigarettes, cigars/cigarillos, little cigars, pipes, smokeless tobacco (chew, dip, snuff, and snus), hookah/water pipe, and electronic vapor products (e-cigarettes, e-hookah, vape pens) since discharge?	Numeric # = 1-digit	1 = Yes; 0 = No; 2 = Unknown/ND	Required
	<CurTobDa>	Is the patient using tobacco products (cigarettes, cigars/cigarillos, little cigars, pipes, smokeless tobacco (chew, dip, snuff, snus), hookah/water pipe, and electronic vapor products (e-cigarettes, e-hookah, vape pens) every day or some days?	Numeric # = 1-digit	1=Daily; 2 = Some days; 3 = Never; 4 = Unknown/ND	Optional
	<SmkMeds>	If patient was a tobacco user (cigarettes, cigars/cigarillos, little cigars, pipes, smokeless tobacco (chew, dip, snuff, snus), hookah/water pipe, and electronic vapor products (e-cigarettes, e-hookah, vape pens) at the time of their stroke, are they using any medications to stop using tobacco?	Numeric # =1-digit	1 = Yes; 0 = No; 2 = Unknown/ND	Optional
	<StopSmk>	Since discharge, has the patient stopped smoking for one day or longer because they were trying to quit smoking?	Numeric # =1-digit	1=Yes; 0=No; 2=Unknown/ND	Optional
	<Quitat>	If yes, how many times?	Numeric # =2-digit	1-100	Optional
	<TobEdu>	Was the patient provided tobacco cessation counseling and/or referred to a cessation program?	Numeric # =1-digit	1 = Yes; 0 = No; 2 = Unknown/ND	Optional
ED VISITS	<EDYN>	Has patient been seen in ED since discharge?	Numeric # =1-digit	1 = Yes; 0 = No; 2 = Unknown/ND	Optional
	<EDGaDate>	If seen in the ED since discharge, date information about ED visits gathered if before 30 days.	__/__/__	Date MMDDYYYY	Optional
	<EDYN30>	Has the patient been seen in ED within 30 days of hospital discharge?	Numeric # =1-digit	1=Yes; 0=No; 2=Unknown	Required
	<EDNum>	How many ED visits since discharge?	Numeric # =1-digit	1 = 1; 2 = 2; 3 = 3 or more; 4 = Unknown/ND	Optional
	<EDDate>	If yes, Date of first ED visit	__/__/__	Date MMDDYYYY	Optional

Item	Variable name	Text Prompt	Field Type	Legal Values	Required/Optional
	<EDReasn>	If yes, was reason for first ED visit: 1. Fall, 2. Trans-ischemic attack, 3. Stroke, 4. Pneumonia, 5. urinary tract infection, 6. Deep venous thrombosis/Pulmonary embolism/blood clot, 7. Acute Myocardial Infarction, 8. Heart Failure, 9. Infection/sepsis, 10. Pneumonia, 11. Surgery, 12. Other	Numeric # =1-digit	1=Fall, 2= TIA, 3= Stroke, 4=Pneumonia, 5= UTI, 6=VTE, 7=Other	Optional
	<EDDisp>	Was the patient admitted to hospital, discharged to home, discharged to SNF or other institutional long term care, or held for observation and then discharged?	Numeric # =1-digit	1 = Discharged to home; 0 = Admitted to hospital;2= Discharged to SNF or other institutional long term care; 3=Held for observation; 4 = Unknown/ND	Optional
BLOOD PRESSURE	<BPMonitr>	<b>Has the patient been monitoring their blood pressure outside of their healthcare provider office visits (at home or in the community)</b>	<b>Numeric # =1-digit</b>	<b>1 = Yes; 0 = No; 2=Unknown/ND</b>	<b>Required</b>
	<BPSys>	If yes, most recent systolic blood pressure?	Numeric # = 3-digit	Number: (Range; 50-220)	Optional
	<BPDia>	If yes, most recent diastolic blood pressure?	Numeric # = 3-digit	Number (Range: 30-160)	Optional
	<BPReport>	<b>If yes, has the patient reported their blood pressure to their health care provider since discharge?</b>	<b>Numeric # = 1-digit</b>	<b>1 = Yes; 0 = No; 2=Unknown/ND</b>	<b>Required</b>
	<BPUsual>	Is this blood pressure usual for you?	Numeric # = 1-digit	1=Yes; 0=No; 2 = Unknown/ND	Optional
FALLS	<DCFalls>	<b>Occurrence of Falls?</b>	<b>Numeric # = 1-digit</b>	<b>1=Yes; 0=No; 2 = Unknown/ND</b>	<b>Required</b>
	<Fall30>	<b>Has the patient fallen within 30 days of discharge?</b>	<b>Numeric # = 1-digit</b>	<b>1=Yes; 0=No; 2 = Unknown/ND</b>	<b>Required</b>
	<FallNum>	<b>If yes, number of falls?</b>	<b>Numeric # = 2-digit</b>	<b>Number (Range: 1-99)</b>	<b>Required</b>
	<FallRep>	Was your fall reported to a healthcare provider?	Numeric # = 1-digit	1=Yes; 0=No; 2 = Unknown/ND	Optional
MEDICATION		Medications prescribed at discharge?	Numeric # = 1-digit	1 = Yes; 0 = No	Optional
	<DCBPMed>	Antihypertensive			
	<DCStatn>	Statin			
	<DCDiab>	Antidiabetic agent			
	<DCAsprn>	Aspirin or other antiplatelet			

Item	Variable name	Text Prompt	Field Type	Legal Values	Required/Optional
FOLLOW UP APPOINTMENT	<DCACoag>	Anticoagulant	Numeric # = 1-digit	1 = Yes; 0 = No	Optional
		Are you currently taking:			
	<BPMedNow>	Antihypertensive			
	<StatnNow>	Statin			
	<DiabNow>	Antidiabetic agent			
	<AsprnNow>	Aspirin or other antiplatelet			
	<ACoagNow>	Anticoagulant	Numeric # = 1-digit	1 = Yes; 0 = No; 2 = Unknown/ND	Optional
	<RevMed>	Did staff review your medications with you before discharge?			
	<StpMed30>	Have you stopped any medications in the 30 days since hospital discharge without being told to do so by your medical provider?	Numeric # = 1-digit	1 = Yes; 0 = No	Optional
		If yes, which meds?	Numeric # = 1-digit	0= No; 1 = Yes - side effects; 2 = Yes - cost; 3 = Yes - no transportation; 4 = Yes - healthcare provider told them to stop; 5 = Yes - forget to take them; 6 =Yes- Ran out; 7= Yes-Was away from home; 8=Yes- Other; 9 = Not documented/UTD	Optional
	<StopBP>	Antihypertensive			
	<StopStn>	Statin			
	<StopDiab>	Antidiabetic agent			
	<StopASA>	Aspirin or other antiplatelet			
	<StopCoag>	Anticoagulant			
<StopOth>	Stopped taking another medication	_____	Open-ended	Optional	
<StpMed60>	Have you stopped any medications in the 60 days since hospital discharge without being told to do so by your medical provider?	Numeric # = 1-digit	1 = Yes; 0 = No	Optional	
<StpMed90>	Have you stopped any medications in the 90 days since hospital discharge without being told to do so by your medical provider?	Numeric # = 1-digit	1 = Yes; 0 = No	Optional	
<DApptYN>	<b>Was an appointment made prior to discharge to follow up with a healthcare provider?</b>	<b>Numeric # = 1-digit</b>	<b>1 = Yes; 0 = No; 2 = Unknown/ND</b>	<b>Required</b>	
<DAppKep>	<b>If yes, was: The appointment kept?</b>	<b>Numeric # = 1-digit</b>	<b>1 = Kept and attended visit; 0= Kept and visit Pending; 2= Unknown/ND</b>	<b>Required</b>	
<DAppRes>	<b>Indicate reason(s) for not re-scheduling appointment:</b>	<b>Numeric # = 1-digit</b>	<b>0 = same reason as cancellation for initial appointment; 1 = No transportation; 2 = No</b>	<b>Required</b>	

Item	Variable name	Text Prompt	Field Type	Legal Values	Required/ Optional
				reminder call; 3 = Patient not aware of initial appointment; 4 = Cost; 5 = Distance to provider; 6 = Scheduling conflict; 7 = Sick; 8 = Other	
	<DAppNKep>	If yes, was the appointment not kept:	Numeric # = 1-digit	1=Not kept; 0=not kept and not rescheduled; 2=Unknown/ND	Required
	<DAppPend>	If no, has an appointment been scheduled since discharge?	Numeric # = 1-digit	1 = Yes; 0 = No; 2 = Unknown/ND	Required
	<DAppType>	Who did patient see or will see?	Numeric # = 1-digit	1 = Stroke Specialist; 2 = Primary Care Provider; 3 =both; 4= Other;	Optional
	<DAppCan>	If the appointment wasn't attended, why?	Numeric # = 1-digit	1=no transportation;2=didn't know about/remember appointment;3= scheduling conflict; 4=sick; 5=other	Optional
	<DAppDate>	Date of first follow up appointment	__/__/____	Date MMDDYYYY	Optional
READMISSIONS	< ReAd>	Has patient been readmitted to a hospital since discharge?	Numeric # = 1-digit	1 = Yes; 0 = No; 2 = Unknown/ND	Required
	<ReAd30D>	Was the patient readmitted to a hospital within 30 days of discharge?	Numeric # = 1-digit	1 = Yes; 0 = No; 2 = Unknown/ND	Required
	<ReAdDate>	If yes, date of first readmission	__/__/____	Date MMDDYYYY	Optional
	<ReAdWhy>	If yes, were any of readmissions due to: 1. Fall, 2. Deep vein thrombosis/pulmonary embolism/blood clot, 3. Carotid Intervention, 4. Acute Myocardial Infarction, 5. Heart Failure, 6. Infection/Sepsis, 7. Blood pressure, 8. Pneumonia, 9. Trans Ischemic Attack, 10. Atrial Fibrillation, 11. Other cardiac survey event, 12. Other surgical procedure, 13. Urinary tract infection, 14. Unknown,	Numeric # = 1-digit	1= Fall, 2=Deep vein thrombosis/pulmonary embolism/blood clot, 3=Carotid Intervention, 4=Acute Myocardial Infarction, 5=Heart Failure, 6= Infection/Sepsis, 7=Blood pressure, 8= Pneumonia, 9=Trans Ischemic Attack, 10= Atrial Fibrillation, 11=Other cardiac survey event, 12= Other surgical procedure, 13=urinary tract infection, 14= Unknown, 15= Other	Optional

Item	Variable name	Text Prompt	Field Type	Legal Values	Required/Optional
		15= Other			
	<ReAdNum>	If yes, how many readmissions since discharge?	Numeric # = 1-digit	1 = 1; 2 = 2; 3 = 3 or more; 4 = Unknown/ND	Optional
DEATH	<Die30d>	<b>Has patient died?</b>	<b>Numeric # = 1-digit</b>	<b>1 = Yes; 0 = No</b>	<b>Required</b>
	<DieDate>	<b>If patient died, date of death</b>	<b>__/__/__</b>	<b>Date MMDDYYYY</b>	<b>Required</b>
	<DieCause>	<b>If patient died, cause of death</b>	<b>Numeric # = 1-digit</b>	<b>1 = new ischemic stroke; 2 = Pneumonia/Respiratory Failure; 3 = myocardial infarction; 4 = Heart Failure; 5=Other Cardiovascular; 6=Deep vein thrombosis or pulmonary embolism; 7= Sepsis/Infection; 8=Intracranial hemorrhage (SAH, ICH, SDH, etc); 9=Other; 10=Unknown/ND</b>	<b>Required</b>
MENTAL HEALTH	Over the past 2 weeks how often have you been bothered by any of the following problems: Not at all, several days, more than half the days, and nearly every day.				Optional
	<MenHea1>	Little interest or pleasure in doing things	Numeric # = 1-digit	0=not at all, 1= Several days, 2=More than half the days, 3=Nearly everyday	Optional
	<MenHea2>	Felling down, depressed, or hopeless	Numeric # = 1-digit	0=not at all, 1= Several days, 2=More than half the days, 3=Nearly everyday	Optional
	<MenHea3>	Trouble falling asleep, staying asleep or sleeping too much	Numeric # = 1-digit	0=not at all, 1= Several days, 2=More than half the days, 3=Nearly everyday	Optional
	<MenHea4>	Feeling tired or having little energy	Numeric # = 1-digit	0=not at all, 1= Several days, 2=More than half the days, 3=Nearly everyday	Optional
	<MenHea5>	Poor appetite or overeating	Numeric # = 1-digit	0=not at all, 1= Several days, 2=More than half the days, 3=Nearly everyday	Optional
	<MenHea6>	Feeling bad about yourself or that you're a failure or have let yourself or your family down	Numeric # = 1-digit	0=not at all, 1= Several days, 2=More than half the days, 3=Nearly everyday	Optional
	<MenHea7>	Trouble concentrating on things, such as reading the newspaper or watching television	Numeric # = 1-digit	0=not at all, 1= Several days, 2=More than half the days, 3=Nearly everyday	Optional
	<MenHea8>	Moving or speaking so slowly that others could have noticed. Or, the opposite, being so fidgety or restless that you have been moving around more than usual	Numeric # = 1-digit	0=not at all, 1= Several days, 2=More than half the days, 3=Nearly everyday	Optional
<MenHea9>	Thoughts that you would be better off dead or of hurting yourself in some way	Numeric # = 1-digit	0=not at all, 1= Several days, 2=More than half the days, 3=Nearly everyday	Optional	