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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1 | comunecg | Does the record of this patient transferred from a community hospital document that any of the following were identified on the initial ECG? 1. ST-segment elevation Acute myocardial infarction (AMI) or myocardial infarction (MI) with any mention of location or combination 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/EVOLVING2. **Left bundle branch block (LBBB)** (new or not known to be old, chronic, or previously seen), intraventricular conduction delay of LBBB type, variable LBBB1. 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 angina11. Sustained ventricular tachycardia runs and/or sustained ventricular tachycardia with hypotension12. ST-segment depression, new or not known to be old13. Documented NSTEMI, non ST-elevation MI1. Not applicable

99. Interpretation not consistent with above terminology | **If no ECG done, or no interpretation found, enter 95**1,2,3,4,5,6,7,8,9,10,11,12,13,95,99

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| **If 1 or 2 is entered, and truami=2, the computer will prevent the abstractor from entering contradictory data.** |

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| Warning window if truami = 1, and comunecg = 7 or 99  |

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| **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

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)

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| **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.**

Cont’d next page |
|  |  |  |  | ECG interpretation hierarchy cont’d1. 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 that clearly refer to the initial ECG. Interpretations may be taken from documentation of ECG findings in ED notes, admission note, or progress note. |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 2 | comunecg\_txt | Please enter the ECG interpretation found in the record. | Text(100) | Text box to capture actual ECG reading when “99” entered |
| 3 | transtrop | Does the record of this patient transferred from a community hospital document that either the initial or peak troponin level was positive?1. initial and peak troponin negative
2. initial or peak troponin positive

unable to determine | 2,3,99 | Use documentation sent from the transferring community hospital if this data is available. If there is no information from the transferring hospital, or no documentation of troponin level, answer “99.”If the patient was transferred soon after presentation to the initial hospital, and the peak troponin level drawn at this VAMC was positive or negative, use this data and answer in accordance with the findings.  |
| 4 | thromtx | Was primary fibrinolytic therapy received at the community hospital or a VHA hospital?1. received at a VHA hospital
2. not received
3. received at the community hospital
4. unable to determine
 | 1,2,3,99If 2 or 99, auto-fill dthrom as 99/99/9999 | Abbokinase, Activase, Alteplase, Anistreplase, Eminase, Reteplase, Kabikinase, Streptase, Streptokinase, Tissue Plasminogen Activator (TPA), Win-kinase, APSAC = Anisylated plasminogen streptokinase activator complex.**The question is applicable to primary fibrinolytic therapy given at the community hospital or at this or another VAMC.**If fibrinolytic therapy was initiated in the ambulance and was infusing at the time of arrival, answer “1.” **Exclude fibrinolytics given during or after a PCI.** |
| 5 | dthrom | Enter the date primary fibrinolytic therapy was received during this episode of care. | mm/dd/yyyyIf thromtx = 2 or 99, will be auto-filled as 99/99/9999

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| < = acutedt and < = dcdate.Warning window if date > 2 weeks prior to acutedt |

 | Check emergency department notes, medication administration record, progress notes, nurses’ notes for specific date fibrinolytic therapy was given**.** **The question is applicable to primary fibrinolytic therapy given at the community hospital or at this VAMC.**If there were two different fibrinolytic administration episodes, enter the date (and time) the earliest fibrinolytic was initiated.Enter exact date. Month = 01 or day = 01 is not acceptable.**Parameters allow for date prior to arrival date at this VAMC**. |

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| **#** | **Name** | QUESTION | **Field Format** | **DEFINITIONS/DECISION RULES** |
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| 6 | pcidone | Was a percutaneous coronary intervention (PCI) performed at the community hospital or at a VHA hospital?1. performed at a VHA hospital
2. not performed
3. performed at the community hospital
4. unable to determine

**If a PCI was performed, ICD-9-CM code 00.66 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.**  | 1,2,3,99**If 2 or 99, auto-fill pcidate1 as 99/99/9999****If 1 or 3, auto-fill pcifail1 as 95 and noptca1 as 95**

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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 unsuccessful.****The question is applicable to PCI performed at the community hospital or at this or another VAMC.**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.”** |
| 7 | pcidate1 | What is the date associated with the first PCI done after hospital arrival? | mm/dd/yyyyIf pcidone = 2 or 99, will be auto-filled as 99/99/9999

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|  < = dcdateWarning window if date > 2 weeks prior to acutedt |

 | **Exact date must be entered. The use of 01 to indicate missing day or month is not acceptable.****Parameters allow for date prior to arrival date at this VAMC**. |
| 8 | pcifail1 | Is there documentation in the record that an attempt at PCI was unsuccessful?1. yes
2. no
3. not applicable
 | 1,2,95If pcidone = 1 or 3, 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. |

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| **#** | **Name** | QUESTION | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 9 | noptca1 | Is there clinician documentation in the record of a reason why PCI was not performed?1. patient co-morbidities preclude procedure
2. other reason documented
3. not applicable
4. patient or family refusal
5. no documented reason
 | 2,3,95,98,99If pcidone = 1 or 3, will be auto-filled as 95  | Clinician = Physician/APN/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** |

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| **#** | **Name** | QUESTION | **Field Format** | **DEFINITIONS/DECISION RULES** |
| 10 | cardsee2 | Was Cardiology involved in the care of this patient?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 carddt2 as 99/99/9999 and cardtme2 as 99:99**  | **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 during the hospital stay.****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.** |

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| **#** | **Name** | **QUESTION** | **Field Format** | **DEFINITIONS/DECISION RULES** |
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| 11 | carddt2 | Enter the date the patient was first seen by Cardiology or a Cardiology consult first occurred. | mm/dd/yyyyIf cardsee2 = 99, will be auto-filled as 99/99/9999

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| > = acutedt 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 at this VAMC, use this date as the documented date of cardiology involvement, unless the patient was seen by cardiology on an earlier date.
 |
| 12 | cardtme2 | Enter the time the patient was first seen by Cardiology or a Cardiology consult first occurred.  | \_\_\_\_\_UMTIf cardsee2 = 99, will be auto-filled as 99:99

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

 | The purpose of the question is to determine when the patient was seen by a cardiologist at this VAMC.* 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 performed at this VAMC, 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 Continuing Care and Assessment Module** |