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| --- | --- | --- | --- | --- |
| 1 | priorecg | Was a 12-lead ECG obtained prior to acute care arrival at a VHA hospital?  | 1,2**If 2, auto-fill wherecg as 95, ecgdate as 99/99/9999, ecgtime as 99:99, and worknecg as 95** | **Prior to acute care arrival = in the ambulance on the way to the hospital, in another VHA treatment setting prior to transfer to the acute care setting.** **Rhythm strip is not acceptable**. ECG must be that performed using the 12 standard leads: the 3 bipolar limb leads, the 3 augmented unipolar limb leads, and the 6 standard precordial leads.**If the clinician references ECG findings but does not specify the ECG was 12-lead, infer that it was 12-lead if lead markings are noted in the report.** **ECG done in an ambulance more than 1 hour prior to hospital arrival is not applicable.** |
| 2 | wherecg | Where was the ECG prior to arrival done?1. at another VAMC
2. in the ambulance
3. non-acute treatment setting at this VAMC
4. other

95. not applicable | 1,2,3,4,95If priorecg = 2, will be auto-filled as 95  | At another VAMC: patient was first treated at another VAMC, either in the ED or admitted as an inpatient, and transferred to this VAMC In an ambulance: during transport to this or another VAMCNon-acute setting in this VAMC: urgent care, ambulatory clinic, NHCU, Rehab unitOther: private sector physician office, urgent care, etc. |
| 3 | ecgdate | Enter the date the12-lead ECG prior to acute care arrival was done. | mm/dd/yyyyIf priorecg = 2, will be auto-filled as 99/99/9999

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| Warning window if date is not acutedt.Date cannot be > than acutedt. |

 | Enter the exact date. The use of 01 to indicate missing day or month is not applicable.**Determining ECG Date****The abstractor can accept only the date and time printed on the ECG tracing.** |

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| 4 | ecgtime | Enter the time the ECG prior to acute care arrival was done. | \_\_\_\_\_UMTIf priorecg = 2, will be auto-filled as 99:99

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| If wherecg = 1, warning at 5 hrs prior to acutedt/acutetmIf wherecg = 2,3, or 4, < =1 hr prior to acutedt/acutetm |

 | 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.**  |
| 5 | worknecg | Did the clinician document this ECG done prior to arrival was the ECG he/she was “working from,” i.e., using to guide patient care?1. yes
2. no
3. not applicable
 | 1,2,95If priorecg = 2, will be auto-filled as 95  | Documentation such as “ECG shows ST elevation – transfer to ED immediately” or “abnormal findings on ECG – ASA, O2, transfer to acute care,” or “ST segment changes not seen previously, transfer and consult cardiology” indicate this ECG was being used to make decisions regarding patient care. Do not expect to find literal statement by clinician that he/she “was working from” this ECG.Will be auto-filled as 95 if PRIORECG = 2. Abstractor cannot enter 95 if PRIORECG = 1. |
| 6 | arvekgdt | Enter the date the first 12-lead ECG after acute care arrival was done. | mm/dd/yyyy**Abstractor can enter default date 99/99/9999 if no ECG was done after acute care arrival**

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| > = acutedt and < = dcdate |

 | **ECG after acute care arrival =arrival at the ED, direct admission to a monitored bed, or seen on arrival by a chest pain rapid Field Format team.****This is the first EKG done after the patient entered a VHA acute care hospital.** If the patient presented initially to another VAMC, the question refers to the date the first EKG at that hospital was done.**Determining ECG Date****The abstractor can accept only the date and time printed on the ECG tracing.****If no ECG was done after acute care arrival, enter default date 99/99/9999** |
| 7 | arvekgtm | Enter the time the first 12-lead ECG after acute care arrival was done. | \_\_\_UMT**Abstractor can enter default time 99:99 if no ECG was done after acute care arrival**

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

 | **This is the first ECG done after the patient entered a VHA acute care hospital.** If the patient presented initially to another VAMC, the question refers to the time the first EKG at that hospital was done.**Determining ECG Time****The abstractor can accept only the date and time printed on the ECG tracing.****If no ECG was done after acute care arrival, enter default time 99:99** |
| 8 | closecg | Is there documented interpretation of the 12-lead ECG performed closest to acute care hospital arrival?

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| **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 closest to hospital arrival** |

  | 1,2**If 1, auto-fill nextecg as 95, nextdate as 99/99/9999, and nextime as 99:99** | Use the 12-lead ECG performed closest to the time of hospital arrival whether prior to or after arrival at this or another VAMC. (Example: 12-lead EKG done in ambulance 10 minutes prior to hospital arrival and a second one done in the ED 30 minutes after arrival. Use the EKG done in the ambulance.)**Do not use an ECG interpretation done more than one hour prior to hospital arrival.****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 that clearly refer to the ECG done closest to arrival. 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.**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 are noted in 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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| 9 | nextecg | Was there a subsequent ECG with a documented interpretation?1. yes
2. no
3. not applicable
 | 1,2,95If closecg = 1, will be auto-filled as 95**If 2 or 95, auto-fill nextdate as 99/99/9999 and nextime as 99:99** | **Use the ECG done second closest to arrival time 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 EKG 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.** |
| 10 | nextdate | Enter the date of the ECG with a documented interpretation. | mm/dd/yyyyIf nextecg = 2 or 95, will be auto-filled as 99/99/9999

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|  > = acutedt 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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| 11 | nextime | Enter the time of the ECG with a documented interpretation. | \_\_\_\_\_\_UMTIf nextecg = 2 or 95, will be auto-filled as 99:99**Abstractor can enter 99:99**

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| > = acutedt/acutetm 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.** |

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| 12 | ecgintrp | What were the specific findings from interpretation of the ECG performed closest to hospital arrival 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/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 (priorecg = 2 (or priorecg = 1 and worknecg = 2)), and closecg = 2, and nextecg = 2, auto-fill as 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 ecgintrp = 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

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)

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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 |

Cont’d next page |
|  |  |  |  | ECG interpretation cont’d**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. |
| 13 | ecgintrp\_txt | Please enter the ECG interpretation found in the record | Text(100) | Text box to capture actual ECG reading when “99” entered |
| 14 | angina | Did the patient experience angina within 24 hours prior to presentation to the hospital? | 1,2 | Angina is defined as: chest pain or severe epigastric pain, non-traumatic in origin; central/substernal compression or crushing chest pain; pressure, tightness, heaviness, cramping, burning or aching sensation; unexplained indigestion, belching, epigastric pain; radiating pain in neck, jaw, shoulders, back, one or both arms; dyspnea; nausea and/or vomiting; diaphoresisThere may be conflicting notes in the ED record, admitting note, H&P, etc, regarding episodes of angina. If angina is noted in any of these sources, answer “1.”  |
| 15 | amisymp1amisymp2amisymp3amisymp4amisymp5amisymp6amisymp7amisymp8amisymp99 | Within 24 hours prior to, or on arrival at any VAMC, did the veteran have any of the following symptoms?**Indicate all that apply**:1. chest pain or severe epigastric pain, non-traumatic in origin
2. central/substernal compression or crushing chest pain
3. pressure, tightness, heaviness, cramping, burning or aching sensation
4. unexplained indigestion, belching, epigastric pain
5. radiating pain in neck, jaw, shoulders, back, one or both arms
6. dyspnea
7. nausea and/or vomiting
8. diaphoresis
9. none of these symptoms
 | 1,2,3,4,5,6,7,8,99

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| **If abstractor enters 99 and angina = 1, computer edit will warn that answers are contradictory. Abstractor will be asked to re-check medical record documentation to ensure accurate data. 99 cannot be entered with any other number in amisymp** |

 | **“Any VAMC” includes this or another VAMC**. The question refers to any acute care hospital within the VHA system. If the patient presented first to a VAMC other than the VAMC in which the case is being reviewed, questions regarding care will be pertinent to the hospital where the patient first presented, since care is expected to be seamless within the VHA system. Prior to or on arrival = patient was experiencing one of more of these symptoms at home or elsewhere, during transport to the hospital, or at the time of initial presentation to the hospital. Even if the symptom(s) had subsided by the time the patient presented to the hospital, indicate the symptom(s) that occurred prior to presentation. |

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| 16 | onsethrs | Enter the number of hours prior to arrival at a VHA hospital that symptom(s) that brought the patient to the hospital began. 1. 0 - 1
2. >1 – 2
3. >2 – 6
4. >6 – 12
5. >12 – 24
6. >24
7. not documented
 | 1,2,3,4,5,6,99 | **The patient may have had a number of symptoms occurring over a period of many hours or days. Count the time period from the earliest onset of symptoms, i.e., count from the furthest point prior to arrival at the acute care hospital. (Example: on 4/10/06 at 1006 hrs, the patient began experiencing an ache in his left arm and jaw. Thinking he might have pulled a muscle, the patient took ibuprofen and tried to ignore the pain. By 2330 that night, the pain was so severe, the patient presented at the VAMC ED. Count from 1006 hrs and enter Field Format # 5.)** The number of hours prior to hospital arrival that the symptoms began may not be explicitly stated in the record, and may have to be inferred or extrapolated from available documentation. (Examples: “the patient began to experience chest pain shortly before midnight.” If hospital arrival time was 4:15 a.m., enter category #3.)(“The patient began taking antacids for severe indigestion yesterday morning, but the epigastric pain continued to worsen untilpresentation at the ED at 3:30 this afternoon.” Enter category #6.)If information in the record is conflicting, use only the ED notes or admitting note as the source of information. Use #99 only if there was no information regarding onset of symptoms.  |
| 17 | chfsymp1chfsymp2chfsymp3chfsymp4chfsymp5chfsymp6chfsymp7chfsymp99 | At the time of presentation to the hospital, did the patient have any of the following symptoms?Indicate all that apply:1. 1. heart failure2. impaired left ventricular function3. new mitral regurgitation murmur4. an S3 gallop5. rales > 3 or 1/3 up6. documentation of a chest x-ray with  evidence of pulmonary edema7. documentation of cardiogenic shock (severe and persistent hypotension in Trendelenburg)99. none of these symptoms documented | 1,2,3,4,5,6,7,99

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| **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.  |
| 18 | arvpress1arvpress2 | Enter the patient’s blood pressure recorded at the time of presentation to a VHA acute care hospital. | ---/---

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| Warning window if arvpress1 < = 70 or > =300 arvpress2 < = 44 or > = 135 Arvpress2 must be < arvpress1 |

 | Do not use the ambulance record. Enter the blood pressure recorded at the earliest time following patient arrival at the hospital. Use data recorded in the ED or observation unit.  |
| 19 | restang | At the time of presentation, does the record document the patient experienced 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. |
| 20 | asa24 | Did the patient receive aspirin within 24 hours before or 24 hours after arrival at a VHA acute care hospital?1. yes
2. no
 | 1,2If 1, auto-fill asanone as 95If 2, auto-fill aspdate as 99/99/9999 and asptime as 99:99, and go to asanone | 2 = patient did not receive aspirin within the time period or unable to determine from medical record documentationIf aspirin was taken by the patient or given by emergency personnel on the way to the hospital, answer “1.” If ASA was given at another level of care at this VAMC, answer “1.”**When unable to determine for certain whether aspirin was received within 24 hours prior to arrival (and aspirin was not received after arrival), answer “2.”** **In the absence of explicit documentation that the patient received aspirin within 24 hours prior to Arrival Time:** * In cases where the patient was received as a transfer from another hospital (inpatient, outpatient, ED, observation): 
* Aspirin listed as “home" medication: Do **not** make inferences. Additional documentation is needed which clearly suggests the patient took aspirin at home within 24 hours prior to Arrival Time. 
* Aspirin listed as “current” medication:
* If there is documentation that aspirin was a current medication at the transferring facility (e.g., aspirin noted on transfer summary, aspirin noted as “current medication” in your facility's H&P), then infer aspirin was taken within 24 hours prior to *Arrival Time*, unless documentation suggests otherwise.
* If documentation suggests “current” aspirin refers to home regimen or documentation is not clear whether “current” means patient was on aspirin at the transferring facility or at home, do **not** make inferences. Additional documentation

is needed which clearly suggests the patient either took aspirin at home or at the transferring facility within 24 hours prior to Arrival Time. * In non-transfer cases:
* Aspirin listed as “current” or “home" medication should be inferred as taken within 24 hours prior to *Arrival Time*, unless documentation suggests otherwise (e.g., Documentation that aspirin is on hold prior to arrival for a scheduled procedure).
* If ASA is listed as home medication and last dose is noted as the day prior to arrival but no time, then infer aspirin was taken within 24 hours.
 |
|  |  |  |  | * When aspirin is noted only as received prior to arrival, without information about the exact time it was received (e.g., "Baby ASA x4" per the "Treatment Prior to Arrival" section of the Triage Assessment), infer that the patient took it within 24 hours prior to Arrival Time, unless documentation suggests otherwise.
* Aspirin documented as a PRN current/home medication does not count unless documentation is clear it was taken within 24 hours prior to Arrival Time. .
 |
| 21 | aspdate | Enter the date the patient received aspirin | mm/dd/yyyyIf asa24 = 2, will be auto-filled as 99/99/9999

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| --- |
| 24 hrs prior to acutedt or 24 hrs. after acutedt and < = dcdate |

 | Enter the exact date. Month = 01 or day = 01 is not acceptable. |
| 22 | asptime | Enter the time the patient received aspirin | \_\_\_\_\_UMT If asa24 = 2, will be auto-filled as 99:99

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| --- |
|  24 hrs prior to acutedt/acutetm or 24 hrs. after acutedt/acutetm and < = dcdate/dctime |

 | If the patient did not receive aspirin post-admission, and whether the patient took aspirin within a 24 hour period prior to arrival 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.”  |
| 23 | asanone | Does the record document any of the following reasons for not administering aspirin on arrival?1. Aspirin allergy

3. Warfarin/Coumadin or Pradaxa/dabigatranas pre-arrival medication95. Not applicable1. Other reason for not prescribing aspirin on arrival documented by a physician/APN/PA or pharmacist
2. Patient refusal of aspirin documented by physician/APN/PA or pharmacist

99. No documented reason  | 1,3,95,97,98,99Will be auto-filled as 95 if asa24=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** |
|  |  |  |  | **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. |
| 24 | platagg | Did the patient receive a platelet aggregation inhibitor within the first 24 hours after acute care arrival? 1. clopidogrel (Plavix)
2. ticlopidine (Ticlid)
	1. dipyridamole (Persantine)
	2. dipyridamole and aspirin (Aggrenox)
	3. other
3. not documented/unable to determine
 | 1,2,3,4,5,99If <> 99, auto-fill platcont as 95**If 99, auto-fill platdate as 99/99/9999 and platime as 99:99, and go to platcont**  | 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 atherosclerotic 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. |
| 25 | platdate | Enter the date the patient received the platelet aggregation inhibitor.  | mm/dd/yyyyIf platagg = 99, will be auto-filled as 99/99/9999

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| --- |
| < =24 hrs. after acutedt and < = dcdate |

 | Enter the exact date. Month = 01 or day = 01 is not acceptable. |
| 26 | platime | Enter the time the patient received the platelet aggregation inhibitor.  | \_\_\_\_\_UMTIf platagg = 99, will be auto-filled as 99:99

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| < =24 hrs. after acutedt/acutetme and < = dcdate/dctime |

 | Enter the time of administration during the first 24 hours after hospital arrival, using military time. |
| 27 | platcont | Is there physician/APN/PA or pharmacist documentation of a reason that a platelet aggregation inhibitor was not administered on arrival?1. Yes2. No95. Not applicable98. Patient refusal of platelet aggregation inhibitor documented by physician/APN/PA or pharmacist | 1,2,95,98Will be auto-filled as 95 if platagg <> 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.  |
| 28 | beta24 | Did the patient receive a beta-blocker within 24 hours after arrival at a VHA acute care hospital? 1. yes
2. no
 | 1,2If 1, auto-fill betanone as 95**If 2, auto-fill bbdate as 99/99/9999, bbtime as 99:99, and specbeta as 95, and go to betanone** | 2 = Beta-blocker not given within 24 hours after hospital arrival or unable to determine from medical record documentationRefer to drug list for listing of beta-blockers.Answer “1” if an IV beta-blocker (e.g. metoprolol) was given in the ED within 24 hours of arrival. |
| 29 | bbdate | Enter the date the patient received a beta-blocker | mm/dd/yyyyIf beta 24 = 2, will be auto-filled as 99/99/9999

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| < =24 hrs. after acutedt and < = dcdate |

 | Enter the exact date. Month = 01 or day = 01 is not acceptable. |
| 30 | bbtime | Enter the time the patient received a beta-blocker | \_\_\_\_\_UMTIf beta 24 = 2, will be auto-filled as 99:99

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| < =24 hrs. after acutedt/acutetme and < = dcdate/dctime |

 | 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. |
| 31 | specbeta | Designate the beta-blocker the patient received within 24 hours after arrival at the hospital:1. metoprolol succinate (Toprol-XL)
2. metoprolol tartrate
3. bisoprolol (Zebeta or Ziac)
4. carvedilol (Coreg)
5. atenolol (Tenormin)
6. acebutolol (Sectral)

7. sotalol (Betapace) 8. betaxolol 1. nadolol (Corgard)
2. nadolol/bendroflumethiazide (Corzide)
3. propranolol (Inderal)
4. propranolol hydrochloride (Inderide)
5. labetalol (Trandate)
6. penbutolol sulfate (Levatol)
7. metoprolol/hydrocholorthiazide (Lopressor HCT )

17. pindolol (Visken) 18. timolol20. esmolol (Brevibloc)21. other1. not applicable
 | 1,2,3,4,5,6,7,8,10,11,12,13,14,15,16,17,18,20,21,95Will be auto-filled as 95 if beta24 = 2 | 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 arrival at the hospital.****Beta-blocker the patient may have been taking prior to arrival at the hospital is not applicable to this question.**For a list of beta-blocker medications, refer to TJC Appendix C, Table 1.3or a drug handbook.**Source**: medication administered in the ED, admitting note, admission orders, medications given |
| 32 | betanone | Does the record document any of the following reasons for not administering a beta- blocker within 24 hours of arrival?1. Beta-blocker allergy
2. Bradycardia (heart rate less than 60 bpm) on arrival or within 24 hours of arrival while not on a beta blocker
3. Second or third-degree heart block on ECG on arrival or within 24 hours of arrival and does not have a pacemaker
	1. Heart failure on arrival or within 24 hours after arrival
	2. Shock on arrival or within 24 hours after arrival
	3. Post-heart transplant patient
	4. Severely decompensated heart failure, as evidenced by patient receiving IV dobutamine, milrinone, or nesiritide

95. Not applicable* + 1. Other reason documented by a physician/APN/ PA or pharmacist for not giving a beta blocker within 24 hours after hospital arrival

98. Patient refusal of beta-blockers documented by physician/APN/PA or pharmacist1. No documented reason
 | 1,2,3,7,8,9,10,95, 97,98, 99Will be auto-filled as 95 if beta24 = 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 60 beats per minute on arrival or within 24 hours of arrival.**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. |
|  33 | hepin24 | Did the patient receive heparin within 24 hours after acute care arrival?1. received unfractionated heparin
2. received low molecular weight heparin

99. did not receive heparin within 24 hours | 1,2,99If 1 or 2, auto-fill noheprin as 95**If 99, auto-fill hepdt as 99/99/9999 and heptme as 99:99, and go to noheprin** | 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 24 hours of arrival.  |
| 34 | hepdt | Enter the date the patient received heparin | mm/dd/yyyyIf hepin24 = 99, will be auto-filled as 99/99/9999

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| < =24 hrs. after acutedt and < = dcdate |

 | Enter the exact date. Month=01 or day=1 is not acceptable |
| 35 | heptme | Enter the time the patient received heparin | \_\_\_\_\_UMTIf hepin24 = 99, will be auto-filled as 99:99

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|  < =24 hrs. after acutedt/acutetme and < = dcdate/dctime |

 | Enter the time of initial administration during the first 24 hours after hospital arrival, using military time. |
| 36 | noheprin | 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 applicable1. 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
 | 1,2,3,4,5,6,7,8,95,97,98,99Will be auto-filled as 95 if hepin24 = 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 prescription of heparin.  |
| 37 | cardseen | Was Cardiology involved in the care of the 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 carddt as 99/99/9999 and cardtme as 99:99**  | **The purpose of the question is to determine whether the patient was seen by a cardiologist within 24 hours following arrival time if AMI was diagnosed or suspected at presentation. If ECG was done prior to acute care arrival, and clinician documentation indicates subsequent patient care was based on this ECG, cardiology involvement time is based on the ECG date/time.** **The cardiologist must be a physician.** 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 a cardiology resident saw the patient, 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.** |
| 38 | carddt | Enter the date the patient was first seen by Cardiology or a Cardiology consult first occurred. | mm/dd/yyyyIf cardseen = 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 within 24 hours of the ACS event, use this date as the documented date of cardiology involvement, unless the patient was seen by cardiology on an earlier date.
 |
| 39 | cardtme | Enter the time the patient was first seen by Cardiology or a Cardiology consult first occurred.  | \_\_\_\_\_UMTIf cardseen = 99, will be auto-filled as 99:99

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

 | **The purpose of the question is to determine whether the patient was seen by a cardiologist within 24 hours following arrival time if AMI was diagnosed or suspected at presentation.** * 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** |