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| 1 | conthth | Does the record document any of the following potential contraindications to fibrinolytic therapy?**Absolute contraindications**1. previous hemorrhagic stroke at any time
2. other strokes or cerebrovascular events, within one year
3. known intracranial neoplasm
4. active internal bleeding (except menses)
5. suspected aortic dissection
6. acute pericarditis
7. clinician documentation of late presentation
8. other contraindication documented by clinician

**Relative contraindications**1. severe uncontrolled hypertension on presentation
2. current use of anticoagulants in therapeutic doses
3. known bleeding problems
4. recent trauma
5. recent major surgery, i.e., within three weeks
6. non-compressible vascular punctures
7. recent internal bleeding, i.e., within 2 to 4 weeks
8. prior exposure to streptokinase, if that agent is to be administered, i.e., within 5 days to 2 years
9. pregnancy
10. active peptic ulcer
11. history of chronic, severe hypertension
12. age > 75 years
13. Stroke risk score > = 4 risk factors
14. cardiogenic shock
15. no documented contraindication
 | 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15, 16,17,18, 19, 20, 21, 22, 99**Cannot enter 17** **if sex = 1****Cannot enter 20 if age < = 75 years** | **4. Active internal bleeding** = patient presents to hospital actively bleeding from non-compressible site, such as biopsy site, subclavian artery, ulcer, lacerated viscera or other internal site. Skin lesions or trauma to external surface is not applicable.**7. Clinician documentation of late presentation** = clinician documents too many hours have passed from the beginning of the patient’s symptoms to his/her arrival at the hospital.**8. Other contraindication documented by a clinician= patient or situation-specific reason why patient is not a candidate for fibrinolytic therapy**(Examples: patient’s advanced age, multiple system failure, patient or family decided against fibrinolytic therapy)**9. Severe uncontrolled hypertension on presentation** = systolic BP > 180mm Hg or diastolic BP > 110 mm Hg, following therapy in the emergency department, or a clinician’s notation diagnosing severe uncontrolled HTN at time of admission.**10. anticoagulants = warfarin (Coumadin); heparin****12. recent trauma =** within 2 to 4 weeks; includes head trauma or traumatic or prolonged ( > 10 minutes) cardiopulmonary resuscitation (CPR)21. Stroke Risk Score > = 4 risk factors* **age > = 75 years**
* **female**
* **African American descent**
* **prior stroke**
* **admission systolic BP > = 160 mm Hg**
* **use of alteplase**
* **excessive anticoagulation ( INR > = 4; APTT > = 24)**
* **below median weight (< = 65 kg for women; <= 80 kg for men)**

**22. cardiogenic shock** = sustainedsystolic BP < 90 mm Hg and evidence of end-organ hypoperfusion, such as cool extremities and urine output < 30 cc/hr) and CHF. Must be documented by a clinician. |
| 2 | ththgvn | Was primary fibrinolytic therapy received during this episode of care? | 1,2If 2, auto-fill specthth as 95, ththdate as 99/99/9999, ththtime as 99:99, fibdelay as 95, and ththfail as 95 | Abbokinase, Activase, Alteplase, Anistreplase, Eminase, Reteplase, Kabikinase, Streptase, Streptokinase, Tissue Plasminogen Activator (TPA), Win-kinase, APSAC = Anisylated plasminogen streptokinase activator complex. **If fibrinolytic therapy was initiated in the ambulance and was infusing at the time of arrival, answer “1.” If infusion of fibrinolytic therapy was completed by the time of hospital arrival, answer “2.”****Exclude fibrinolytics given during or after a PCI.** |
| 3 | specthth | Indicate which of the following fibrinolytic agents were administered to the patient:1. streptokinase
2. reteplase
3. tPA (Alteplase)
4. tenecteplase
5. other agent administered
6. not applicable
 | 1,2,3,4,5,95If ththgvn =2, will be auto-filled as 95 | Streptokinase: 1.5 million units (MU) over 60 minutesReteplase (rPA): 10 U over 2 minutes followed by a second 10 U IV bolus 30 minutes laterAlteplase (tPA): (100 mg maximum), 15 mg IV bolus, then 0.75 mg/kg over 30 minutes, then 0.5 mg/kg over the next 60 minutesTenectaplase: IV bolus weight adjusted  |
| 4 | ththdate | Enter the date primary fibrinolytic therapy was initiated during this hospital stay. | mm/dd/yyyyIf ththgvn = 2, will be auto-filled as Abstractor may enter 99/99/9999

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| If inptacs =2, > = acutedt and < = dcdateIf inptacs = 1 > = sign1dt (if sign1dt null default to > = inekgdt) and < = dcdate. |

 | Check emergency department notes, medication administration record, progress notes, nurses’ notes for specific date fibrinolytic therapy was given**. Do not use order sheets for this data element.** If there are two or more different fibrinolytic administration dates (either different fibrinolytic episodes or corresponding with the same episode), enter the date (and time) the earliest fibrinolytic agent was initiated.**Enter exact date. Month = 01 or day = 01 is not acceptable**.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.**Exclude fibrinolytics given during or after a PCI.**If the date primary fibrinolytic therapy was initiated is unable to be determined from medical record documentation, enter 99/99/9999.If the date documented in the medical record is obviously in error (not valid, e.g. 03/**42**/2007) and no other documentation is found, enter 99/99/9999. |
| 5 | ththtime | Enter the time primary fibrinolytic therapy was initiated during this hospital stay. | \_\_\_\_\_UMTIf ththgvn = 2, will be auto-filled as 99:99Abstractor may enter 99:99

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| If inptacs =2, > = acutedt/acutetm and < = dcdate/dctimeIf inptacs = 1 > sign1dt/sign1tm (if sign1dt/sgn1tm null default to > inekgdt/inekgtme) and < = dcdate/dctime |

 | **If fibrinolytic therapy was initiated in the ambulance and was infusing at the time of arrival, use the hospital arrival time.**  Do not use order sheets for this data element. 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.Time must be in Universal Military TimeIf the time is in the a.m., conversion is not required.If the time is in the p.m., add 12 to the clock time hour.**Exclude fibrinolytics given during or after a PCI.**If the time primary fibrinolytic therapy was initiated is unable to be determined from medical record documentation, enter 99:99.If the time documented in the medical record is obviously in error (not valid, e.g. **33**:00) and no other documentation is found, enter 99/99/9999. |
| 6 | fibdelay | Is there a reason documented by a physician, APN, or PA for a delay in initiating fibrinolytic therapy after hospital arrival?1. Yes
2. No
3. Not applicable
 | 1,2,95If ththgvn = 2, will be auto-filled as 95 | **Physician/APN/PA documentation must be clear in the record that:** **1) a “hold,” “delay,” 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.** **Examples of acceptable physician/APN/PA documentation: “Hold fibrinolytics. Need to consult with neurology regarding bleeding risk.” “Patient waiting for family to arrive—wants to consult with them before fibrinolysis.” “Need to control BP before administering lytics.”****System reasons for delay are NOT acceptable, regardless of any linkage to the delay in the fibrinolysis/reperfusion.** Some examples: equipment-related problems, staff related issues (waiting for medication to be sent from pharmacy), consultation with other clinician that is not clearly linked to a patient-centered reason for delay.**EXCEPTIONS that do NOT require documentation that a delay in initiating fibrinolytic therapy occurred:*** **Physician/APN/PA documentation that cardiopulmonary arrest, balloon pump insertion, or intubation occurred within 30 minutes after arrival. In order to be acceptable, documentation must be CLEAR that the arrest, balloon pump insertion, or intubation occurred within 30 minutes after arrival (use the earliest time documented to confirm the cardiopulmonary arrest occurred within 30 minutes).**

**Include:** * balloon pump, aortic balloon pump, intra-aortic balloon, intra-aortic balloon counterpulsation, intra-aortic balloon pump, intra-aortic counterpulsation, intra-aortic counterpulsation balloon pump
* cardiopulmonary arrest, cardiac arrest, cardiopulmonary resuscitation (CPR), code, defibrillation, respiratory arrest, and ventricular fibrillation
* endotracheal intubation, mechanical ventilation, nasotracheal intubation, orotracheal intubation
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|  |  |  |  | **Reason for Delay in Fibrinolytic Therapy cont’d*** **Physician/APN/PA documentation of initial patient/family refusal of fibrinolysis/reperfusion**

**If unable to determine whether a documented reason is system in nature, select “2.”**The following examples are **NOT** acceptable documentation of reasons for a delay in initiating fibrinolytic therapy:“Patient is discussing PCI with family” (Not specific enough – no mention of reperfusion/fibrinolytic therapy.) “Fibrinolytics contraindicated—too high risk.” (Effect on timing/delay of fibrinolysis not documented.) “ST-elevation on initial ECG resolved. Chest pain now recurring. Begin lytics.” (Requires clinical judgment –linkage to delay in fibrinolysis not clear.) “Patient presented to ED with non-cardiac symptoms. AMI confirmed later that morning. Fibrinolytic therapy started.” (Requires clinical judgment –linkage to delay in fibrinolysis not documented.)  |
| 7 | ththfail | Is there documentation in the record that fibrinolytic therapy was unsuccessful?1. yes
2. no
3. not applicable
 | 1,2,95If ththgvn = 2, will be auto-filled as 95 | **To answer “yes,” there must be specific documentation by a clinician (physician, APN, or PA) that reperfusion by fibrinolytic therapy was unsuccessful or ineffective.** |
| 8 | outpci | Was the patient discharged to another acute care hospital for an emergent cardiac cath or probable PCI?(Emergent: within < = 24 hours) | 1,2**If 2, auto-fill docneed as 95, tranplan as 95, actvdt as 99/99/9999, actime as 99:99, trnfrdt as 99/99/9999, and timeout as 99:99** | **Emergent cardiac cath: transferred out within < = 24 hours from arrival time or, if the patient was already an inpatient, abnormal ECG time or positive troponin report time.** If the patient is sent to a hospital affiliated with this VAMC for a PCI, and returned to this VAMC within 12 hours for further care, answer “2” since this is not a discharge, and the cath/PCI is considered as done at this VAMC.Answer “1” if the patient was discharged to another VAMC or community-based acute care hospital, and the record documents a planned cath with consideration of a PCI depending on the outcome of the cath. |
| 9 | docneed | Does the record indicate urgent need for catheterization/probable PCI based on ECG interpretation of ST elevation or LBBB (new or not known to be old)?1. yes
2. no
3. not applicable
 | 1,2,95If outpci = 2, will be auto-filled as 95 | **Documentation of the need for an emergent cath can state “discharged for a cath or PCI.” The abstractor does not need to know whether both will be performed.** There must be documentation in the record of ECG interpretation as noted, or documentation of a STEMI, and an indication that need for intervention is urgent.  |
| 10 | tranplan | Is there documentation of a plan for transfer, i.e., acceptance by the receiving facility and transportation arrangements made?1. yes
2. no
3. not applicable
 | 1,2,95If outpci = 2, will be auto-filled as 95**If 2, auto-fill actvdt as 99/99/9999 and actime as 99:99 and trnfrdt as 99/99/9999 and timeout as 99:99** | **Plan of transfer must be comprised of the two noted parts: the receiving facility must be contacted and agree to accept the patient, and arrangements for transportation must be made.** |
| 11 | actvdt | Enter the date the plan was activated. | mm/dd/yyyyIf outpci = 2 or tranplan = 2, will be auto-filled as 99/99/9999

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| If inptacs = 2, > = acutedt and < = dcdateIf inptacs = 1, > = sign1dt ( if sign1dt null, default to inekgdt) and < =dcdate |

 | **Plan activated = the latest date when both components of the plan were completed**Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.Will be auto-filled as 99/99/9999 if TRANPLAN = 2. Abstractor cannot enter 99/99/9999 default date if TRANPLAN = 1. |
| 12 | actime | Enter the time of activation. | \_\_\_\_\_UMTIf outpci = 2 or tranplan = 2, will be auto-filled as 99:99**Abstractor can enter 99:99 default time if the time of activation is unknown.**

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| If inptacs = 2, > = acutedt/acutetm and < = dcdate/dctimeIf inptacs = 1, > = 1signdt/1signtm (if 1signdt/1signtm null, default to inekgdt/inekgtme) and < = dcdate/dctime |

 | Time must be entered in universal military time.The time is the latest time that the receiving facility agreed to take the patient and transportation arrangements were completed.**Abstractor can enter 99:99 default time if the time of activation is unknown.** |
| 13 | trnfrdt | Enter the date the patient left the hospital. | mm/dd/yyyyIf outpci = 2 or tranplan = 2, will be auto-filled as 99/99/9999

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| > = actvdt and < = dcdate |

 | Source: MD orders, progress notes Date of transfer = date patient actually left the VAMC for another acute care hospital for planned cath and possible PCI.Enter the exact date. The use of 01 to indicate missing day or month is not applicable.  |
| 14 | timeout | Enter the time the patient left the hospital. | \_\_\_\_\_UMTIf outpci = 2 or tranplan = 2, will be auto-filled as 99:99**Abstractor can enter default time 99:99** i**f unable to determine time the patient left the hospital**

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| > = actvdt/actime and < = dcdate/dctime |

 | Time must be entered in universal military time.If the time is in the a.m., conversion is not required.If the time is in the p.m., add 12 to the clock time hour.**If unable to determine the time the patient left the hospital, enter 99:99.** |
| 15 | noptca | Is there clinician documentation in the record of a contraindication to PCI?1. patient co-morbidities preclude procedure
2. other reason documented
3. patient or family refusal
4. no documented contraindication
 | 2,3,98,99 | Clinician = physician, APN, or PADocumentation may include patient or family’s refusal to consent to PCI, documentation that patient co-morbidities likely preclude a successful outcome, or other clinical reason why PCI is not an option for this patient. **The reason why PCI was not performed must be clearly documented by a clinician** |
| 16 | ptcadne | Was a percutaneous coronary intervention (PCI) performed during this episode of care?1. Yes
2. No
3. Emergent PCI done as an outpatient at this VAMC immediately prior to acute care arrival

**If a PCI was performed, ICD-9-CM code should be entered in pxcode or othrpxs if documented in the medical record. Do not enter any procedure codes that are not present in the medical record. The codes for stent placement (36.06) or drug-eluting stent placement (36.07) should be added, if applicable, but can only be an adjunct to 00.66.**  | 1,2,3**If 1, auto-fill planpci as 95 and pcifail as 95****If 2**, **auto-fill** **opcicpt as 95, primepci as 2, pcidate as 99/99/9999, pcitime as 99:99, stentplc as 95, zero-fill stentnum, auto-fill drugstnt as 95, and auto-fill pcidelay as 95****If 3, auto-fill planpci as 95 and pcidelay as 95****Cannot enter 3** **if outpci = 1**

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| Warning window if 2 and 00.66 entered in pxcode or othrpxs  |
| Warning window if 1 and 00.66 not entered in pxcode or othrpxs |

 | **Do not include PCIs that were attempted but not completed on at least one vessel. Include PCIs that are completed but unsuccessful in maintaining the flow of blood through the artery.** Percutaneous coronary intervention: dilation of a coronary arterial obstruction by means of a balloon catheter inserted through the skin and into the lumen of the vessel to the site of the narrowing. The balloon is inflated to flatten plaque against the artery wall. This may be performed with or without a stent, which is a metal scaffold that is used to assist in establishing and maintaining vessel patency. Cardiac cath alone is not a PCI.**If the patient is transferred to a hospital affiliated with this VAMC for a PCI, returns to this VAMC within 12 hours for further care, and the PCI report is accessible, answer “1.”**All questions after PTCADNE reference the PCI done after acute care hospital arrival and do not reference a PCI done in the outpatient setting immediately prior to acute care arrival.  |
| 17 | opcicpt | If the PCI was performed prior to admission at this VAMC, does the record contain CPT code 92980, 92981, 92982, 92983, or 92984? 1. Yes2. No95. Not applicable | 1,2,95Will be auto-filled as 95 if ptcadne = 2**Computer will auto-fill as 95 if pxcode or othrpxs = 00.66** | This question applies to PCIs which may have been performed either immediately prior to or after acute care arrival for this episode of care, but prior to formal admission. Look under outpatient encounters to determine if the PCI was coded using one of the listed CPT codes.  |
| 18 | planpci | Did the physician/APN/PA document the patient was sent to the cardiac cath lab emergently with a plan for PCI?1. Yes
2. No
3. Not applicable
 | 1,2,95Will be auto-filled as 95 if ptcadne = 1 or 3 | **This element is applicable to patients who do not have a PCI performed or completed. The intent is to look for clinician documentation reflecting that the patient was sent to the cath lab emergently with a plan for PCI. For example, ED physician notes, “STEMI, discussed with Dr. Smith, cardiologist. Patient transported to cath lab for emergent cath” and cardiologist notes in cath report, “lesions not amenable to PCI, consult for CABG.” Select “1.”** **Consideration of PCI must be documented either prior to the emergent cardiac cath procedure or in a note referencing the emergent cardiac cath procedure.** Suggested Sources: ED notes, cardiology consult, cardiac cath report, post-cath notes |
| 19 | primepci | Did a physician, APN, or PA describe the first PCI as NOT primary?1. Yes
2. No
3. Not applicable
 | 1,2,95

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| Hard edit: Cannot = 1 if ptcadne = 3  |

 | A PCI is considered NOT primary when it is used for reasons that are not emergent in nature. **Non-primary PCIs are described as elective, not emergent, not immediate, not primary, not urgent, or secondary.** A primary PCI is the use of a percutaneous reperfusion procedure in the acute phase of ST-segment elevation MI (usually within 12 hours or less from the onset of ischemic symptoms) with the goal of restoring blood to the affected myocardium.**Use only physician, APN, or PA documentation which explicitly describes the first PCI as not primary. Do not attempt to determine whether the PCI was non-primary or not based on symptomatology, circumstances, timing, etc.****If ANY physician/APN/PA documentation referring to the first PCI describes the procedure as non-primary (elective, not emergent, not immediate, not primary, not urgent, secondary), enter “1.”** **Examples:** Physician notes, “Will schedule elective PCI” or “No indication for immediate PCI.” Select “1.”**If the documentation does not specifically describe the first PCI as not primary, enter “2.”** |
| 20 | pcidate | What is the date associated with the time of the first PCI done after hospital arrival? | mm/dd/yyyyIf ptcadne = 2, will be auto-filled as 99/99/9999Abstractor may enter 99/99/9999

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| If inptacs =2 and ptcadne = 1, > = acutedt and < = dcdateIf inptacs =2 and ptcadne = 3, < = 1 day prior to or = acutedt If inptacs = 1 > = sign1dt (if sign1dt null default to > = inekgdt) and < = dcdate. |

 | **Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.****Do NOT include PCIs which were attempted but not completed on at least one vessel – e.g., angioplasty device (balloon, stent, thrombectomy device) could not be delivered to the blocked area of the artery, balloon could not be inflated, guidewire could not be advanced).** **Include PCIs that are completed but unsuccessful in maintaining the flow of blood through the artery. These may be described as “failed completed.”**If the date of the first PCI is unable to be determined from medical record documentation, enter 99/99/9999.If the date documented in the medical record is obviously in error (not valid, e.g. 03/**42**/20xx) and no other documentation is found, enter 99/99/9999. |
| 21 | pcitime | What was the time of the first PCI done after hospital arrival?**Use the earliest time from the following allowable times:**1. Time of the first balloon inflation (Inflate #1, Balloon inflated, #ATM for #minutes/seconds, Time balloon deployed)
2. Time of first stent deployment (Time stent deployed, Time stent placed, Time stent inserted, Time stent expanded)
3. Time of the first treatment of lesion with another device (Time angiojet or other thrombectomy device used, Time of aspiration, Time of suction, Time of device pass, Excimer time, Laser time, Time Rotablator used)
 | \_\_\_\_\_UMTIf ptcadne = 2, will be auto-filled as 99:99Abstractor may enter 99:99

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| If inptacs =2 and ptcadne = 1, > acutedt/acutetm and < = dcdate/dctimeIf inptacs =2 and ptcadne = 3, < = 8 hrs prior to acutedt/acutetm and < acutedt/acutetmIf inptacs = 1 > sign1dt/sign1tm (if sign1dt/sign1tm null default to > inekgdt/inekgtme) and < = dcdate/dctime. |

 | **The earliest time from the allowable times should be used regardless of how many vessels were treated or which ones were successful vs. unsuccessful.**1. **Time of first balloon inflation:**
* If there is documentation of a time associated with a balloon but not of a specific time that the balloon was inflated or deployed (e.g., “11:35 Voyager balloon” only), infer this to be the time of use, unless documentation suggests otherwise.

2. **Time of first stent deployment:*** If there is documentation of a time associated with a stent but not of a specific time that the stent was deployed, placed, etc. (e.g., “11:35 Cypher stent” only), infer this to be the time deployed, placed, etc., unless documentation suggests otherwise.

**3. Time of first treatment of lesion:** * If there is documentation of a time associated with a device but not of a specific time that the device was used (e.g., “11:35 Angiojet” only), infer this to be the time of use, unless documentation suggests otherwise.

**Do NOT include PCIs which were attempted but not completed on at least one vessel – e.g., angioplasty device (balloon, stent, thrombectomy device) could not be delivered to the blocked area of the artery, balloon could not be inflated, guidewire could not be advanced).** **Include PCIs that are completed but unsuccessful in maintaining the flow of blood through the artery. (These may be described as “failed completed.”)** **If conflicting times are documented, use the earliest allowable time**.Use the allowable times regardless of the time of documentation of coronary blood flow (e.g. TIMI-3 flow, reperfusion).Disregard documentation on the procedure sheet of “lesion” accompanied solely by a time (e.g., “8:52 – RCA lesion”). Do NOT make the inference that this reflects lesion treatment time.If PCI time is unable to be determined from the medical record documentation, enter 99:99. If the time documented in the medical record is obviously in error (not valid, e.g. 33:00) and no other documentation is found, enter 99:99. |
| 22 | stentplc | Were stents placed during the first PCI done after hospital arrival?1. yes
2. no
3. not applicable
 | 1,2,95If ptcadne = 2, will be auto-filled as 95**If 2, fill stentnum as zz and auto-fill drugstnt as 95** | Stents are tiny metal mesh tubes which are placed in the artery after the interventional procedure is performed. The stent acts as a scaffold providing support inside the artery to prevent restenosis. |
| 23 | stentnum | Enter the number of stents placed during the first PCI done.  | \_\_\_\_\_\_If ptcadne = 2 or stentplc = 2, will be z-filled

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| > 0 and warning window if > 6; hard edit at 20 |

 |  |
| 24 | drugstnt | Were drug eluting stents used?1. yes
2. no
3. not applicable
 | 1,2,95If ptcadne = 2 or stentplc = 2, will be auto-filled as 95 | Drug-eluting stents are coated or “medicated” with a pharmacologic agent that is known to interfere with the process of restenosis.Drug-eluting stents that have received FDA approval in the U.S. include:* Cordis CYPHER® sirolimus-eluting stent
* Boston Scientific TAXUS® paclitaxel-eluting stent
* Medtronic Endeavor® zotarolimus-eluting stent
* Abbott Laboratories XIENCE/Promus® everolimus-eluting

Code for drug eluting stent: 36.07. It is desirable but not required that stent codes 36.06 and 36.07 be entered in othrpxs |

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| 25 | pcidelay | Is there a reason documented by a physician, APN, or PA for a delay in doing the first PCI after arrival?1. Yes
2. No
3. Not applicable
 | 1,2,95If ptcadne = 2 or 3, will be auto-filled as 95 | **Physician/APN/PA documentation must be clear in the record that:** **1) a “hold,” “delay,” or “wait” in performing PCI/reperfusion/cath/transfer to cath lab 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.** Examples of acceptable physician/APN/PA documentation: “Hold on PCI. Need to consult with neurology regarding bleeding risk.” “PCI delayed due to intermittent hypotensive episodes when crossing lesion.”**System reasons for delay are NOT acceptable, regardless of any linkage to the delay in PCI/reperfusion.** Some examples: equipment-related problems, staff related issues (waiting for cath lab staff, delay in transport), consultation with other clinician that is not clearly linked to patient-centered reason for delay, cath lab unavailability.**EXCEPTIONS that do NOT require documentation that a delay in performing the PCI actually occurred:** * **Physician/APN/PA documentation that cardiopulmonary arrest, balloon pump insertion, or intubation occurred within 30 minutes after arrival. In order to be acceptable, documentation must be CLEAR that the arrest, balloon pump insertion, or intubation occurred within 30 minutes after arrival (use the earliest time documented to confirm the cardiopulmonary arrest occurred within 30 minutes).**

**Include:** * balloon pump, aortic balloon pump, intra-aortic balloon, intra-aortic balloon counterpulsation, intra-aortic balloon pump, intra-aortic counterpulsation, intra-aortic counterpulsation balloon pump
* cardiopulmonary arrest, cardiac arrest, cardiopulmonary resuscitation (CPR), code, defibrillation, respiratory arrest, and ventricular fibrillation
* endotracheal intubation, mechanical ventilation, nasotracheal intubation, orotracheal intubation

Cont’d next page |
|  |  |  |  | **Reason for Delay in PCI cont’d*** **Physician/APN/PA documentation of initial patient/family refusal of PCI, reperfusion, cath, or transfer to cath lab**

**If unable to determine whether a documented reason is system in nature, select “2.”**The following examples alone are NOT acceptable documentation of reasons for a delay in doing the first PCI:“Patient is discussing PCI with family.” **(Not specific enough – no mention of reperfusion/PCI.)**  “ST-elevation on initial ECG resolved. Chest pain now recurring. To cath lab for PCI**.” (Requires clinical judgment –linkage to delay in PCI not clear.)**  “Patient presented to ED with non-cardiac symptoms. AMI confirmed later that morning. PCI done.” **(Requires clinical judgment –linkage to delay in PCI not clear.)** “PCI not indicated.” **(Effect on timing/delay of PCI not documented.)**  |
| 26 | pcifail | Is there documentation in the record that an attempt at PCI was unsuccessful?1. yes
2. no
3. not applicable
 | 1,2,95If ptcadne = 1, will be auto-filled as 95 | To answer “yes,” there must be specific documentation by a clinician (physician, APN, or PA) that reperfusion by PCI failed or was unsuccessful.**PCIs that were attempted but not completed on at least one vessel are included as “unsuccessful.” PCIs that are completed but unsuccessful in maintaining the flow of blood through the artery are NOT to be considered “unsuccessful.”**  |
| 27 | nogpbloc1nogpbloc2nogpbloc3nogpbloc4nogpbloc5nogpbloc6nogpbloc7nogpbloc8nogpbloc9nogpbloc10nogpbloc11nogpbloc98nogpbloc99 | Does the record document any of the following contraindications to GP IIb/IIIa inhibitors?**Indicate all that apply:**active internal bleeding or history of bleeding within 30 dayshistory of intracranial hemorrhageintracranial neoplasmarteriovenous malformation or aneurysmhistory of thrombocytopenia after previous exposure to GP IIb/IIIa inhibitorshistory of ischemic stroke within 30 days or any history of hemorrhagic strokemajor surgery or severe trauma within the previous 30 dayshistory, symptoms, or findings suggestive of aortic dissectionsevere hypertension (SBP >180 and/or DBP >90), unless corrected prior to administrationacute pericarditisconcomitant use of GP IIb/IIIa inhibitor1. patient refused a glycoprotein IIb/IIIa inhibitor

no documented contraindication  | 1,2,3,4,5,6,7,8,9,10,11,98,99 | The most common adverse drug reactions associated with GP IIb/IIIa inhibitors are both major and minor bleeding and acute profound thrombocytopenia. Acute profound thrombocytopenia is defined as platelet count dropping to less than 50,000/mm within 24 hours of infusion. If the patient has a documented diagnosis of acute pericarditis, intracranial neoplasm, arteriovenous malformation or aneurysm, ischemic stroke within the past 30 days or history of any hemorrhagic stroke, the abstractor may accept these as contraindications to use of a GP IIb/IIIa inhibitor without other documentation.All other contraindications require notation by a clinician of their occurrence. |

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| 28 | gpbloc | Did the patient receive a glycoprotein IIb/IIIa inhibitor?1. tirofiban (Aggrastat)
2. eptifibatide (Integrilin)
3. abciximab (ReoPro)
4. none of these medications
 | 1,2,3,99**If 99, auto-fill gpblocdt as 99/99/9999 and gpbloctm as 99:99** | Current data from at least 10 randomized, placebo-controlled, double-blind trials in ACS indicate that intravenous glycoprotein IIb/IIIa inhibitor therapy has a beneficial effect (reduction in death, MI, or revascularization) when used with patients with UA/NSTEMI. However, there is not yet consensus for their routine use in all patients with UA/NSTEMI.**Glycoprotein IIb/IIIa inhibitors are administered IV.** |
| 29 | gpblocdt | Enter the date the patient received a glycoproteinIIb/IIIa inhibitor.  | mm/dd/yyyyIf gpbloc = 99, will be auto-filled as 99/99/9999

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| > = acutedt and < = dcdate |

 | **Glycoprotein IIb/IIIa inhibitors are administered IV**. Look in nursing IV medication administration records for date and time.Exact date must be entered. |
| 30 | gpbloctm | Enter the time the patient received a glycoproteinIIb/IIIa inhibitor.  | \_\_\_\_\_UMTIf gpbloc = 99, will be auto-filled as 99:99

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| > = acutedt/acutetm and < = dcdate/dctime |

 | The exact time of administration of the glycoprotein IIb/IIIa inhibitor must be known.Enter time in military time.If the time is in the a.m., conversion is not required.If the time is in the p.m., add 12 to the clock time hour. |
| 31 | cabgdone | Was a CABG performed during this episode of care?1. performed at this VAMC
2. performed at another VAMC
3. performed at a community hospital
4. patient and/or family refused CABG
5. no CABG performed during this episode of care
 | 1,2,3,98,99**If 98 or 99, auto-fill cabgdt as 99/99/9999**  | Option #1 cannot be selected unless the CABG was done at this VAMC. If the patient is transferred/discharged to a hospital affiliated with this VAMC for a CABG, it is unlikely the patient will return in 12 hours. Designate the location where the CABG was performed.Patient and/or family’s direct refusal of CABG must be documented in the record if 98 is entered. |
| 32 | cabgdt | Enter the date the CABG was performed. | mm/dd/yyyyIf cabgdone = 98 or 99, will be auto-filled as 99/99/9999

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| > = acutedt and < = dcdate |

 | If the patient was discharged to another VAMC or a community hospital, and there is no record of the CABG in the medical record, do not presume the CABG was performed the same or following day. Entry of month and year only of CABG is acceptable if the procedure was not performed at the VAMC under review. |
| **Go to Continuing Care and Assessment Module** |