#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
1	priorecg	Was a 12-lead ECG obtained prior to acute care arrival at a VHA hospital? 1. Yes 2. No	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, 95 If 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 VAMC Non-acute setting in this VAMC: urgent care, ambulatory clinic, NHCU, Rehab unit Other: private sector physician office, urgent care, etc.
3	ecgdate	Enter the date the 12-lead ECG prior to acute care arrival was done.	mm/dd/yyyy If priorecg = 2, will be auto-filled as 99/99/9999 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 <u>only</u> the date and time printed on the ECG tracing.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
4	ecgtime	Enter the time the ECG prior to acute care arrival was done.	_____ UMT If priorecg = 2, will be auto-filled as 99:99 If wherecg = 1, warning at 5 hrs prior to acutedt/acutetm If 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 <u>only</u> the date and time printed on the ECG tracing.**
5	worknecg	Did the clinician document this ECG <u>done prior to arrival</u> was the ECG he/she was "working from," i.e., using to guide patient care? 1. yes 2. no 95. not applicable	1, 2, 95 If 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** > = 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 <u>entered a VHA acute care hospital.</u>** 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 <u>only</u> the date and time printed on the ECG tracing.** **If no ECG was done after acute care arrival, enter default date 99/99/9999**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
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** > = acutedt/acutetm and < = dcdate/dctime	**This is the first ECG done after the patient <u>entered a VHA acute care hospital.</u>** If the patient presented initially to another VAMC, the question refers to the time the first EKG at that hospital was done. **<u>Determining ECG Time</u>** **The abstractor can accept <u>only</u> the date and time printed on the ECG tracing.** **If no ECG was done after acute care arrival, enter default time 99:99**
8	intrpecg	What were the specific findings from interpretation of the ECG performed closest to hospital arrival? **1. ST-segment elevation** **Inclusion Guidelines** • 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 (e.g., "posterior AMI") • Q wave MI, 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 • "STEMI or equivalent" • Transmural MI, IF DESCRIBED AS ACUTE/EVOLVING	**1, 2, 3, 4, 95, 99** **If priorecg = 2 (or priorecg = 1 and worknecg = 2) and arvekgdt = 99/99/9999, auto-fill as 95** **If 1, 2 or 3 is entered, and truami=2, the computer will prevent the abstractor from entering contradictory data.** **Warning window if truami = 1 and intrpecg = 99**	**ECG Interpretation is defined as:** • 12-lead tracing with name/initials of the physician/APN/PA who reviewed the ECG signed or typed on the report, **OR** • Physician/APN/PA documentation of ECG findings in another source (e.g., ED notes, progress notes). **Do not measure ST-segments or attempt to determine if there is an LBBB from the tracing itself.** **Identify the ECG performed closest to arrival, either before or after hospital arrival, but not more than 1 hour prior to arrival. Must be prior to any procedures (cardiac cath or PCI) and not longer than 24 hours after arrival.** **Exception: If the pre-arrival ECG and the first ECG performed after arrival are exactly the same amount of time away from hospital arrival (e.g., both ECGs are 10 minutes away from Arrival Time), use the first ECG performed after hospital arrival.** **1. ST-SEGMENT ELEVATION:** new or presumed new ST-segment elevation >/= .10mV in more than one lead. **ST Elevation Exclusion Guidelines** • Non Q wave MI (NQWMI) • Non ST-elevation MI (NSTEMI) • ST ↑ clearly described as confined to ONE lead

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		2. Left Bundle Branch Block (LBBB) **Inclusion Guidelines** • Intraventricular conduction delay of LBBB type • Variable LBBB **3. Isolated Posterior MI** **4. Non-ST Elevation MI (NSTEMI)** 95. Not applicable **99. Interpretation not consistent with above terminology**		• ST ↑ with any mention of early repolarization, left ventricular hypertrophy (LVH), normal variant, pericarditis, or Printzmetal/Printzmetal's variant in one interpretation • 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 modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except "possible") • ST-segment elevation, or any of the other ST-segment elevation Inclusion terms, with any mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker) in one interpretation • ALL ST-elevation (ST ↑, STE) in one interpretation is described in one or more of the following ways: ◦ Minimal ◦ Non-diagnostic ◦ Non-specific ◦ ST-elevation or ST-segment noted as greater than or equal to .10mV/1mm AND described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except "possible") ◦ ST-elevation or ST-segment noted as less than .10mV in elevation ◦ ST-elevation or ST-segment noted as less than 1mm in elevation ◦ ST ↑ described as a range where it cannot be determined it is less than 1mm (e.g., "0.5-1mm ST ↑", "ST > 0.06mV V2-V6") ◦ old, chronic, previously seen, unchanged, no new changes, no acute changes, no significant changes when compared to a prior ECG. **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.** ◦ using the qualifier "possible" is neither Inclusion nor Exclusion **2. LEFT BUNDLE BRANCH BLOCK (LBBB):** LBBB that was not known to be old on the initial ECG

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				LBBB Exclusion Guidelines • Incomplete LBBB • LBBB or any of the other LBBB inclusion terms described using one of the negative modifiers or qualifiers listed in Appendix H, Table 2.6, Qualifiers and Modifiers Table (except "possible") • LBBB or any of the other LBBB inclusion terms, with any mention of pacemaker/pacing (unless atrial only or nonfunctioning pacemaker) in one interpretation • LBBB described as old, chronic, previously seen, unchanged, no new changes, no acute changes, no significant changes when compared to a prior ECG **3. ISOLATED POSTERIOR MI:** infarction of the posterobasal wall of the left ventricle. Use of posterior leads V7-V9 will show ST segment elevation in patients with posterior infarction. If posterior leads were not applied, ST depression in V1-V3, without ST elevation in other leads may be considered as indicative of posterior ischemia or infarction. **4. NSTEMI: (non-ST-segment elevation myocardial infarction, non-ST elevation MI) must be clearly documented by a physician/APN/PA** in association with the initial ECG findings. **NOTE: ECG changes may or may not be present with NSTEMI and it is not always diagnosed by ECG alone. Documentation of NSTEMI may be found in progress notes associated with the initial ECG interpretation. Example: physician/APN/PA may document, "no ST elevation - ECG shows T wave inversion - positive troponin levels - Impression: NSTEMI".** **JC Appendix H, Table 2.6 Qualifiers/Modifiers**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES	
				Qualifiers: and/or, (+/-), cannot exclude, cannot rule out, could/may/might be, could/may/might have, could/may/might have been, could/may/might have had, could/may/might indicate, questionable (?), risk of, ruled out (r'd/o, r/o'd), suggestive of, suspect, or suspicious	**Modifiers: borderline, insignificant, not significant, no significant, minor, scant, slight, 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.	

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
9	angsymp	Within 24 hours prior to, or on arrival at any VAMC, is there documentation that the patient had any of the following angina symptoms? **Angina symptoms include but are not limited to:** • chest or epigastric pain, or discomfort described as pressure, squeezing, burning, tightness, heaviness • arm, shoulder, neck, jaw, throat or back pain described as above • unexplained indigestion, nausea or vomiting • dyspnea • dizziness, lightheadedness • fatigue, tiredness, weakness • diaphoresis 1. Yes 2. No	1, 2	**Angina:** chest pain or discomfort that occurs if an area of the heart muscle does not get enough oxygen-rich blood (ischemia). Pain or discomfort may radiate to shoulders, arms, neck, jaws, back, upper abdomen. **Prior to or on arrival:** patient was experiencing one or more 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, answer "1". **"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. There 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". If there is documentation that the patient's symptoms were "atypical" (i.e. not clearly ischemic symptoms), but the documentation indicates the symptoms are an anginal equivalent, answer "1".
10	hfpres	At the time of presentation to the hospital, is there physician/APN/PA documentation or report of heart failure? 1. Yes 2. No	1, 2	**Heart Failure (congestive heart failure [CHF]):** clinician documentation of clinical signs/symptoms of heart failure, diagnosis of heart failure/CHF, diagnosis of pulmonary edema. 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.
11	shokpres	At the time of presentation to the hospital, is there physician/APN/PA documentation the patient was in a state of cardiogenic shock? 1. Yes 2. No	1, 2	**Cardiogenic shock:** sustained (> 30 Minutes) episode of systolic blood pressure < 90 mm/Hg and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., intra-aortic balloon pump [IABP], extracorporeal circulation, ventricular assist devices). The abstractor may not make this determination. **The diagnosis of cardiogenic shock must be documented by a physician/APN/PA.**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
12	frstrate	Enter the patient's heart rate recorded at the time of presentation to a VHA acute care hospital.	_ _ _ Must be >= 0 Warning if < 40 or >= 250	Do not use the ambulance record. Indicate the first measurement or earliest record of heart rate (in beats per minute)
13	arvpress2 arvpress1	Enter the patient's blood pressure recorded at the time of presentation to a VHA acute care hospital.	---/--- 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.
14	restang	At the time of presentation, does the record document the patient experienced prolonged ongoing rest pain (pain in chest, arm, or neck >/= 10 minutes)? 1. Yes 2. No	1, 2	Myocardial ischemic pain is usually described as pressing, squeezing, or weight-like. 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.
15	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, 2 If 1, auto-fill asanone as 95 **If 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 documentation If 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:**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				- 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

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				Time. For a list of aspirin and aspirin-containing medications, refer to TJC Appendix C, Table 1.1 or a drug handbook. **Exclude:** Aggrenox (aspirin/dipyridamole): Aggrenox contains only a sub-therapeutic amount of aspirin and does **NOT** count for aspirin.
16	aspdate	Enter the date the patient received aspirin	mm/dd/yyyy If asa24 = 2, will be auto-filled as 99/99/9999 24 hrs prior to acutedt or 24 hrs. after acutedt and < = dcdate	Enter the exact date. Month = 01 or day = 01 is not acceptable.
17	asptime	Enter the time the patient received aspirin	____ UMT If asa24 = 2, will be auto-filled as 99:99 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."
18	asanone	Does the record document any of the following reasons for not administering aspirin on arrival? 1. Aspirin allergy 3. One or more of the medications listed in the Inclusion List as pre-arrival medication 95. Not applicable 97. Other reason for not prescribing aspirin on arrival documented by a physician/APN/PA or pharmacist 98. Patient refusal of aspirin documented by	1, 3, 95, 97, 98, 99 Will 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. One or more of the medications listed in the Inclusion List as pre-arrival medication:** consider a medication listed in the Inclusion List to be a pre-arrival medication (a reason for not prescribing aspirin on arrival) if there is documentation the patient was on it prior to arrival, regardless of setting. Include cases where there is indication the medication was on temporary hold or the patient has been non-compliant/self-discontinued their medication (e.g., refusal, side effects, cost).

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		physician/APN/PA or pharmacist 99. No documented reason		**Inclusion List** (Pre-arrival medications that count as an automatic reason for no aspirin): • apixaban (Eliquis) • dabigatran (Pradaxa) • rivaroxiban (Xarelto) • warfarin/warfarin sodium (Coumadin/Jantoven) **97. "Other reason" documented by a <u>physician/APN/PA or pharmacist</u>:** • 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. <u>**EXCEPTION:**</u> 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. • 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

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				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.
19	platagg	Did the patient receive a platelet aggregation inhibitor within the first 24 hours after acute care arrival? 1. clopidogrel (Plavix) 2. ticlopidine (Ticlid) 3. dipyridamole (Persantine) 4. dipyridamole and aspirin (Aggrenox) 5. other 6. prasugrel (Effient) 7. ticagrelor (Brilinta) 99. not documented/unable to determine	1, 2, 3, 4, 5, 6, 7, 99 If <> 99, auto-fill platcont as 95 **If 99, auto-fill platdate as 99/99/9999 and platime as 99:99, and go to platcont**	Platelet aggregation inhibitors are drugs used to prevent clotting and thus reduce risk of further heart attack or stroke in patients with cardiovascular disease. Patients who have a true allergy to aspirin and no contraindication to antiplatelet therapy may be given drugs such as clopidogrel, ticlopidine, dypyridamole, prasugrel or ticagrelor.
20	platdate	Enter the date the patient received the platelet aggregation inhibitor.	mm/dd/yyyy If platagg = 99, will be auto-filled as 99/99/9999 < =24 hrs. after acutedt and < = dcdate	Enter the exact date. Month = 01 or day = 01 is not acceptable.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
21	platime	Enter the time the patient received the platelet aggregation inhibitor.	____ UMT If platagg = 99, will be auto-filled as 99:99 < =24 hrs. after acutedt/acutetme and < = dcdate/dctime	Enter the time of administration during the first 24 hours after hospital arrival, using military time.
22	platcont	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 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.
23	beta24	Did the patient receive a beta-blocker within 24 hours after arrival at a VHA acute care hospital? Examples of beta-blockers include, but are not limited to: • metropolol succinate or tartrate • carvedilol • atenolol • nadolol • propranolol • combination of beta-blocker with other drugs 1. Yes 2. No	1, 2 If 1, auto-fill betanone as 95 **If 2, auto-fill bbdate as 99/99/9999, bbtime as 99:99 and go to betanone**	2 = Beta-blocker not given within 24 hours after hospital arrival or unable to determine from medical record documentation Refer to TJC Appendix C, Table 1.3 or a drug book for a more complete listing of beta-blockers. Answer "1" if an IV beta-blocker (e.g. metoprolol) was given in the ED within 24 hours of arrival.

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
24	bbdate	Enter the date the patient received a beta-blocker	mm/dd/yyyy If beta 24 = 2, will be auto-filled as 99/99/9999 < =24 hrs. after acutedt and < = dcdate	Enter the exact date. Month = 01 or day = 01 is not acceptable.
25	bbtime	Enter the time the patient received a beta-blocker	____ UMT If beta 24 = 2, will be auto-filled as 99:99 < =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.
26	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, 2, 3, 7, 8, 9, 10, 95, 97, 98, 99 Will 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):**

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		7. Heart failure on arrival or within 24 hours after arrival 8. Shock on arrival or within 24 hours after arrival 9. Post-heart transplant patient 10. Severely decompensated heart failure, as evidenced by patient receiving IV dobutamine, milrinone, or nesiritide 95. Not applicable 97. 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 pharmacist 99. No documented reason		• 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"

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
				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.
27	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, 99 If 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.
28	hepdt	Enter the date the patient received heparin	mm/dd/yyyy If hepin24 = 99, will be auto-filled as 99/99/9999 < =24 hrs. after acutedt and < = dcdate	Enter the exact date. Month=01 or day=1 is not acceptable

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29	heptme	Enter the time the patient received heparin	____ UMT If hepin24 = 99, will be auto-filled as 99:99 < =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.
30	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 applicable 97. other reason documented by a physician, APN, PA, or pharmacist 98. Patient refusal of heparin documented by physician/APN/PA or pharmacist 99. No documented reason	1, 2, 3, 4, 5, 6, 7, 8, 95, 97, 98, 99 Will 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.
31	cardseen	Was Cardiology involved in the care of the patient? 1. A cardiologist was the attending physician 3. 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

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				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.**

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32	carddt	Enter the date the patient was first seen by Cardiology or a Cardiology consult first occurred.	mm/dd/yyyy If cardseen = 99, will be auto-filled as 99/99/9999 >= 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.
33	cardtme	Enter the time the patient was first seen by Cardiology or a Cardiology consult first occurred.	____ UMT If cardseen = 99, will be auto-filled as 99:99 >= 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		