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| 1 | frstsign | What was the first indication of an evolving ACS?   1. ACS symptoms 2. elevated troponin 3. ECG changes 4. other | 1,2,3,4 | Evolving ACS: developing, in the process of occurring – or may already have occurred  ACS symptoms = chest/substernal discomfort, pressure, or pain. May include pain radiating to one or both arms, shoulder, jaw, neck, or back. May be severe epigastric pain, nausea, vomiting, dyspnea, or diaphoresis. An elevated troponin may be first indicator of ACS and/or the patient may have no definitive symptoms of ACS.  **ECG changes refers to incidental ECG, not to ECG done in response to other ACS symptoms or an elevated troponin.** |
| 2 | sign1dt | Enter the date the first indication of evolving ACS occurred. | mm/dd/yyyy   |  | | --- | | > = admdt and < = dcdate | | **If ACS symptoms were the first indicator, use the date of onset of symptoms. If a positive troponin is the first indicator of ACS, use the troponin report date.** Enter the exact date. The use of 01 to indicate missing day or month is not acceptable. |
| 3 | sign1tm | Enter the time the first indication of evolving ACS occurred. | \_\_\_\_\_ (UMT)  **Abstractor can enter default time 99:99 if unable to determine the time of indicator**   |  | | --- | | > = admdt/admtime and < = dcdate/dctime | | **If ACS symptoms were the first indicator, use the time of onset of symptoms. If a positive troponin is the first indicator of ACS, use the troponin report time.**  **If unable to determine the time the first indicator occurred, abstractor may enter default time 99:99.** |
| 4 | didecg | Was a 12-lead ECG done in response to the first indication of evolving ACS? | 1,2  **If 2, auto-fill inekgdt as 99/99/9999 and inekgtme as 99:99** | **Rhythm strip is not acceptable**. ECG must be that performed using the 12 standard leads. If the clinician references ECG/EKG findings but does not specify the ECG/EKG was 12-lead, infer that it was 12-lead unless documentation indicates otherwise.  **The question refers to an ECG done in response to the indication (either symptoms or a positive troponin) that ACS has occurred.** |

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| 5 | inekgdt | Enter the date of the ECG done in response to the first indication of evolving ACS. | mm/dd/yyyy  If didecg = 2, will be auto-filled as 99/99/9999   |  | | --- | | > = sign1dt and < = dcdate | | The question does not refer to a routine ECG on admission, but to the ECG done when the patient complained of chest pain or other symptoms indicative of ACS**. If the first ECG done following ACS symptoms or a positive troponin was normal but a later ECG was abnormal or diagnostic for ACS, use the date of the abnormal ECG.**  Enter the exact date. The use of 01 to indicate missing day or month is not acceptable**.**  **Determining ECG Date**  **The abstractor can accept only the date and time printed on the ECG tracing.** |
| 6 | inekgtme | Enter the time of the ECG done in response to the first indication of evolving ACS. | \_\_\_\_\_ UMT  If didecg = 2, will be auto-filled as 99:99   |  | | --- | | > = sign1dt/sign1tm and < = dcdate | | The question does not refer to a routine ECG on admission, but to the ECG **done in response to the indication (either symptoms or a positive troponin) that ACS has occurred.** If the first ECG done following ACS symptoms or a positive troponin was normal but a later ECG was abnormal or diagnostic for ACS, use the time of the abnormal ECG.  **Determining ECG Time**  **The abstractor can accept only the date and time printed on the ECG tracing.** |

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| 7 | frstecg | Is there documented interpretation of the 12-lead ECG done closest to the ACS event?  |  | | --- | | **A diagnosis of AMI or Unstable Angina with no interpretation of the initial ECG documented in the record is problematic data. Review the Definitions/Decision Rules, and ask the EPRP Liaison for assistance if unable to identify the ECG done closest to the ACS event.** | | 1,2  **If 1, auto-fill nextecg1 as 95** | **Do not use an ECG interpretation done more than one hour prior to the first indicator of evolving ACS.** Look for interpretation of the 12-lead ECG performed closest to the first indicator of the ACS event.  **Hierarchy for ECG interpretation:**   1. If there is a cardiologist’s note that refers to interpretation of the first ECG, 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 tracing in which the name or initials of the MD/NP/ or PA who reviewed the ECG is signed or typed on the tracing. 4. Any physician interpretation of ECG findings. Interpretations may be taken from documentation of ECG findings in ED notes, admission note, or progress note. 5. If the ECG/EKG interpretation is an electronic “reading,” do not use clinician documentation of the ECG findings unless the clinician “signs off” on the electronic interpretation as described above.   If the ECG/EKG report is not specifically labeled “12-lead”, infer that it was 12-lead if lead markings (i.e., I, II, III, aVR, aVL, aVF, V1, V2, V3, V4, V5, V6) are noted on the report.  **Interpretations must be taken directly from documentation of ECG findings. Do not measure ST-segments or attempt to identify or judge LBBB or ST-elevation on the ECG tracing.** |

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| 8 | nextecg1 | Was there a subsequent ECG with a documented interpretation?  1. yes 2. no 3. not applicable | 1,2,95  If frstecg = 1, will be auto-filled as 95  **If 2, auto-fill nextdate1 as 99/99/9999 and nextime1 as 99:99** | **Use the ECG done second closest to the ACS event if there is no documented interpretation of the first ECG. If there is no interpretation of the second closest ECG, look further in the record until a documented ECG interpretation is found.**  **Hierarchy for ECG interpretation:**   1. If there is a cardiologist’s note that refers to interpretation of the first ECG, 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 tracing in which the name or initials of the MD/NP/ or PA who reviewed the ECG is signed or typed on the tracing. 4. Any physician interpretation of ECG findings. Interpretations may be taken from documentation of ECG findings in ED notes, admission note, or progress note. 5. If the ECG/EKG interpretation is an electronic “reading,” do not use clinician documentation of the ECG findings unless the clinician “signs off” on the electronic interpretation as described above.   **If the physician references ECG/EKG findings but does not specify the ECG/EKG was 12-lead, infer that it was 12-lead if lead markings** ( i.e., I, II, III, aVR, aVL, aVF, V1, V2, V3,V4, V5, V6)  **are noted in the report.** |
| 9 | nextdate1 | Enter the date of the ECG with a documented interpretation. | mm/dd/yyyy  If nextecg1 = 2 or 95, will be auto-filled as 99/99/9999   |  | | --- | | > = inekgdt and < = dcdate. If inekgdt null, > = admdt and < = dcdate. | | Enter the exact date. The use of 01 to indicate missing day or month is not acceptable.  Will auto-fill as 99/99/9999 if NEXTECG = 2. Abstractor cannot enter default date 99/99/9999 if NEXTECG = 1.  **Determining ECG Date**  **The abstractor can accept only the date and time printed on the ECG tracing.** |

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| 10 | nextime1 | | Enter the time of the ECG with a documented interpretation. | | \_\_\_\_\_\_ UMT  If nextecg1 = 2, will be auto-filled as 99:99  **Abstractor can enter 99:99**   |  | | --- | | > = inekgdt/inekgtm and < dcdate/dctime. If inekgdt/inekgtm null, > admdt/admtime 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.  **Determining ECG Time**  **The abstractor can accept only the date and time printed on the ECG tracing.**  Will auto-fill as 99:99 if NEXTECG = 2.  **If unable to find the time of the ECG with a documented interpretation, enter default time 99:99.** |
| 11 | ecgintrp1 | What were the specific findings from interpretation of the ECG performed closest to ACS indication or a subsequent ECG if the first was non-diagnostic?  1. ST-segment elevation   Acute myocardial infarction (AMI) or 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  Q wave AMI, 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  Transmural AMI  Transmural MI, IF DESCRIBED AS ACUTE/EVOLVING  2. **Left bundle branch block (LBBB)** (new or not known to be old, chronic, or previously seen)  intraventricular conduction delay of LBBB type  variable LBBB   1. LBBB described as old or chronic 2. ST-segment depression, old and/or unchanged 3. T wave inversion 4. Non-specific ST-segment and T wave changes 5. Normal ECG 6. Q waves 7. Right bundle branch block   10. Transient or dynamic ST-segment changes in association with rest angina  11. Sustained ventricular tachycardia runs and/or sustained ventricular tachycardia with hypotension  12. ST-segment depression, new or not known to be old  13. Documented NSTEMI, non ST-elevation MI   1. Not applicable   99. Interpretation not consistent with above terminology | | **If frstecg =2 and nextecg1 = 2, auto-fill as 95**  1,2,3,4,5,6,7,8,9,  10,11,12,13,95,99   |  | | --- | | **If 1 or 2 is entered, and truami=2, the computer will prevent the abstractor from entering contradictory data.** |  |  | | --- | | Warning window if truami = 1, and ecgintrp1 = 7 or 99 |  |  | | --- | | **Text box to capture actual ECG reading when “99” entered** | | | **Do Not include the following as ST-elevation:**   * Non Q wave MI (NQWMI) * Non ST-elevation MI (NSTEMI) * ST ↑ clearly described as confined to ONE lead * ST-elevation (ST ↑) described as minimal, < .10mV, < 1mm, non-diagnostic, or non-specific either in ALL leads noted to have ST-elevation or in GENERAL terms, where lead(s) are NOT specified (e.g., “minimal ST-elevation”) * ST-elevation described as a range where it cannot be determined if ST-elevation is less than 1mm/.10mV (e.g. 0.5 – 1mm ST-elevation) * ST-elevation (ST ↑) with mention of early repolarization, left ventricular hypertrophy (LVH), normal variant, pericarditis, or Printzmetal/Printzmetal’s variant * ST-segment elevation, any of the other ST-segment elevation inclusion terms, ST, ST abnormality, or ST changes consistent with injury or acute/evolving MI OR any of the “myocardial infarction” (MI) inclusion terms described using one of the negative qualifiers or modifiers listed below * Any ST-segment elevation terms with mention of pacemaker (unless atrial only or non-functioning pacemaker) * ST-elevation described as old, chronic, or previously seen   EXCEPTION: When the ST-elevation on the ECG done closest to arrival is described as previously seen on an ECG done by EMS or physician office prior to arrival, this ST-elevation may count as an Inclusion. Documentation must be explicit **within the ECG interpretation** itself (e.g., “Initial ECG shows ST-elevation 1mm V1-V2. Improved from ECG done in the field.”). Do NOT make inferences based on documentation outside of the interpretation (context, sequence of events, etc.)  MI described as “new, recent, or subacute” should not be considered as synonymous with “acute.”  **Do Not include the following as Left Bundle Branch Block**   * incomplete left bundle branch block (LBBB) * left bundle branch block (LBBB), or any other left bundle branch block inclusion term, described using one of the negative qualifiers or modifiers listed below * LBBB with mention of pacemaker/pacing (unless atrial only or non-functioning pacemaker)  |  |  | | --- | --- | | **JC Appendix H, Table 2.6 Qualifiers/Modifiers** | | | **Qualifiers:** cannot exclude, cannot rule out, could be, could have been, may have, may have had, may indicate, questionable, risk of, ruled out, suggestive of, suspect, or suspicious | **Modifiers**: borderline, insignificant, scant, sub-clinical, subtle, trace, trivial | | |
|  |  | |  | |  | | **Hierarchy for ECG interpretation:**  1. If there is a cardiologist’s note that refers to interpretation of the first ECG, 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. |
| 12 | ecgintrp\_txt1 | | Please enter the ECG interpretation found in the record | | Text(100) | | Text box to capture actual ECG reading when “99” entered |
| 13 | ipchfsym1  ipchfsym2  ipchfsym3  ipchfsym4  ipchfsym5  ipchfsym6  ipchfsym7  ipchfsym99 | | At the time the ACS event occurred, did the patient have any of the following symptoms?  Indicate all that apply:  1. 1. heart failure  2. impaired left ventricular function  3. new mitral regurgitation murmur  4. an S3 gallop  5. rales > 3 or 1/3 up  6. documentation of a chest x-ray with  evidence of pulmonary edema  7. documentation of cardiogenic shock (severe and persistent hypotension in Trendelenburg)  99. none of these symptoms documented | | 1,2,3,4,5,6,7,99   |  | | --- | | **99 cannot be entered with any other number** | | | MR murmur, S3 gallop, rales, or cardiogenic shock must be documented in the record by a physician, APN, or PA. The abstractor may not make this judgment based on other documentation in the record.  MR murmur: Heard on auscultation of the heart, it is a murmur due to leakage or backward flow of blood current through the mitral valve.  Rales are abnormal sounds heard on auscultation of the chest. Documentation in the record must specify rales > 3, or 1/3 up.  Chest x-ray evidence of pulmonary edema may be taken from the chest x-ray report, but the abstractor must be certain the x-ray was done at the time of presentation to the hospital, or transfer to a monitored bed if the AMI occurred post-admission. |
| 14 | frstrate1 | | Enter the patient’s heart rate recorded closest to onset of the evolving ACS. | | \_\_\_\_\_bpm   |  | | --- | | Warning window if < 40 or > 120 | | | Use the heart rate recorded closest to the onset of ACS symptoms, time of elevated troponin, or to the abnormal ECG, whichever marked the onset of the ACS event. |
| 15 | arvipres1  arvipres2 | | Enter the patient’s blood pressure recorded closest to onset of the evolving ACS. | | ---/---   |  | | --- | | Warning window if arvipres1 < = 70 or > =300  arvipres2 < = 44 or > = 135  arvipres2 must be < arvipres1 | | | Use the blood pressure recorded closest to the onset of ACS symptoms, time of elevated troponin, or to the abnormal ECG, whichever marked the onset of the ACS event. |

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| 16 | restang1 | At the time of the ACS event, did the patient experience prolonged ongoing rest pain (pain in chest, arm, or neck > 20 minutes)? | 1,2 | Myocardial ischemic pain is usually described as pressing, squeezing, or weightlike. The pain is greatest in the central precordium. The pain frequently radiates in the distribution of the lower cervical nerves and may therefore be felt in the neck, lower jaw, or either shoulder or arm. Myocardial ischemic pain due to coronary arteriosclerosis is usually exertion-related, at least initially, but may occur suddenly when the patient is at rest.  Rest pain = the patient is sitting or lying in bed and not involved in exertion-related activity. |
| 17 | ipasa24 | Did the patient receive aspirin within 24 hours before or 24 hours after onset of the evolving ACS?   1. yes 2. no | 1,2  If 1 auto-fill  asanone1 as 95 If 2, auto-fill aspdate1 as 99/99/9999 and asptime1 as 99:99, and go to asanone1 | 2 = patient did not receive aspirin within the time period or unable to determine from medical record documentation  If ASA was given at another level of care at this VAMC, answer “1.” If the patient took ASA prior to hospital arrival, and the ACS occurred within the 24-hour time period, answer “1.”  **Documentation must indicate the patient actually received aspirin within the 24-hour time frame.** |
| 18 | aspdate1 | Enter the date the patient received aspirin | mm/dd/yyyy  If ipasa24 = 2, will be auto-filled as 99/99/9999   |  | | --- | | < = 24 hrs.prior to sign1dt or < = 24 hrs after sign1dt  If sign1dt null, default to inekgdt | | Enter the exact date. Month = 01 or day = 01 is not acceptable. |
| 19 | asptime1 | Enter the time the patient received aspirin | \_\_\_\_\_ UMT  If ipasa24 = 2, will be auto-filled as 99:99   |  | | --- | | < = 24 hrs prior to sign1dt/sign1tm or < = 24 hrs after sign1dt/sign1tm  If sign1dt/sign1tm null, default to intekgdt/inekgtm | | If the patient did not receive aspirin within 24 hours following the ACS event, and whether the patient took aspirin within a 24 hour period prior to the event cannot be known,(Example: “patient’s wife thinks he took aspirin during the night before he came to the hospital”), do not guess. Answer 2 to “asa24.” |
| 20 | asanone1 | Does the record document any of the following reasons for not administering aspirin on arrival?   1. Aspirin allergy 2. Warfarin/Coumadin or Pradaxa/dabigatranas pre-arrival medication   95. Not applicable   1. Other reason documented by a physician/APN/ PA or pharmacist 2. Patient refusal of aspirin documented by physician/APN/PA or pharmacist 3. No documented reason | 1,3,95,97,98,99  Will be auto-filled as 95 if ipasa24 = 1 | **1. Aspirin allergy:** “allergy” or “sensitivity” documented at anytime during the hospital stay counts as an allergy regardless of what type of reaction might be noted (e.g. “Allergies: ASA - Upsets stomach” - select “1.”)  **3.** **Warfarin/Coumadin or Pradaxa/dabigatran as pre-arrival medication:** consider warfarin/Coumadin or Pradaxa/dabigatranto be a pre-arrival medication if there is documentation the patient was on it prior to arrival, regardless of setting. Includes cases where there is indication the warfarin/Coumadin or Pradaxa/dabigatranwas on temporary hold or the patient has been non-compliant/self-discontinued their medication.  **97.** **“Other reason” documented by a physician/APN/PA or pharmacist:**   * Reasons must be explicitly documented (e.g., “Chronic hepatitis - No ASA”) or clearly implied (e.g., “GI bleeding with aspirin in past,” “ASA contraindicated.” aspirin on pre-printed order form is crossed out, “No aspirin” [no reason given]) * If reasons are not mentioned in the context of aspirin, do not make inferences. **Examples:** (a) **If the patient is taking clopidogrel (Plavix) or ticlopidine hydrochloride (Ticlid), clinician documentation must specify the use of this drug is the reason aspirin was not given.** (b) Do not assume that aspirin is not being prescribed because of the patient’s history of PUD alone. * Documentation of a hold on aspirin or discontinuation of aspirin within the first 24 hours after arrival constitutes a “clearly implied” reason for no aspirin on arrival**.**   **EXCEPTION:** Documentation of a one-time hold, dose adjustment, switch to a different aspirin medication, or conditional hold/discontinuation (“Hold ASA if fecal occult blood test is positive”) should not be considered as a reason for not prescribing aspirin. Documentation must be clear that the given reason for not prescribing aspirin on arrival applies to the first 24 hour time period.  Cont’d next page |

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|  |  |  |  | Reason for no ASA cont’d   * Documentation of a plan to initiate/restart aspirin and notation of the reason/problem underlying the delay in starting/restarting aspirin constitutes a “clearly implied” reason for not administering aspirin on arrival. For example, “Stool positive for occult blood. Start aspirin in morning.” * Documentation which refers to a more general medication class is not acceptable (e.g., “Hold all anticoagulants”). **EXCEPTION:** Documentation of a reason for not prescribing "antiplatelets" should be considered implicit documentation of a reason for no aspirin on arrival (e.g., "Antiplatelet therapy contraindicated”). * Documentation of a pre-arrival hold, discontinuation of aspirin, or “other reason” counts as a reason for not prescribing aspirin on arrival **ONLY** if the underlying reason is noted.   **98.** **Patient refusal:** Documentation by a physician/APN/PA or pharmacist that the patient refused aspirin or refused all medications is acceptable.  If there is conflicting documentation in the record regarding a reason for not administering aspirin on arrival, accept as a “yes” for the applicable reason. |
| 21 | platagg1 | Did the patient receive a platelet aggregation inhibitor within the first 24 hours after onset of the evolving ACS?   1. clopidogrel (Plavix) 2. ticlopidine (Ticlid)    1. dipyridamole (Persantine)    2. dipyridamole and aspirin (Aggrenox)    3. other 3. not documented/unable to determine | 1,2,3,4,5, 99  If <> 99, auto-fill platcont1 as 95  **If 99, auto-fill platdate1 as 99/99/9999 and platime1as 99:99, and go to platcont1** | Clopidogrel and ticlopidine are inhibitors of platelet aggregation. A variety of drugs that inhibit platelet function have been shown to decrease morbid events in patients with established athererosclerotic cardiovascular disease as evidenced by stroke, TIA, and AMI. Patients who have a true allergy to aspirin and no contraindication to antiplatelet therapy may be given clopidogrel, ticlopidine, or dypyridamole. |
| 22 | platdate1 | Enter the date the patient received the platelet aggregation inhibitor. | mm/dd/yyyy  If platagg1 = 99, will be auto-filled as 99/99/9999   |  | | --- | | < =24 hrs after sign1dt. If sign1dt null, default to inekgdt. | | Enter the exact date. Month = 01 or day = 01 is not acceptable.  Will auto-fill as 99/99/9999 if PLATAGG = 98 or 99. Abstractor cannot enter default date 99/99/9999 if PLATAGG = <> 98 or 99. |
| 23 | platime1 | Enter the time the patient received the platelet aggregation inhibitor. | \_\_\_\_\_ UMT  If platagg1 = 99, will be auto-filled as 99:99   |  | | --- | | < =24 hrs after sign1dt/sign1tm. If sign1dt/sign1tm null, default to inekgdt/inekgtme. | | Enter the time of administration during the first 24 hours after onset of the evolving ACS, using military time.  Will auto-fill as 99:99 if PLATAGG = 98 or 99. Abstractor cannot enter default time 99:99 if PLATAGG = <> 98 or 99. |
| 24 | platcont1 | Is there physician/APN/PA or pharmacist documentation of a reason that a platelet aggregation inhibitor was not administered on arrival?  1. Yes  2. No  95. Not applicable  98. Patient refusal of platelet aggregation inhibitor documented by physician/APN/PA or pharmacist | 1,2,95,98  Will be auto-filled as 95 if platagg1 <> 99 | There must be physician/APN/PA or pharmacist documentation of the reason a platelet aggregation inhibitor was not administered. Potential adverse effects of platelet aggregation inhibitors: nephrotic syndrome, hyponatremia, blood cell disorders, TTP (thrombotic thrombocytopenic purpura). The abstractor may not infer that a platelet aggregation inhibitor was not administered because one of these factors was present. |

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| 25 | ipbeta24 | Did the patient receive a beta-blocker within 24 hours after onset of evolving ACS?   1. yes 2. no | 1,2  If 1, auto-fill betanon1 as 95  **If 2, auto-fill bbdate1 as 99/99/9999, bbtime1 as 99:99, specbb1 as 95, and go to betanon1** | 2 = Beta-blocker not given within 24 hours after onset of the evolving ACS or unable to determine from medical record documentation  Refer to drug list for listing of beta-blockers. |
| 26 | bbdate1 | Enter the date the patient received a beta-blocker | mm/dd/yyyy  If beta24 = 2, will be auto-filled as 99/99/9999   |  | | --- | | < =24 hrs after sign1dt. If sign1dt null, default to inekgdt. | | Enter the exact date. Month = 01 or day = 01 is not acceptable. |
| 27 | bbtime1 | Enter the time the patient received a beta-blocker | \_\_\_\_\_ UMT  If ipbeta24 = 2, will be auto-filled as 99:99   |  | | --- | | < =24 hrs after sign1dt/sign1tm. If sign1dt/sign1tm null, default to inekgdt/inekgtme. | | To convert from am/pm time to military, add 12 to 1:00 pm and after. To convert from military to am/pm, subtract 12 after 1:00 p.m., i.e., 1842 hrs = 6:42 p.m. |

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| 28 | specbb1 | Designate the beta-blocker the patient received within 24 hours after onset of the evolving ACS:   1. metoprolol succinate (Toprol-XL) 2. metoprolol tartrate 3. bisoprolol (Zebeta or Ziac) 4. carvedilol (Coreg) 5. atenolol (Tenoretic or Tenormin) 6. acebutolol (Sectral) 7. sotalol (Betapace) 8. betaxolol (Kerlone) 9. carteolol (Cartrol) 10. nadolol (Corgard) 11. nadolol/bendroflumethiazide (Corzide) 12. propranolol (Inderal) 13. propranolol hydrochloride (Inderide) 14. labetalol (Normodyne or Trandate) 15. penbutolol sulfate (Levatol) 16. metoprolol/hydrochlorothiazide (Lopressor HCT ) 17. pindolol (Visken) 18. timolol (Timolide or Blocadren) 19. timolol/hydrochlorothiazide 20. brevibloc (Esmolol) 21. other 22. not applicable | 1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16, 18,19,20,21,95  If ipbeta24 =2, will be auto-filled as 95 | Beta-blocker generic names are not capitalized. Brand names are capitalized.  Enter the number corresponding to the generic name documented in the medical record.  **Question is applicable to the beta blocker administered to the patient within 24 hours after onset of the evolving ACS.**  **Beta-blocker the patient may have been taking prior to arrival at the hospital is not applicable to this question.**  **Source**: medication administered in the ED, admitting note, admission orders, medications given |
| 29 | betanon1 | Does the record document any of the following reasons for not prescribing a beta-blocker after onset of evolving ACS?   1. Beta-blocker allergy 2. Bradycardia (heart rate less than 60 bpm) while not on a beta blocker 3. Second or third degree heart block on ECG and does not have a pacemaker    1. Heart failure on admission or within 24 hours after event    2. Shock on admission or within 24 hours after event   9. Post-heart transplant patient  10. Documentation of severely decompensated  heart failure  95. Not applicable   1. Other reasons documented by a physician/APN/PA or pharmacist for not prescribing a beta blocker   98. Patient refusal of beta-blockers documented by physician/APN/PA or pharmacist  99. No documented reason | 1,2,3,7,8, 9, 10,95,97,98,99  Will be auto-filled as 95 if ipbeta24 = 1 | **1. Beta-blocker (BB) allergy/sensitivity/intolerance:** documented **allergy/sensitivity/intolerance** counts regardless of type of reaction noted; allergy/sensitivity/intolerance to one BB is acceptable as allergy to all BBs. **EXCLUDE:** Allergy to BB eye drops (e.g., Cosopt).  **2. Bradycardia:** must be substantiated by documentation of a heart rate of less than 60 beats per minute at onset of ACS event or within 24 hours of onset of evolving ACS event.  **3. Second or third degree heart block (HB):**   * Findings on arrival ECG or ECG within 24 hours that does not show pacemaker findings **OR** findings without mention of pacemaker (e.g., “second-degree heart block” per ED report). * Disregard pacemaker findings if documentation suggests non-functioning pacemaker. * Any notation of 2nd/3rd degree HB and pacemaker findings on ECG report or other source is acceptable with/without physician/APN/PA signature.   **INCLUDE: Stand alone/modified by “variable” or “intermittent”:** Atrioventricular (AV) block described as 2:1, 3:1, 2nd degree, or 3rd degree; AV dissociation; HB described as 2:1, 3:1, complete (CHB), high degree, high grade, 2nd degree, 3rd degree; Mobitz Type 1 or 2; Wenckebach; Pacemaker findings of paced rhythm/spikes; pacing described as atrial, AV, dual chamber or ventricular.  **EXCLUDE:** HB, or any other 2nd/3rd degree HB inclusion terms described using qualifiers: cannot exclude, cannot rule out, may have, may have had, may indicate, possible, suggestive of, suspect, or suspicious; atrial flutter; AV block; AV conduction block; 1st degree AV block; 1st degree HB; HB type/degree not specified; intraventricular conduction delay (IVCD).  **7.** **Heart failure (HF):** must be documented by physician/APN/PA. If listed as an admitting diagnosis, infer HF was present within first 24 hours after arrival. Do not use chest x-ray reports unless a physician/APN/PA references chest x-ray findings substantiating heart failure.  **8. Shock:** must be documented by physician/APN/PA |
|  |  |  |  | **97. Other reason documented by physician/APN/PA or pharmacist:**   * **must explicitly link the noted reason with non-prescription of a beta-blocker.** For example: COPD listed as a diagnosis is not a specific contraindication to beta-blocker therapy. There must be clinician documentation that beta-blockers have not been prescribed for this patient due to his/her COPD or asthma. * Documentation of a hold on a beta blocker or discontinuation of a beta-blocker within the first 24 hours after arrival constitutes a “clearly implied” reason for no beta-blocker on arrival. Documentation must be clear that the given reason for not prescribing a beta-blocker on arrival applies to the first 24 hour time period after arrival. * Documentation of a pre-arrival hold, discontinuation of a beta-blocker, or “other reason” counts as a reason for not prescribing beta- blocker on arrival ONLY if the underlying reason is noted. * When conflicting documentation regarding a reason for not administering a beta-blocker within 24 hours of arrival is documented in the medical record, select “yes” for the applicable reason.   **98. Patient refusal:** Documentation by a physician/APN/PA or pharmacist that the patient refused beta-blockers or refused all medications is acceptable. Documentation that the patient refused BP (or cardiac) medications is NOT acceptable. |

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| 30 | iphep24 | Did the patient receive heparin within 24 hours after onset of evolving ACS?  1. received unfractionated heparin 2. received low molecular weight heparin   99.did not receive heparin within 24 hours | 1,2,99  If 1 or 2, auto-fill nohep1 as 95  **If 99, auto-fill hepdt1 as 99/99/9999, heptme1 as 99:99, and go to nohep1** | Unfractionated heparin= heparin sodium (Heparin)  Low molecular weight heparin= enoxaparin (Lovenox), dalteparin (Fragmin), tinzaparin (Innohep), nadroparin (Fraxiparine), reviparin (Clivarin), certoparin (Sandoparin), and fondaparinux (Arixtra).  99 = patient did not receive heparin or did not receive initial dose within the 24 hour period following onset of evolving ACS. |
| 31 | hepdt1 | Enter the date the patient received heparin | mm/dd/yyyy  If iphep24 = 99, will be auto-filled as 99/99/9999   |  | | --- | | < =24 hrs after sign1dt. If sign1dt null, default to inekgdt. | | Enter the exact date. Month=01 or day=1 is not acceptable |

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| 32 | heptme1 | Enter the time the patient received heparin | \_\_\_\_\_ UMT If iphep24 = 99, will be auto-filled as 99:99   |  | | --- | | < =24 hrs after sign1dt/1sign1tm. If sign1dt/sign1tm null, default to inekgdt/inekgtme. | | Enter the time of initial administration during the first 24 hours after hospital arrival or ECG if the veteran was already an inpatient, using military time. |
| 33 | nohep1 | Does the record document any of the following reasons for not prescribing heparin?   1. active or recent bleeding 2. allergy, intolerance, or hypersensitivity to heparin 3. Platelet count < 100,000/mm3 4. ulcer or serious GI/GU bleeding 5. history of thrombocytopenia 6. decision not to treat 7. Do Not Resuscitate status 8. Patient in a clinical trial testing anticoagulants other than heparin   95. Not applicable   1. Other reason documented by a physician/APN/ PA or pharmacist 2. Patient refusal of heparin documented by physician/APN/PA or pharmacist 3. No documented reason | 1,2,3,4,5,6,7,8,  95,97,98,99  Will be auto-filled as 95 if inhep24 = 1 or 2 | Abstractor may accept the following without specific physician/APN/PA or pharmacist documentation:   * allergy to heparin clearly noted in the record as patient drug allergy or intolerance * current diagnosis or history of thrombocytopenia, documented in the record or on a problem list * platelet count, as specified, on admission or at the time of onset of ACS if veteran was already an inpatient * DNR status in physician orders for this episode of care * Notation in record that patient is in an anticoagulant clinical trial   The severity of active or recent bleeding, ulcer or serious GI/GU bleeding, decision not to treat, or “other” must be documented by a physician/APN/PA or pharmacist and linked to the non-prescription of heparin. The abstractor may not use his/her judgment in determining whether the severity of a bleed, co-morbid illness, etc. precludes use of heparin. |
| 34 | cardsee1 | Was Cardiology involved in the care of the patient following the ACS event?   1. A cardiologist was the attending physician 2. A cardiologist was consulted in person, by telephone, or telemedicine   99. Cardiology not involved in the patient’s care | 1,3,99  **If 99, auto-fill carddt1 as 99/99/9999 and cardtme1 as 99:99** | **The purpose of the question is to determine whether the patient was seen by a cardiologist within 24 hours following the ACS event. A cardiology consult done before the ACS actually occurred is not applicable.**  **The cardiologist must be a physician.** Cardiology involvement may be at any time during the hospital stay and is not limited to initial presentation or in the ED.  Consultation by cardiology = face to face contact with patient, phone call between the primary provider and the cardiologist in which recommendations are made, or consult via telemedicine. There must be a documented synopsis of the discussion with the cardiologist and the name of the cardiologist. “Discussed with cardiology” is not acceptable documentation.  **Answer yes if a cardiologist was attending physician, saw the patient in consultation, or there was consultation by telephone or telemedicine, or a cardiac cath or PCI was done within 24 hours.**  **If the patient was seen by a cardiology resident, the staff practitioner overseeing the resident must be a cardiologist, and cardiology resident notes must be signed by the supervising practitioner.**  **Documentation of supervision of the resident’s care may be entered in the record in any of the following ways:**  **Applicable to the admission note if the cardiologist is the attending physician:**   1. Progress note or other entry by the supervising practitioner 2. Addendum to the resident’s note by the supervising practitioner 3. Countersignature alone is acceptable for this measure.   **Applicable to cardiology consult or cardiology involvement later in the stay:**   1. Progress note or other entry by the supervising practitioner 2. Addendum to the resident’s note by the supervising practitioner 3. Countersignature of the resident’s note by the supervising practitioner 4. Resident progress note documents a summary of discussion with the supervising practitioner and names the supervising practitioner.   **A cardiology “Fellow” is considered to have attained a higher level of education than a resident and the rules pertaining to resident supervision do not apply.** |
| 35 | carddt1 | Enter the date the patient was first seen by Cardiology or a Cardiology consult first occurred. | mm/dd/yyyy  If cardsee1 = 99, will be auto-filled as 99/99/9999   |  | | --- | | > = sign1dt. If sign1dt null, > = inekgdt and < = dcdate. | | Involvement by cardiology = face to face contact with patient, phone call between the primary provider and the cardiologist in which recommendations are made, or consult via telemedicine.   * If a cardiologist was the attending physician, saw the patient in consultation or there was consultation by telephone or telemedicine, use the date the patient was seen or the telephone/telemedicine consult was completed. * If a cardiac catheterization or PCI was done within 24 hours of the ACS event, use this date as the documented date of cardiology involvement, unless the patient was seen by cardiology pre-procedure on an earlier date. |
| 36 | cardtme1 | Enter the time the patient was first seen by Cardiology or a Cardiology consult first occurred. | \_\_\_\_\_  UMT  If cardsee1 = 99, will be auto-filled as 99:99   |  | | --- | | > = sign1dt/sign1tm. If sign1dt/sign1tm null, > = inekgdt/inekgtme and < = dcdate/dctime. | | **The purpose of the question is to determine whether the patient was seen by a cardiologist within 24 hours following the ACS event.**   * If a cardiologist was the attending physician, or saw the patient in consultation enter the time the cardiology note was started. * If there was cardiology consultation by telephone or telemedicine, and recommendations were made to the attending physician, enter the time the attending physician documented the telephone or telemedicine consult was completed. * If a cardiac catheterization or PCI was done within 24 hours of the ACS event use the start time of the cath or PCI as the documented time of cardiology involvement, unless the patient was seen by cardiology pre-procedure. |
| **Go to Revascularization Module** | | | | |