DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **STEMI RECEIVING CENTER DATA DICTIONARY** REFERENCE NO. 648

# STEMI Receiving Center Data Dictionary

Los Angeles County

Emergency Medical Services Agency

*EFFECTIVE OCTOBER 2024*

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# TABLE OF CONTENTS

# INCLUSION CRITERIA

# INCLUSION CRITERIA FOR STEMI PATIENTS AND CARDIAC ARREST PATIENTS

1) STEMI and Cardiac Arrest patients from the age of 15 years and older require entry into the SRC Database

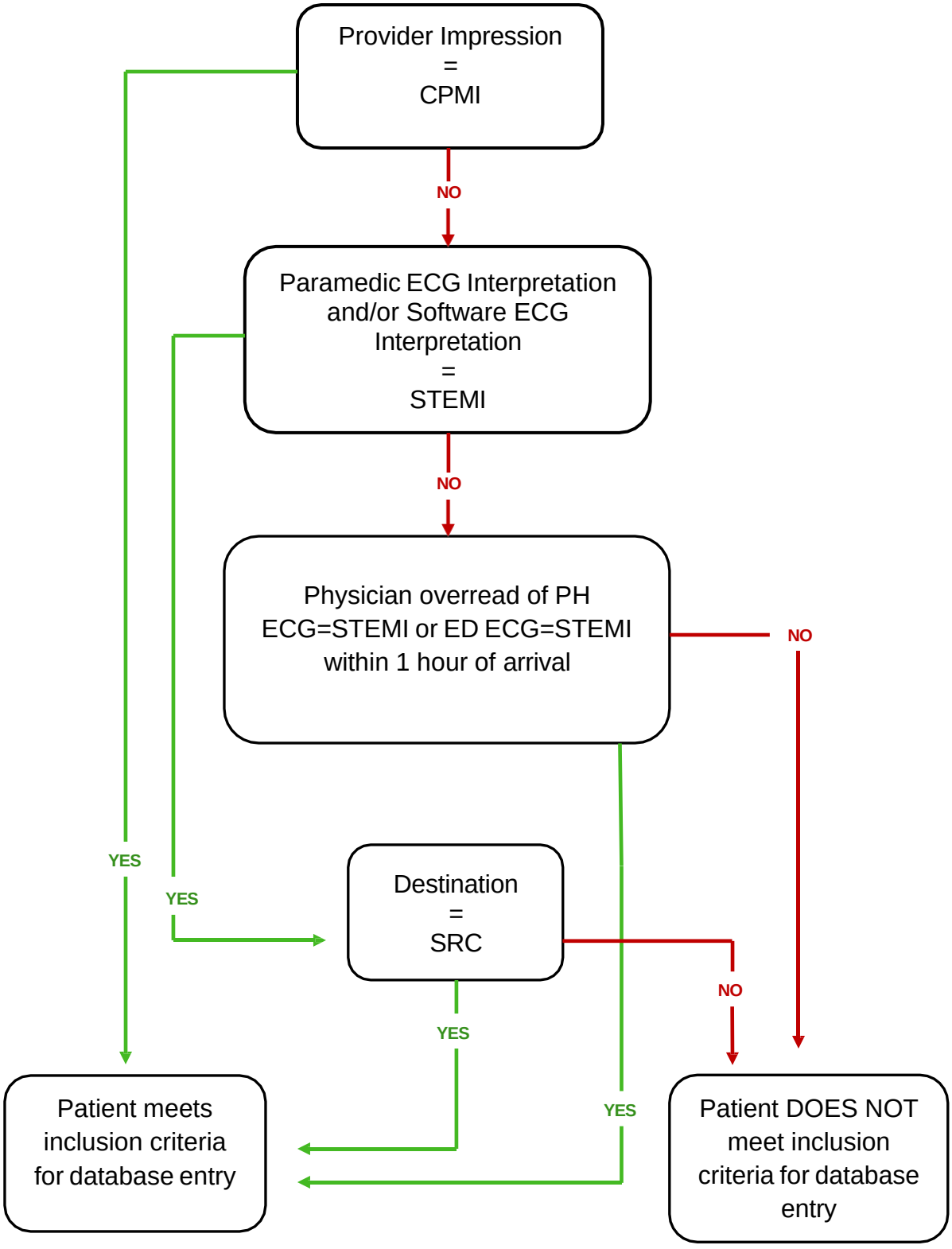
2) STEMI patients need to meet one of the following:
   - **Patients with STEMI identified prehospital by:**
     - Provider Impression of Chest Pain – STEMI (CPMI) **OR**
     - Destination hospital was documented as a STEMI Receiving Center by EMS **AND** Software AND/OR Paramedic ECG interpretation of STEMI
   - **Patients transported by 911 with an ED interpretation of STEMI**:
     - Identified by physician over-read of a prehospital ECG **OR**
     - Identified on the first ED ECG within 1 hour of arrival and no prehospital ECG=STEMI **OR**
     - Identified on a subsequent ED ECG within 1 hour of arrival
   - **ED inter-facility transfer (IFT) to the SRC suspected STEMI to be evaluated for emergent PCI if:**
     - Transported via 911 to the SRF with an ECG identified as a STEMI within one hour of SRF ED arrival **AND/OR**
     - Transported via 911 from the SRF to the SRC

3) Cardiac arrest patients need to meet one of the following:
   - **Patients age 15 years and older with Cardiac Arrest identified prehospital by:**
     - Provider Impression of Cardiac Arrest – Non-Traumatic (CANT) **OR**
     - Patients transported by 9-1-1 with non-traumatic out-of-hospital cardiac arrest (OHCA), where resuscitation is attempted by a 911 Responder (CPR and/or defibrillation), patients that receive an AED shock by a bystander prior to the arrival of 911 responders (with or without return of spontaneous circulation (ROSC) after EMS assessment) **OR**
     - Patient with STEMI complicated by cardiac arrest, with or without ROSC, at any point in the acute phase (prehospital, ED or cath lab)

4) Cardiac Arrest due to hanging and/or drowning is defined as a non-traumatic cardiac arrest by asphyxiation, NOT a traumatic arrest and requires entry into the SRC Database

5) Cardiac Arrest due to electrocution is defined as a non-traumatic cardiac arrest NOT a traumatic arrest and requires entry into the SRC Database

# INCLUSION CRITERIA FOR STEMI PATIENT ALGORITHIM



# INCLUSION CRITERIA FOR ECPR CARDIAC ARREST PATIENTS

1) ECPR patients that require entry into the SRC Database need to meet the cardiac arrest patient inclusion criteria AND one of the following:
    - The patient was routed for ECPR by EMS or by Base Hospital **OR**
    - Patient received emergent ECPR on arrival to SRC

# STEMI?

**Definition**

Patients with a STEMI identified by prehospital Provider Impression of Chest Pain – STEMI (CPMI) or ED ECG of STEMI

**Field Values**

- Yes
- No

**Additional Information**

- Includes one of the following:
    - **Patients with STEMI identified prehospital by:**
        - Provider Impression of Chest Pain – STEMI (CPMI) **OR** Destination hospital was documented as a STEMI Receiving Center by EMS **AND** Software AND/OR Paramedic ECG interpretation of STEMI
    - **Patients transported by 911 with an ED interpretation of STEMI**:
        - Identified by physician over-read of a prehospital ECG **OR**
        - Identified on the first ED ECG within 1 hour of arrival and no prehospital ECG=STEMI **OR**
        - Identified on a subsequent ED ECG within 1 hour of arrival
    - **ED inter-facility transfer (IFT) to the SRC via 911 or other private ALS transport for suspected STEMI to be evaluated for emergent PCI** (includes Nurse Specialty Care Interfacility Transports) **if:**
        - Identified on an ED ECG within 1 hour of arrival to the SRF **AND**
        - Transported via 911 either to the SRF or from the SRF to the SRC

**Uses**

- Identify patients for inclusion
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- SRC Log
- ED Records

# CARDIAC ARREST?

**Definition**

Patients age 15 and older who suffer a non-traumatic OHCA, which includes patients where resuscitation is attempted by a 911 Responder (CPR and/or defibrillation), patients that receive an AED shock by a bystander prior to the arrival of 911 responders (with or without ROSC after EMS assessment), and STEMI patients transported by EMS that are complicated by cardiac arrest at any point in the acute phase (prehospital, ED, or cath lab)

**Field Values**

- Yes
- No

**Additional Information**

- This includes patients in non-acute care facilities (SNF, LTC, etc.)
- 'Bystander' is any person outside of an acute healthcare setting, including personnel working at skilled nursing facilities and other healthcare professionals not in a hospital setting
- This does not include bystander-suspected cardiac arrest where ROSC was achieved without the need for defibrillation or 911 responder CPR
- If EMS does not document PI=CANT or there is no evidence of cardiac arrest (AED defibrillation) prior to EMS arrival, patient should not be entered into the database

**Uses**

- Identify patients for inclusion
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- SRC Log
- ED Records
- Cath Lab Records

# ECPR?

**Definition**

Cardiac Arrest patient that meets the cardiac arrest patient inclusion criteria AND the patient was routed for ECPR by EMS or a Base hospital, OR patient received emergent ECPR on arrival to SRC

**Field Values**

- Yes
- No

**Additional Information:**

- Excludes interfacility transfers for ECMO and ECMO performed inpatient

**Uses**

- Identify patients for inclusion
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- SRC Log
- ED Records
- Cath Lab Records

# GENERAL INFO

# SEQUENCE NUMBER

**Definition**

Unique alphanumeric EMS record number found pre-printed at the top right corner of paper EMS Report Forms, or electronically assigned to electronic patient care records (ePCRs) by the EMS provider's electronic capture device

**Field Values**

- Providers utilizing field electronic data capture devices will have a 12-digit alpha-numeric value, always beginning with the two-letter provider code followed by the two-digit year
- Providers utilizing paper EMS Report Forms will have an 8-digit alpha-numeric value

**Additional Information**

- **REQUIRED** for all records - data entry cannot begin without this number
- If the sequence number is missing or incorrectly documented, every effort must be taken by the SRC to obtain it – by reviewing the patient's medical record, by contacting either the Prehospital Care Coordinator of the applicable base hospital, or the provider who transported the patient. Only after all efforts to obtain the actual sequence number have been exhausted may a request be made of the EMS Agency for assistance, or as a last resort, a 'dummy' sequence number, in a **timely** fashion
- A fictitious sequence number **should not** be generated for any reason

**Uses**

- Unique patient identifier
- Essential link between other EMS Agency databases

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Base Hospital Log
- Fire Station Logs
- SRC Log

# PROVIDER

**Definition**

Two-letter code for the EMS provider primarily responsible for the patient's prehospital care

**Field Values**

| | | | |
|---|---|---|---|
| PUBLIC PROVIDERS | | | |
| AF | Arcadia Fire | LV | La Verne Fire |
| AH | Alhambra Fire | MB | Manhattan Beach Fire |
| AV | Avalon Fire | MF | Monrovia Fire |
| BA | Burbank Airport Fire | MO | Montebello Fire |
| BF | Burbank Fire | MP | Monterey Park Fire |
| BH | Beverly Hills Fire | ND | Not Documented |
| CC | Culver City Fire | OT | Other Provider |
| CF | LA County Fire | PF | Pasadena Fire |
| CG | US Coast Guard | RB | Redondo Beach Fire |
| CI | LA City Fire | SA | San Marino Fire |
| CM | Compton Fire | SG | San Gabriel Fire |
| CS | LA County Sheriff | SI | Sierra Madre Fire |
| DF | Downey Fire | SM | Santa Monica Fire |
| ES | El Segundo Fire | SP | South Pasadena Fire |
| FS | U.S. Forest Service | SS | Santa Fe Springs Fire |
| GL | Glendale Fire | TF | Torrance Fire |
| LB | Long Beach Fire | VE | Ventura County Fire |
| LH | La Habra Heights Fire | WC | West Covina Fire |
| PRIVATE PROVIDERS | | | |
| AA | American Professional Ambulance Corp. | LE | EastWest Protot, Inc. dba Lifeline Ambulance |
| AB | AmbuLife Ambulance, Inc. | LY | Filyn Corporation, dba Lynch |
| AN | Antelope Ambulance Service | MA | Mauran Ambulance Service, Inc. |
| AR | American Medical Response of So. Calif. | MD | MedTrans, Inc. |
| AT | All Town Ambulance, LLC | MI | MedResponse, Inc. |
| AU | AmbuServe, Inc. | MR | MedReach, Inc. dba MedReach Ambulance |
| AW | Amwest, Inc. dba Amwest Ambulance | MU | Mercury Ambulance Services, LLC |
| CA | Falck Mobile Health Corp. dba Care Ambulance | MY | Mercy Air |
| CL | California Medical Response, Inc. dba Cal- Med Ambulance | PE | Premier Medical Transport, Inc. dba Premier Ambulance |
| CO | College Coastal Care, LLC | PN | PRN Ambulance, Inc |
| CW | Citywide Ambulance LLC | RE | REACH Air Medical Service, LLC |
| EA | Emergency Ambulance Service, Incorporated | RR | Rescue Services International, Ltd. dba Medic-1 Ambulance |
| EX | Explorer 1 Ambulance & Medical Services, LLC | RY | Royalty Ambulance Services, Inc. |
| FC | First Rescue Ambulance, Inc. | SO | Symbiosis (Di Biassi) |
| FM | Firstmed Ambulance Services, Inc. | SY | Symons Emergency Specialties, Inc. dba Symbiosis |
| GR | Gentle Ride Ambulance, Inc. | VA | Viewpoint Ambulance, Inc. |
| GU | Guardian Ambulance Service | VI | Vital Care Ambulance |
| HE | Heart Ambulance Corporation | WE | Westcoast Ambulance, Inc. |
| HN | Horizon OC. LLC, dba Horizon OC Ambulance | WM | Westmed Ambulance, Inc. dba McCormick Ambulance |
| JA | Journey via Gurney, LLC., dba Journey Ambulance | ZM | Solartricity dba Zoom Medical Transportation |
| LE | EastWestProto, Inc. dba Lifeline Ambulance | | |

**Uses**

- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form

# ALS UNIT #

**Definition**

Number assigned to the Advanced Life Support (ALS) provider unit that transported the patient

**Field Values**

- Up to five-digit alphabetic and numeric field
- **ND:** Not Documented

**Uses**

- System evaluation and monitoring

**Data Hierarchy**

- EMS Record
- Base Hospital Form
- Base Hospital Log
- SRC Log
- ED Records

# DISPATCH DATE

**Definition**
Date the provider was notified by dispatch of the incident

**Field Values**
- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**
- Establishes care intervals and incident timelines
- System evaluation and monitoring

**Data Source Hierarchy**
- EMS Record

# DISPATCH TIME

**Definition**

Time of day the provider was notified by dispatch of the incident

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND**: Not Documented

**Additional Information**

- Enter the time documented by EMS, even if the time does not align with other times documented in the EMS record
- Enter the earliest dispatch time and if the earliest dispatch time is after the prehospital ECG date/time (and the patient did not come from the clinic, doctor's office, or SRF), please put a comment that the time stamped on the prehospital ECG was before the first dispatch time

**Uses**

- Establishes care intervals and incident timelines
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record

# PATIENT AGE

**Definition**

Numeric value for the age (actual or best approximation) of the patient

**Field Values**

- Up to three-digit numeric value
- **ND:** Not Documented

**Uses**

- Allows for data sorting and tracking by age
- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

**Data Source Hierarchy**

- Facesheet
- ED Records
- History and Physical
- EMS Record
- Base Hospital Form
- Base Hospital Log
- Billing Sheet/Medical Records Coding Summary Sheet
- SRC Log

# PATIENT GENDER

**Definition**

Checkbox indicating the gender of the patient

**Field Values**

- **F:** Female
- **M:** Male
- **N:** Nonbinary

**Additional Information**

- Patients who are undergoing or have undergone a hormonal and/or surgical sex reassignment should be coded using their stated preference
- Patients unable to state their preference should be coded according to best medical observation/judgment

**Uses**

- Assists with patient identification
- Epidemiological statistics
- System evaluation and monitoring

**Data Source Hierarchy**

- Facesheet
- ED Records
- History and Physical
- EMS Record
- Base Hospital Form
- Base Hospital Log
- Billing Sheet/Medical Records Coding Summary Sheet
- SRC Log

# RACE/ETHNICITY

**Definition**

Checkbox indicating the race and/or ethnicity of the patient

**Field Values**

- **A:** Asian/Non-Pacific Islander: person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam
- **B:** Black/African American: person having origins in any of the Black racial groups of Africa (includes Haitians)
- **H:** Latino/Hispanic: person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race
- **N:** Native American/Alaska Native: person having origins in any of the original peoples of North, Central, and South America and who maintains tribal affiliation or community attachment
- **P:** Pacific Islander/Native Hawaiian: person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
- **W:** White: person having origins in any of the original peoples of Europe, the Middle East, or North Africa (e.g., Caucasian, Iranian, White)
- **O:** Other
- **U:** Unknown: race is unknown or not documented

**Additional Information**

- Patient race/ethnicity should be coded as stated by patient or family member
- Select all race/ethnicity field values that apply

**Uses**

- Epidemiological statistics
- System evaluation and monitoring

**Data Source Hierarchy**

- Facesheet
- ED Records
- History and Physical
- Billing Sheet/Medical Records Coding Summary Sheet

# PROVIDER IMPRESSION

**Definition**

Four-letter code(s) representing the paramedic's primary impression of the patient's presentation

**Field Values**

| | | | | | |
|---|---|---|---|---|---|
| **ABOP** | Abdominal Pain/Problems | **DYRX** | Dystonic Reaction | **ODPO** | Overdose/Poisoning/Ingestion |
| **ALOC** | ALOC – Not Hypoglycemia or Seizure | **DYSR** | Cardiac Dysrhythmia | **PALP** | Palpitations |
| **ALRX** | Allergic Reaction | **ELCT** | Electrocution | **PREG** | Pregnancy Complications |
| **ANPH** | Anaphylaxis | **ENTP** | ENT/Dental Emergencies | **PSYC** | Behavioral/Psychiatric Crisis |
| **BRTH** | Childbirth (Mother) | **EXNT** | Extremity Pain/Swelling – Non-Traumatic | **RARF** | Respiratory Arrest/Failure |
| **BPNT** | Body Pain – Non-Traumatic | **EYEP** | Eye Problem – Unspecified | **RDOT** | Resp. Distress/Other |
| **BURN** | Burn | **FAIL** | Medical Device Malfunction – Fail | **SEAC** | Seizure – Active |
| **CHOK** | Airway Obstruction/Choking | **FEVR** | Fever | **SEPI** | Seizure – Postictal |
| **ETOH** | Alcohol Intoxication | **GUDO** | Genitourinary Weakness– Unspecified | **SEPS** | Sepsis |
| **CANT** | Cardiac Arrest– Non-Traumatic | **HEAT** | Hyperthermia | **SHOK** | Shock |
| **CHFF** | Resp. Distress/Pulmonary Edema/CHF | **HOTN** | Hypotension | **SMOK** | Smoke Inhalation |
| **COFL** | Cold/Flu Symptoms | **HPNT** | Head Pain – Non-Traumatic | **SOBB** | Resp. Distress/Bronchospasm |
| **COLD** | Hypothermia/Cold Injury | **HYPO** | Hypoglycemia | **STNG** | Stings/Venomous Bites |
| **COMO** | Carbon Monoxide | **HYPR** | Hyperglycemia | **STRK** | Stroke/CVA/TIA |
| **CPMI** | Chest Pain – STEMI | **HYTN** | Hypertension | **SYNC** | Syncope/Near Syncope |
| **CPNC** | Chest Pain – Non-Cardiac | **INHL** | Inhalation Injury | **TRMA** | Traumatic Injury |
| **CPSC** | Chest Pain – Suspected Cardiac | **LABR** | Pregnancy/Labor | **UPGI** | Upper GI Bleeding |
| **DCON** | HazMat Skin Exposure | **LOGI** | Lower GI Bleeding | **VABL** | Vaginal Bleeding |
| **DIZZ** | Dizziness/Vertigo | **NAVM** | Nausea/Vomiting | **WEAK** | Weakness – General |
| **DRHA** | Diarrhea | **NOBL** | Epistaxis - Nosebleed | | |
| **DRWN** | Submersion/Drowning | **NOMC** | No Medical Complaint | | |

**Additional Information**

- Enter up to two provider impressions, if applicable, by pressing down and holding the "Ctrl" key while making your selections
- Do not enter more than one copy of the same provider impression code

**Uses**

- System evaluation and monitoring
- Epidemiological statistics

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form

# CHIEF COMPLAINT

**Definition**

Two-letter code(s) representing the patient's most significant medical complaints

**Field Values**

| | |
|---|---|
| AP | Abdominal/Pelvic Pain |
| AR | Allergic Reaction |
| AL | Altered Level of Consciousness |
| AE | Apneic Episode |
| EH | Behavioral (abnormal behavior of apparent mental or emotional origin) |
| OS | Bleeding: Other Site (NOT associated with trauma, e.g., dialysis shunt) |
| CA | Cardiac Arrest (NOT associated with trauma) |
| CP | Chest Pain (NOT associated with trauma) |
| CH | Choking/Airway Obstruction |
| CC | Cough/Congestion |
| DC | Device Complaint (associated with existing medical device, e.g., g-tube, AICD, ventilator, etc.) |
| DI | Dizzy (sensation of spinning or feeling off-balance) |
| DY | Dysrhythmia |
| FE | Fever |
| FB | Foreign Body (anywhere in body) |
| GI | Gastrointestinal Bleeding |
| HP | Head Pain (NOT associated with trauma) |
| HY | Hypoglycemia |
| IM | Inpatient Medical Interfacility Transfer (IFT) of an admitted, ill (NOT injured) patient, from one facility to an inpatient bed at another facility, excluding ER To ER transfers |
| LN | Local Neuro signs (e.g., weakness, numbness, paralysis, slurred speech, facial droop, aphasia) |
| NV | Nausea/Vomiting |
| ND | Near-Drowning/Drowning (submersion causing water inhalation, unconsciousness, or death) |
| NB | Neck/Back Pain (NOT associated with trauma) |
| NC | No Medical Complaint, or signs or symptoms of illness (NOT associated with trauma) |
| NO | Nosebleed (NOT associated with trauma) |
| OB | Obstetrics (any complaint possibly related to a known pregnancy, e.g., bleeding, pain, hypertension) |
| OP | Other Pain (pain at site not listed, NOT associated with trauma – e.g., toothache, earache, etc.) |
| OD | Overdose (dose greater than recommended or generally given) |
| PO | Poisoning (ingestion of or contact with a toxic substance) |
| PS | Palpitations |
| RA | Respiratory Arrest (cessation of breathing NOT associated with trauma) |
| SE | Seizure (NOT associated with trauma) |
| SB | Shortness of Breath |
| SY | Syncope |
| VA | Vaginal Bleeding |

| | |
|---|---|
| WE | Weakness |
| OT | Other (signs or symptoms not listed above, NOT associated with trauma) |
| N/D | Not Documented |

**Additional Information**

- Enter up to three complaints, if applicable, by pressing down and holding the “Ctrl” key while making your selections
- Electrical shock, lightning strike, and hanging are mechanisms of injury rather than chief complaints – use “Other” and document the injury description in the comment section of the General Info tab
- Do not enter more than one copy of the same chief complaint code

**Uses**

- System evaluation and monitoring
- Epidemiological statistics

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Base Hospital Log
- SRC Log
- ED Records
- History and Physical

# SRC ED ARRIVAL DATE

**Definition**

Date the patient arrived at the SRC ED

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- If the patient bypassed the ED and was transported directly to the cath lab, enter the cath lab door date

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- SRC Log
- ED Records
- EMS Record
- Other Hospital Records

# SRC ED ARRIVAL TIME

**Definition**

Time of day the patient arrived at the SRC ED

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- If the patient bypassed the ED and was transported directly to the cath lab, enter the cath lab door time

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- SRC Log
- ED Records
- EMS Record
- Other Hospital Records

# ED OUTCOME

**Definition**

Checkbox indicating the disposition of the patient from the emergency department (ED)

**Field Values**

- **DC:** Discharged
- **DE:** Died in ED
- **AD:** Admitted
- **TX:** Transferred to Another Acute Care Facility

**Additional Information**

- If patient died in the ED, ‘ED Pronounced Time’ must have a value

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Hospital Discharge Summary
- ED Records
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

# HOSP. DISCHARGE DATE

**Definition**

Date the patient was discharged from the SRC acute care facility

**Field Values**

- MMDDYYYY
- **ND:** Not Documented

**Additional Information**

- Applicable when the patient:
  - Expires
  - Is discharged
  - Leaves against medical advice (AMA)
  - Leaves without being seen (LWBS) or elopes
  - Is transferred to a rehabilitation, skilled nursing, or hospice unit (at your facility or another facility)
  - Is transferred to an acute inpatient unit at another facility
  - Is transferred to another facility for organ procurement
- Patients with a CPC of 5 who are transferred for organ procurement should be documented as “died” in the Hospital Outcome field and the discharge date should be documented as the date that the patient is transferred to another facility from the SRC for organ procurement

**Uses**

- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

# HOSPITAL OUTCOME

**Definition**

Checkbox indicating whether the patient lived or died during their hospital stay at your facility

**Field Values**

- **L:** Lived
- **CL:** Died in Cath Lab
- **OT:** Died in Other

**Additional Information**

- If patient is considered to have brain death (e.g. candidate for organ procurement), the patient should be entered as:
  - **CL:** Died in Cath Lab or
  - **OT:** Died in Other

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

# ED PRONOUNCED TIME

**Definition**

Time of day patient was pronounced dead at your facility's Emergency Department, if applicable

**Field Values**

- HHMM
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Hospital Discharge Summary
- Billing Sheet/Medical Records Coding Summary Sheet

# DNR STATUS

**Definition**

Field indicating the patient's Do Not Resuscitate (DNR) status

**Field Values**

- **E:** Existing (DNR order in place upon arrival)
- **NE:** New (DNR order written during hospital stay)
- **NO:** None (patient does not have a DNR order)

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- ED Records
- Other Hospital Records
- Progress Notes
- Hospital Discharge Summary

# COMORBIDITIES

**Definition**

Field indicating whether co-morbid conditions or factors were present (check all that apply)

**Field Values**

- **BM:** Body Mass Index greater than 40
- **BP:** Hypertension
- **CD**: Coronary Artery Disease
- **CG:** Prior CABG
- **CH:** Congestive Heart Failure
- **CO:** Chronic Obstructive Pulmonary Disease
- **CS:** Cardiogenic Shock on presentation
- **CV:** Cerebrovascular Disease
- **DM:** Diabetes
- **ES:** End-stage Renal Disease
- **HX:** Family History of Coronary Artery Disease (CAD)
- **HL:** Hyperlipidemia
- **KD:** Chronic Kidney Disease
- **MI:** Prior Myocardial Infarction
- **NO:** None
- **PC:** Prior Percutaneous Coronary Intervention (PCI)
- **PV:** Peripheral Vascular Disease
- **SM:** Smoker - current/recent Tobacco (within 1 year)
- **VF:** Prior VF/VT Arrest
- **ND:** Not Documented
- **OT:** Other

**Additional Information**

- Enter multiple selections, if applicable, by pressing down and holding the “Ctrl” key while making your selections
- If Field Value of OT: Other is selected, a description of OT: Other in the comment section is required
- Body Mass Index is calculated as weight in kg divided by height in meters-squared
- Coronary Artery Disease is defined as patient had known coronary lesions based on a prior catheterization or coronary CT
- Cardiogenic shock is defined as:
    - Sustained (>30 min) episode of systolic blood pressure <90mm Hg **and/or**
    - Cardiac index <2.2L/min/$m^2$ determined to be secondary to cardiac dysfunction **and/or**
    - Requires parenteral inotropic or vasopressor agents **OR**
    - Requires mechanical support (from an IABP, extracorporeal circulation, ventricular assist devices, etc.) to maintain blood pressure and cardiac index above specified levels
- Cerebrovascular disease is defined as history of TIA or stroke

- Chronic Kidney Disease is defined as a history of chronic kidney disease without dialysis
- End-stage renal disease is defined as patient receiving peritoneal or hemodialysis
- Family history of coronary artery disease is defined as a parent or sibling with history of myocardial infarction, PCI and/or CABG
- Prior VF/VT Arrest is defined as a cardiac arrest in the past where the initial rhythm was ventricular fibrillation or ventricular tachycardia

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Hospital Discharge Summary
- Billing Sheet/Medical Records Coding Summary Sheet

# COMMENT TO OTHER

**Definition**

Field provided to specify why “Other” was selected from the Comorbidities field

**Field Values**

- Free-text

**Additional Information**

- Do not enter information into this field unless ‘Comorbidities’ has a Field Value of “Other”

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# HOSP. DISPOSITION

**Definition**

Checkbox indicating the patient's destination upon discharge from the SRC acute care facility

**Field Values**

- **Home:** Home/Previous place of residence
- **SNF:** Extended Care/Skilled Nursing Facility (SNF)
- **Subacute:** Sub-Acute/Transitional Care/Rehabilitation Care Facility
- **Acute:** Other Acute Care Facility
- **Hospice:** Hospice Facility
- **Organ Procurement:** Transferred to other facility for organ procurement
- **Morgue:** Morgue/Mortuary
- **AMA:** Left Against Medical Advice (AMA)/Eloped/Left Without Being Seen (LWBS)
- **Other:** Other

**Additional Information**

- If a patient is discharged home with hospice care, enter "Home"
- If Acute: Other Acute Care Facility is selected, also select the name of the facility listed from the field value list of hospitals
- If a patient was residing in an Extended/Skilled Nursing Facility prior to hospital arrival and is discharged back to the same Extended/Skilled Nursing Facility, enter "Home"

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

# TRANSFER RATIONALE

**Definition**

Checkbox indicating the rationale for transfer of the patient, if applicable

**Field Values**

| | | |
|---|---|---|
| **EC** | Extended Care | Extended Care/Skilled Nursing Facility (SNF)/Long term Care |
| **FI** | Financial | Decision based on financial status (i.e., cash or self-pay, uninsured) |
| **HL** | Higher Level of Care | Patient required higher level of care not available at transferring facility |
| **HS** | Hospice | Patient transferred to hospice |
| **HP** | Health Plan | Health Plan decision |
| **RH** | Rehab | Patient required rehabilitation |
| **OT** | Other | Transfer rationale other than above |

**Additional Information**

- If a patient is discharged home with hospice care, enter “Home”
- If a patient was residing in an Extended/Skilled Nursing Facility prior to hospital arrival and is discharged back to the same Extended/Skilled Nursing Facility, enter “Home”

**Uses**

- Provides documentation of assessment and/or care
- System evaluation and monitoring

**Data Source Hierarchy**

- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

# TRANSFER TO

**Definition**

Three-letter code of the name of facility to which the patient was transferred to upon leaving the SRC, if applicable

**Field Values**

| LOS ANGELES COUNTY 9-1-1 RECEIVING HOSPITALS | | | |
|---|---|---|---|
| ACH | Alhambra Hospital Medical Center | LBM | MemorialCare Long Beach Medical Center |
| AHM | Catalina Island Medical Center | LBV | Veteran's Administration Hospital - Long Beach |
| AMH | USC Arcadia Hospital | LCH | Palmdale Regional Medical Center |
| AVH | Antelope Valley Medical Center | LCM | Providence Little Company of Mary Medical Center Torrance |
| BEV | Adventist Health White Memorial Montebello | LMC | Los Angeles General Medical Center |
| BMC | Southern California Hospital at Culver City | MCP | Mission Community Hospital |
| CAL | Dignity Health - California Hospital Medical Center | MHG | Memorial Hospital of Gardena |
| CHH | Children's Hospital Los Angeles | MLK | Martin Luther King Jr. Community Hospital |
| CHP | Community Hospital of Huntington Park | MPH | Monterey Park Hospital |
| CNT | Centinela Hospital Medical Center | NOR | Norwalk Community Hospital |
| CPM | Coast Plaza Hospital | NRH | Dignity Health - Northridge Hospital Medical Center |
| CSM | Cedars-Sinai Medical Center | OTH | Other (FACILITY NOT LISTED) |
| DCH | PIH Health Downey Hospital | OVM | Olive View - UCLA Medical Center |
| DFM | Cedars-Sinai Marina Del Rey Hospital | PAC | Pacifica Hospital of the Valley |
| DHL | UCI Health-Lakewood | PIH | PIH Health Whittier Hospital |
| ELA | East Los Angeles Doctors Hospital | PLB | College Medical Center |
| ENH | Encino Hospital Medical Center | PVC | Pomona Valley Hospital Medical Center |
| FPH | Emanate Health Foothill Presbyterian Hospital | QOA | Hollywood Presbyterian Medical Center |
| GAR | Garfield Medical Center | QVH | Emanate Health Queen of the Valley Hospital |
| GEM | Greater El Monte Community Hospital | SDC | San Dimas Community Hospital |
| GMH | Dignity Health - Glendale Memorial Hospital and Health Center | SFM | St. Francis Medical Center |
| GSH | PIH Health Good Samaritan Hospital | SGC | San Gabriel Valley Medical Center |
| GWT | Adventist Health Glendale | SJH | Providence Saint John's Health Center |
| HBC | Hyperbaric Chamber (NON-BASIC) | SJS | Providence Saint Joseph Medical Center |
| HCH | Providence Holy Cross Medical Center | SMH | Santa Monica - UCLA Medical Center and Orthopaedic Hospital |
| HGH | Harbor-UCLA Medical Center | SMM | Dignity Health - St. Mary Medical Center |
| HMH | Huntington Hospital | SOC | Sherman Oaks Hospital |
| HMN | Henry Mayo Newhall Hospital | SPP | Providence Little Company of Mary Medical Center San Pedro |
| HWH | UCLA West Valley Medical Center | TOR | Torrance Memorial Medical Center |
| ICH | Emanate Health Inter-Community Hospital | TRM | Providence Cedars-Sinai Tarzana Medical Center |
| KFA | Kaiser Foundation Hospital - Baldwin Park | UCL | Ronald Reagan UCLA Medical Center |
| KFB | Kaiser Foundation Hospital - Downey | VHH | USC Verdugo Hills Hospital |

| | | | |
|---|---|---|---|
| KFH | Kaiser Foundation Hospital - South Bay | VPH | Valley Presbyterian Hospital |
| KFL | Kaiser Foundation Hospital – Los Angeles | WHH | Whittier Hospital Medical Center |
| KFO | Kaiser Foundation Hospital - Woodland Hills | WMH | Adventist Health - White Memorial |
| KFP | Kaiser Foundation Hospital - Panorama City | WVA | Wadsworth VA Medical Center |
| KFW | Kaiser Foundation Hospital - West Los Angeles | | |

| **ORANGE COUNTY 9-1-1 RECEIVING HOSPITALS** | | | |
|---|---|---|---|
| ANH | AHMC Anaheim Regional Medical Center | LPI | La Palma Intercommunity Hospital |
| CHO | Children's Hospital of Orange County | PLH | Placentia-Linda Hospital |
| FHP | Fountain Valley Regional Hospital | SJD | St. Jude Medical Center |
| KHA | Kaiser Foundation Hospital - Anaheim | UCI | University of California, Irvine Medical Center |
| KFI | Kaiser Foundation Hospital - Irvine | WMC | Orange County Global Medical Center |
| LAG | UCI Health-Los Alamitos | | |
| **SAN BERNARDINO COUNTY 9-1-1 RECEIVING HOSPITALS** | | | |
| ARM | Arrowhead Regional Medical Center | KFN | Kaiser Foundation Hospital - Ontario |
| CHI | Chino Valley Medical Center | LLU | Loma Linda University Medical Center |
| DHM | Montclair Hospital Medical Center | SAC | San Antonio Regional Hospital |
| KFF | Kaiser Foundation Hospital - Fontana | | |
| **OTHER COUNTY 9-1-1 RECEIVING HOSPITALS** | | | |
| LRR | Los Robles Regional Medical Center (Ventura) | SIM | Adventist Health Simi Valley (Ventura) |
| RCC | Ridgecrest Regional Hospital (Kern) | SJO | Saint John's Regional Medical Center (Ventura) |

**Uses**

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- SRC Progress Notes
- Other Hospital Records

# COMMENT

**Definition**

Field provided to document relevant information regarding the patient's care, not already captured by a defined data field

**Field Values**

- Free-text

**Uses**

- Assists with determination of appropriate treatment and transport destination and rationale
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Notes
- Progress Notes
- Other Hospital Records

# SRC

# EARLIEST REPORTED SYMPTOM ONSET DATE

**Definition**

Date when the patient first noted to have symptoms lasting longer than ten minutes

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Additional Information**

- If symptoms are intermittent, symptom onset can be determined by when the symptoms became constant in quality or intensity
- Symptoms may include jaw pain, arm pain, shortness of breath, nausea, vomiting, fatigue/malaise, or other symptoms suggestive of a myocardial infarction

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of assessment
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- EMS Record
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records

# EARLIEST REPORTED SYMPTOM ONSET TIME

**Definition**

Time of day when the patient first noted to have symptoms lasting longer than ten minutes

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- If symptom onset time is not specified, it may be recorded as:
  - 0700 for morning
  - 1200 for lunchtime
  - 1500 for afternoon
  - 1800 for dinnertime
  - 2200 for evening
  - 0300 if awakened from sleep

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of assessment
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- EMS Record
- Base Hospital Form
- Physician’s Office/Clinic/Urgent Care Records

# TRANSFER?

**Definition**

Checkbox indicating whether the patient was transferred to the SRC from another acute care facility

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- SRC Log
- ED Records

# TRANSFERRING FACILITY

**Definition**

Three-letter code of the facility from which the patient was transferred, if applicable

**Field Values**

| **LOS ANGELES COUNTY 9-1-1 RECEIVING HOSPITALS** | | | |
|---|---|---|---|
| ACH | Alhambra Hospital Medical Center | LBM | MemorialCare Long Beach Medical Center |
| AHM | Catalina Island Medical Center | LBV | Veteran's Administration Hospital - Long Beach |
| AMH | USC Arcadia Hospital | LCH | Palmdale Regional Medical Center |
| AVH | Antelope Valley Medical Center | LCM | Providence Little Company of Mary Medical Center Torrance |
| BEV | Adventist Health White Memorial Montebello | LMC | Los Angeles General Medical Center |
| BMC | Southern California Hospital at Culver City | MCP | Mission Community Hospital |
| CAL | Dignity Health - California Hospital Medical Center | MHG | Memorial Hospital of Gardena |
| CHH | Children's Hospital Los Angeles | MLK | Martin Luther King Jr. Community Hospital |
| CHP | Community Hospital of Huntington Park | MPH | Monterey Park Hospital |
| CNT | Centinela Hospital Medical Center | NOR | Norwalk Community Hospital |
| CPM | Coast Plaza Hospital | NRH | Dignity Health - Northridge Hospital Medical Center |
| CSM | Cedars-Sinai Medical Center | OTH | Other (FACILITY NOT LISTED) |
| DCH | PIH Health Downey Hospital | OVM | Olive View - UCLA Medical Center |
| DFM | Cedars-Sinai Marina Del Rey Hospital | PAC | Pacifica Hospital of the Valley |
| DHL | UCI Health-Lakewood | PIH | PIH Health Whittier Hospital |
| ELA | East Los Angeles Doctors Hospital | PLB | College Medical Center |
| ENH | Encino Hospital Medical Center | PVC | Pomona Valley Hospital Medical Center |
| FPH | Emanate Health Foothill Presbyterian Hospital | QOA | Hollywood Presbyterian Medical Center |
| GAR | Garfield Medical Center | QVH | Emanate Health Queen of the Valley Hospital |
| GEM | Greater El Monte Community Hospital | SDC | San Dimas Community Hospital |
| GMH | Dignity Health - Glendale Memorial Hospital and Health Center | SFM | St. Francis Medical Center |
| GSH | PIH Health Good Samaritan Hospital | SGC | San Gabriel Valley Medical Center |
| GWT | Adventist Health Glendale | SJH | Providence Saint John's Health Center |
| HBC | Hyperbaric Chamber (NON-BASIC) | SJS | Providence Saint Joseph Medical Center |
| HCH | Providence Holy Cross Medical Center | SMH | Santa Monica - UCLA Medical Center and Orthopaedic Hospital |
| HGH | Harbor-UCLA Medical Center | SMM | Dignity Health - St. Mary Medical Center |
| HMH | Huntington Hospital | SOC | Sherman Oaks Hospital |
| HMN | Henry Mayo Newhall Hospital | SPP | Providence Little Company of Mary Medical Center San Pedro |
| HWH | UCLA West Valley Medical Center | TOR | Torrance Memorial Medical Center |
| ICH | Emanate Health Inter-Community Hospital | TRM | Providence Cedars-Sinai Tarzana Medical Center |
| KFA | Kaiser Foundation Hospital - Baldwin Park | UCL | Ronald Reagan UCLA Medical Center |
| KFB | Kaiser Foundation Hospital - Downey | VHH | USC Verdugo Hills Hospital |
| KFH | Kaiser Foundation Hospital - South Bay | VPH | Valley Presbyterian Hospital |
| KFL | Kaiser Foundation Hospital – Los Angeles | WHH | Whittier Hospital Medical Center |
| KFO | Kaiser Foundation Hospital - Woodland Hills | WMH | Adventist Health - White Memorial |

| | | | |
|---|---|---|---|
| KFP | Kaiser Foundation Hospital - Panorama City | WVA | Wadsworth VA Medical Center |
| KFW | Kaiser Foundation Hospital - West Los Angeles | | |

| **ORANGE COUNTY 9-1-1 RECEIVING HOSPITALS** | | | |
|---|---|---|---|
| ANH | AHMC Anaheim Regional Medical Center | LPI | La Palma Intercommunity Hospital |
| CHO | Children's Hospital of Orange County | PLH | Placentia-Linda Hospital |
| FHP | Fountain Valley Regional Hospital | SJD | St. Jude Medical Center |
| KHA | Kaiser Foundation Hospital - Anaheim | UCI | University of California, Irvine Medical Center |
| KFI | Kaiser Foundation Hospital - Irvine | WMC | Orange County Global Medical Center |
| LAG | UCI Health-Los Alamitos | | |
| **SAN BERNARDINO COUNTY 9-1-1 RECEIVING HOSPITALS** | | | |
| ARM | Arrowhead Regional Medical Center | KFN | Kaiser Foundation Hospital - Ontario |
| CHI | Chino Valley Medical Center | LLU | Loma Linda University Medical Center |
| DHM | Montclair Hospital Medical Center | SAC | San Antonio Regional Hospital |
| KFF | Kaiser Foundation Hospital - Fontana | | |
| **OTHER COUNTY 9-1-1 RECEIVING HOSPITALS** | | | |
| LRR | Los Robles Regional Medical Center (Ventura) | SIM | Adventist Health Simi Valley (Ventura) |
| RCC | Ridgecrest Regional Hospital (Kern) | SJO | Saint John's Regional Medical Center (Ventura) |

**Uses**

- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- SRC Log
- SRC ED Records
- SRC Progress Notes

# SRF ED ARRIVAL DATE

**Definition**

Date the patient arrived at the STEMI Referral Facility (SRF) ED

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- SRF Facesheet
- SRF Records
- EMS Record
- SRC Log
- SRC ED Records
- Other SRC Hospital Records

# SRF ED ARRIVAL TIME

**Definition**

Time of day the patient arrived at the SRF ED

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- SRF Facesheet
- SRF Records
- EMS Record
- SRC Log
- SRC ED Records
- Other SRC Hospital Records

# 1st SRF ED ECG DATE

**Definition**

Date the initial ECG was performed at the STEMI Referral Facility (SRF) ED

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- SRF Facesheet
- SRF Records
- EMS Record
- Other SRC Hospital Records

# 1st SRF ED ECG TIME

**Definition**
Time of day the initial ECG was performed at the SRF ED

**Field Values**
- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Uses**
- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**
- SRF Facesheet
- SRF Records
- EMS Record

# NON-SYSTEM DELAYS TO SRF ECG?

**Definition**

Checkbox indicating whether there were patient-related delays to performing SRF ED ECG

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# DELAYS TO SRF ED ECG

**Definition**

Checkbox indicating patient-related delays to performing SRF ED ECG

**Field Values**

- **CA:** Cardiac Arrest
- **IN:** Intubation Required

**Additional Information**

- Select Cardiac Arrest if the patient was in cardiac arrest with ongoing resuscitation in the SRF ED
- Select Intubation for the patient who required emergent intubation on arrival to the SRF ED
- Field allows multiple field value selections. Select all field values that apply
- Enter multiple selections, if applicable, by pressing and holding the “Ctrl” key while making your selections

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# 1st SRF STEMI ECG DATE

**Definition**

Date the first ECG performed at the SRF was interpreted as STEMI

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- SRF ED Records
- SRF Progress Notes
- SRF ECG Tracing
- EMS Record
- Base Hospital Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records

# 1st SRF STEMI ECG TIME

**Definition**

Time of day the first ECG performed at the SRF was interpreted as STEMI

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- SRF ED Records
- SRF Progress Notes
- SRF ECG Tracing
- EMS Record
- Base Hospital Form
- SRC Log
- SRC ED Records
- Other SRC Hospital Records

# SRF ED DEPARTURE DATE

**Definition**

Date the patient left the SRF ED en route to the SRC ED

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- SRF Facesheet
- SRF Records
- EMS Record
- SRC Log
- SRC ED Records
- Other SRC Hospital Records

# SRF ED DEPARTURE TIME

**Definition**

Time of day the patient left the SRF en route to the SRC ED

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- If departure time is not documented by the SRF, it is acceptable to use the departure time (‘Left’ time) documented by the medic on the EMS record

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- SRF Facesheet
- SRF ED Records
- EMS Record
- SRC Log
- SRC ED Records
- Other SRC Hospital Records

# PREHOSPITAL ECG PERFORMED?

**Definition**

Checkbox indicating whether an ECG was performed by EMS Personnel, Physician's Office, Clinic or Urgent Care prior to the patient's arrival at the SRC ED

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- SRC Log
- ED Records
- Progress Notes

# 1st PREHOSPITAL ECG DATE

**Definition**

Date of the first ECG performed by EMS Personnel, Physician's Office, Clinic or Urgent Care prior to the patient's arrival at the SRC ED

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Additional Information**

- Enter the date of the first ECG performed, regardless of impression

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- SRC Log
- ECG Tracing
- ED Records
- Progress Notes

# 1st PREHOSPITAL ECG TIME

**Definition**

Time of day of the first ECG performed by EMS Personnel, Physician's Office, Clinic or Urgent Care prior to the patient's arrival at the SRC ED

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- Enter the time of the first ECG performed, regardless of impression
- Enter the time documented by EMS, even if the time does not align with other times documented in the EMS record

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- SRC Log
- ECG Tracing
- ED Records
- Progress Notes

# 1st PREHOSPITAL ECG PERFORMED BY

**Definition**

Checkbox indicating who performed the first ECG prior to the patient's arrival at the SRC ED

**Field Values**

- **EMS:** EMS Personnel
- **Clinic:** Physician's office, clinic, urgent care, other facility where medical care provided, etc.
- **ND:** Not Documented

**Additional Information**

- Enter the information from the first ECG performed, regardless of impression

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- ED Records
- Progress Notes

# PRE-HOSPITAL ECG=STEMI?

**Definition**

Checkbox indicating whether any of the ECGs performed prior to the patient's arrival at the SRC ED had an interpretation of STEMI

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- ED Records
- Progress Notes

# 1st PREHOSPITAL STEMI ECG DATE

**Definition**

Date of the first ECG performed prior to the patient's arrival at the SRC ED that was interpreted as STEMI

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- SRC Log
- ECG Tracing
- ED Records
- Progress Notes

# 1st PREHOSPITAL STEMI ECG TIME

**Definition**

Time of day of the first ECG performed prior to the patient's arrival at the SRC ED that was interpreted as STEMI, if applicable

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- Enter the time documented by EMS, even if the time does not align with other times documented in the EMS record

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- Physician's Office/Clinic/Urgent Care Records
- SRC Log
- ECG Tracing
- ED Records
- Progress Notes

# SOFTWARE INTERPRETED STEMI?

**Definition**

Checkbox indicating whether STEMI was interpreted by prehospital equipment software

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Additional Information**

- Indicate yes if the software interpretation is ***MEETS ST ELEVATION MI CRITERIA*** (Physio-Control) or ***STEMI*** (Zoll) or other manufacturer equivalent

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ECG Tracing
- ED Records

# EMS INTERPRETED STEMI?

**Definition**

Checkbox indicating whether STEMI was identified by EMS interpretation of the ECG

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Additional Information**

- Indicate yes if there is an EMS interpretation of STEMI with 1-2 mm of ST Elevation in two (2) contiguous leads

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ECG Tracing
- ED Records

# WAS THE PREHOSPITAL ECG RECEIVED PRIOR TO PATIENT ARRIVAL?

**Definition**

Checkbox indicating whether a transmitted copy of the prehospital ECG was received by the SRC ED prior to the patient's arrival

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ECG Receiving Equipment (Cloud/Xchanger/Email/Fax)
- SRC Log
- ED Records

# PREHOSPITAL ECG RECEIVED DATE

**Definition**

Date the prehospital ECG was received by your facility's ECG receiving equipment

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Additional Information**

- ECG receiving equipment includes the Cloud, Xchanger, email (Gmail, etc.), or fax
- Enter "ND" if the prehospital ECG was not received by your facility's ECG receiving equipment

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ECG Receiving Equipment
- SRC Log
- ED Records

# PREHOSPITAL ECG RECEIVED TIME

**Definition**

Time of day the prehospital ECG was received by your facility's ECG receiving equipment

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- ECG receiving equipment includes the Cloud, Xchanger, email (Gmail, etc.), or fax
- Enter "ND" if the prehospital ECG was not received by your facility's ECG receiving equipment

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ECG Receiving Equipment
- SRC Log
- ED Records

# WAS THE PREHOSPITAL ECG REVIEWED BY THE ED MD?

**Definition**

Checkbox indicating whether a transmitted copy of the prehospital ECG was reviewed by the SRC ED MD prior to the patient's arrival

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- SRC Log
- ED Records

# ED MD PREHOSPITAL ECG REVIEW DATE

**Definition**

Date the prehospital ECG was reviewed by the SRC ED MD

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Additional Information**

- Enter “ND” if the prehospital ECG was not reviewed by the SRC ED MD

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- SRC Log
- ED Records

# ED MD PREHOSPITAL ECG REVIEW TIME

**Definition**

Time of day the prehospital ECG was reviewed by the SRC ED MD

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- Enter “ND” if the prehospital ECG was not reviewed by the SRC ED MD

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- 
- SRC Log
- ED Records

# SRC ED ECG PERFORMED?

**Definition**

Checkbox indicating whether an ECG was performed in the SRC ED

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

# INITIAL SRC ED ECG DATE

**Definition**

Date the initial ECG was performed at the SRC ED

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Additional Information**

- Enter the date of the first ECG performed at the SRC ED, regardless of impression

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

# INITIAL SRC ED ECG TIME

**Definition**

Time of day the initial ECG was performed at the SRC ED

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- Enter the time of the first ECG performed at the SRC ED, regardless of impression

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

# NON-SYSTEM DELAYS TO SRC ECG?

**Definition**

Checkbox indicating whether there were patient-related delays to performing SRC ED ECG

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# DELAYS TO SRC ED ECG

**Definition**

Checkbox indicating patient-related delays to performing SRC ED ECG

**Field Values**

- **CA:** Cardiac Arrest
- **Intubation:** Intubation Required

**Additional Information**

- Select Cardiac Arrest if the patient was in cardiac arrest with ongoing resuscitation in the SRC ED
- Select Intubation for the patient who required emergent intubation on arrival to the SRC ED
- Field allows multiple field value selections. Select all field values that apply
- Enter multiple selections, if applicable, by pressing and holding the “Ctrl” key while making your selections

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# STEMI IDENT. ON INITIAL SRC ED ECG?

**Definition**

Checkbox indicating whether the initial ECG performed at the SRC ED had a physician interpretation of STEMI

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

# STEMI IDENT. ON SUBSEQUENT SRC ED ECG?

**Definition**

Checkbox indicating whether a subsequent ECG performed at the SRC ED had a physician interpretation of STEMI

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Additional Information**

- Only enter a value when the initial SRC ED ECG is negative for STEMI and there is a repeat ECG positive for STEMI

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

# SUBSEQUENT SRC ED STEMI ECG DATE

**Definition**

Date that a subsequent ECG performed at the SRC ED had a physician interpretation of STEMI

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Additional Information**

- Only enter the date of the subsequent SRC ED ECG when the initial SRC ED ECG is negative for STEMI and there is a repeat ECG positive for STEMI

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

# SUBSEQUENT SRC ED STEMI ECG TIME

**Definition**

Time of day that a subsequent ECG performed at the SRC ED had a physician interpretation of STEMI

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- Only enter the time of the subsequent SRC ED ECG when the initial SRC ED ECG is negative for STEMI and there is a repeat ECG positive for STEMI

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ECG Tracing
- ED Records
- Progress Notes
- Other Hospital Records

# SRC ED SBP

**Definition**

Patient's initial SRC ED systolic blood pressure (SBP)

**Field values**

- Up to three-digit numeric field

**Additional Information**

- Value cannot be greater than 300
- If the patient bypassed the ED and was transported directly to the cath lab, enter the initial cath lab SBP

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Cath Lab Report
- Other Hospital Records

# SRC ED HR

**Definition**

Patient's initial SRC ED heart rate (HR)

**Field values**

- Up to three-digit numeric field

**Additional Information**

- If the patient bypassed the ED and was transported directly to the cath lab, enter the initial cath lab HR

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Cath Lab Report
- Other Hospital Records

# ELEVATED TROPONIN?

**Definition**

Checkbox indicating whether the troponin level was elevated above lab threshold within the first 24 hours from SRC ED arrival

**Field Values**

- **Y:** Yes
- **N:** No
- **D:** Not Drawn

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Lab Records
- Progress Notes
- Other Hospital Records
- ED Records

# PEAK TROPONIN VALUE

**Definition**

The highest troponin value resulted within the first 24 hours from SRC ED arrival

**Field Values**

- Up to seven-digit numeric value

**Additional Information**

- Include decimals when indicated

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Lab Records
- Progress Notes
- Other Hospital Records
- ED Records

# PEAK TROPONIN VALUE UNITS

**Definition**

The units associated with the highest troponin value resulted within the first 24 hours from SRC ED arrival

**Field Values**

- **ngmL:** ng/mL
- **ngL:** ng/L
- **pgmL:** pg/mL

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Lab Records
- Progress Notes
- Other Hospital Records
- ED Records

# FIBRINOLYTIC INFUSION?

**Definition**

Checkbox indicating whether the patient received a fibrinolytic infusion at the SRF or SRC ED as an urgent treatment for a STEMI

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Additional Information:**

- Do not include the fibrinolytics used during percutaneous intervention (PCI)

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Medication Records
- ED Records
- Progress Notes
- Other Hospital Records

# FIBRINOLYTIC INFUSION DATE

**Definition**

Date patient received a fibrinolytic infusion at the SRF or SRC ED, if applicable

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- SRF Records
- Medication Records
- ED Records
- Progress Notes
- Other Hospital Records

# FIBRINOLYTIC INFUSION TIME

**Definition**

Time of day the patient received a fibrinolytic infusion at the SRF or SRC ED, if applicable

**Field Values**

- Collected as HHMM
- Use 24-hr clock
- **ND:** Not Documented

**Additional Information**

- Enter the time the infusion began

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- SRF Records
- Medication Records
- ED Records
- Progress Notes
- Other Hospital Records

# CL ACTIVATED FROM PRE-SRC OR SRC ED?

**Definition**

Checkbox indicating whether the cath lab (CL) team was activated from pre-SRC or SRC ED

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Additional Information**

- Enter “No” if the patient was routed to the CL from an inpatient bed

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Pager
- ED Records
- SRC Log
- Progress Notes
- Other Hospital Records

# REASON CL NOT ACTIVATED

**Definition**

Checkbox indicating the primary reason why the CL team was not activated from pre-SRC or SRC ED

**Field Values**

- **MD Interpret.**: Physician Interpretation is not a STEMI
- **Vasospasm:** Vasospasm
- **DNR:** DNR
- **Refused:** Patient refused
- **Expired:** Patient expired
- **Other:** Other
- **ND:** Not Documented

**Additional Information**

- MD Interpretation includes a review of the ECG by the ED Physician or Cardiologist and it is determined that the ECG does not show ST elevation
- If “Other” is marked, must document reason in ‘Comment to Other’ field

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- SRC Log
- Progress Notes
- Other Hospital Records

# COMMENT TO OTHER

**Definition**

Field provided to specify why “Other” was selected as the primary reason why the CL team was not activated

**Field Values**

- Free-text

**Additional Information**

- Do not enter information into this field unless ‘Reason CL Not Activated’ has a value of “Other”

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# DIAGNOSIS AT DISCHARGE

**Definition**

Checkbox indicating whether any of the below diagnoses were included in the list of final diagnoses for the patient

**Field Values**

- **STEMI:** STEMI
- **NSTEMI:** NSTEMI
- **Neither:** Neither

**Additional Information**

- Patients with a final diagnosis of STEMI would have any of the following ICD-10 codes (and their sub lists, if applicable):
  - I21.0
  - I21.1
  - I21.2
  - I21.3
  - I22.0
  - I22.1
  - I22.8
  - I22.9
- Patients with a final diagnosis of NSTEMI would have any of the following ICD-10 codes (and their sub lists, if applicable):
  - I21.4
  - I22.2

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- SRC Log
- Progress Notes
- Other Hospital Records

# CL

# PT LOCATION WHEN CL ACTIVATED

**Definition**

Patient's location when the CL team was activated

**Field Values**

- **Pre-SRC:** Pre-SRC
- **SRC:** SRC ED
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- SRC Log
- Cath Lab Report
- EMS Record

# CL ACTIVATION DATE

**Definition**

Date the CL team was activated

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Additional Information**

- If the CL activation was cancelled and then re-activated, enter the date it was re-activated

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Pager
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Records

# CL ACTIVATION TIME

**Definition**

Time of day the CL team was activated

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- If the CL activation was cancelled and then re-activated, enter the time it was re-activated

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Pager
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports

# DID THE PATIENT GO TO THE CATH LAB?

**Definition**

Checkbox indicating whether the patient went to the cath lab

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports

# REASON PT DID NOT GO TO CL

**Definition**

Checkbox indicating the primary reason why the patient was not transported to the cath lab directly from the field or ED

**Field Values**

- **MD Interpret.**: Physician Interpretation is not a STEMI
- **Age:** Age
- **Allergy:** Allergic to contrast
- **CL Not Avail:** Cath lab not available
- **DNR:** DNR
- **Co-morbid:** Co-morbidities
- **Multi-vessel:** Known multi-vessel disease
- **CABG:** CABG (candidate or recent surgery)
- **Vasospasm:** Vasospasm
- **Refused:** Patient refused
- **Expired:** Patient expired
- **Other:** Other
- **ND:** Not documented

**Additional Information**

- MD Interpretation includes a review of the ECG by the ED Physician or Cardiologist and it is determined that the ECG does not show ST elevation
- If “Other” is marked, must document reason in ‘Comment to Other’ field

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report
- Progress Notes
- ED Records

# COMMENT TO OTHER

**Definition**

Field provided to specify why “Other” was selected as the primary reason why patient did not go to cath lab directly from the field or ED

**Field Values**

- Free- text

**Additional Information**

- Do not enter information into this field unless ‘Reason Pt Did Not Go to CL’ has a value of “Other”

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report
- Progress Notes
- ED Records

# LOCATION OF PATIENT WHEN ROUTED TO CATH LAB

**Definition**

Patient's location when directed to the cath lab

**Field Values**

- **E:** SRC ED
- **P:** Pre-SRC
- **I:** Inpatient

**Additional Information**

- Enter "SRC ED" if the patient was transported to the cath lab from the SRC ED
- Enter "Pre-SRC" if the patient was transported directly to the cath lab by EMS and did not stop in the SRC ED
- Enter "Inpatient" if the patient was transported to the cath lab from an inpatient bed within 24 hours of hospital admission (time that admitting orders were placed)

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports

# CL ARRIVAL DATE

**Definition**

Date patient arrived in the cath lab

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# CL ARRIVAL TIME

**Definition**

Time of day patient arrived in the cath lab

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# CATH STATUS

**Definition**

Checkbox indicating the urgency of the primary diagnostic catheterization

**Field Values**

- **E:** Emergent
- **U:** Urgent
- **S:** Salvage

**Additional Information**

- Emergent: there is a concern for ongoing STEMI
- Urgent: inpatient procedure prior to discharge, includes non-salvage catheterization following ROSC
- Salvage: last resort to save the patient's life, defined by the presence of **at least** one of the following:
    - The patient is in cardiogenic shock at the start of the procedure **OR**
    - The patient has received chest compressions within ten minutes of the start of the procedure **OR**
    - The patient was on unanticipated extracorporeal support

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report
- Progress Notes

# ARTERIAL ACCESS SITE

**Definition**

Checkbox indicating the location used to gain vascular access for catheterization

**Field Values**

- **F:** Femoral only
- **B:** Brachial only
- **R:** Radial only
- **FB:** Femoral then Brachial
- **FR:** Femoral then Radial
- **BF:** Brachial then Femoral
- **RF:** Radial then Femoral
- **RB:** Radial then Brachial
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# PCI PERFORMED?

**Definition**

Checkbox indicating whether a PCI, or placement of a device for the purpose of mechanical coronary revascularization, was performed

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# PCI PROCEDURE PERFORMED

**Definition**

Checkbox indicating which type of PCI, or placement of a device for the purpose of mechanical coronary revascularization, was performed

**Field Values**

- **Wire:** Guidewire
- **Thrombectomy:** Mechanical Thrombectomy
- **Balloon:** Balloon Angioplasty
- **Stent:** Cardiac Stent Placed
- **OT:** Other

**Additional Information**

- Field allows multiple field value selections. Select all field values that apply
- Enter multiple selections, if applicable, by pressing and holding the “Ctrl” key while making your selections

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# REASON PCI NOT PERFORMED

**Definition**

Checkbox indicating the primary reason why PCI was not performed

**Field Values**

- **CABG:** Candidate for CABG
- **No Access:** Unable to Gain Vascular Access
- **Lesion Unable:** Unable to Cross Lesion
- **Multi-vessel:** Multi-Vessel Disease
- **No Lesions:** No Lesions Found/Normal Coronaries
- **Expired:** Patient Expired in Cath Lab
- **Takotsubo:** Takotsubo Syndrome
- **Spasm:** Vessel Spasm
- **Other:** Other
- **ND:** Not Documented

**Additional Information**

- If “Other” is marked, must document reason in ‘Comment to Other’ field

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# COMMENT TO OTHER

**Definition**

Field provided to specify why “Other” was selected as the primary reason why PCI was not performed

**Field Values**

- Free- text

**Additional Information**

- Do not enter information into this field unless ‘Reason PCI Not Performed’ has a value of “Other”

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# PCI DATE

**Definition**

Date PCI was performed

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Additional Information**

- Use the date that the first device (excluding guidewire) intervened at the culprit lesion during the first PCI only

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# PCI TIME

**Definition**

Time of day PCI was performed

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- Use the time that the first device (excluding guidewire) intervened at the culprit lesion during the first PCI only
-

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# NON-SYSTEM DELAYS TO PCI?

**Definition**

Checkbox indicating whether there were patient-related delays to performing PCI

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# DELAYS TO PCI

**Definition**

Checkbox indicating patient-related delays to performing PCI

**Field Values**

- **Access:** Difficulty Obtaining Vascular Access
- **CA:** Cardiac Arrest
- **Consent:** Consent Delay
- **EC:** Extracorporeal Membrane Oxygenation
- **IA:** Intra Aortic Balloon Pump
- **IM:** Impella Ventricular Support System
- **Intubation:** Intubation Required
- **Lesion:** Difficulty Crossing Lesion
- **Other:** Other
- **ND:** Not Documented

**Additional Information**

- If there is a change in approach, select “Access: Difficulty Obtaining Vascular Access”
- If “Other” is marked, must document reason in ‘Comment to Other’ field
- Enter multiple selections, if applicable, by pressing and holding the “Ctrl” key while making your selections

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# COMMENT TO OTHER

**Definition**

Field provided to specify why “Other” was selected as the reason why there were patient-related delays to performing PCI

**Field Values**

- Free-text

**Additional Information**

- Do not enter information into this field unless ‘Delays to PCI’ has a value of “Other”

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# CULPRIT LESION?

**Definition**

Checkbox indicating whether the primary lesion responsible for the acute coronary event was located

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Additional Information**

- Refers to the primary lesion responsible for the acute coronary event as documented by the interventionalist
- If more than one lesion is stented, the lesion in the segment supplying blood to the largest area of myocardium should be considered the culprit lesion

**Data Source Hierarchy**

- Cath Lab Report
- Progress Notes
- Other Hospital Records

# CULPRIT LESION LOCATION

**Definition**

Checkbox indicating the segment where the primary lesion responsible for the acute coronary event was located

**Field Values**

| Culprit Lesion Segment Location | | | |
|---|---|---|---|
| **pRCA** | Proximal right coronary artery conduit | **mCIRC** | Mid-circumflex artery |
| **mRCA** | Mid-right coronary artery conduit | **dCIRC** | Distal circumflex artery |
| **dRCA** | Distal right coronary artery conduit | **1st OM** | First obtuse marginal branch |
| **rPDA** | Right posterior descending artery | **Lat 1st OM** | Lateral first obtuse marginal branch |
| **rPAV** | Right posterior atrioventricular | **2nd OM** | Second obtuse marginal branch |
| **1st RPL** | First right posterolateral | **Lat 2nd OM** | Lateral second obtuse marginal branch |
| **2nd RPL** | Second right posterolateral | **3rd OM** | Third obtuse marginal branch |
| **3rd RPL** | Third right posterolateral | **Lat 3rd OM** | Lateral third obtuse marginal branch |
| **pDSP** | Posterior descending septal perforators | **CIRC AV** | Circumflex artery AV groove continuation |
| **aMarg** | Acute marginal(s) | **1st LPL** | First left posterolateral branch |
| **LM** | Left main coronary artery | **2nd LPL** | Second left posterolateral branch |
| **pLAD** | Proximal LAD artery | **3rd LPL** | Third left posterolateral branch |
| **mLAD** | Mid - LAD artery | **LPDA** | Left posterolateral descending artery |
| **dLAD** | Distal LAD artery | **Ramus** | Ramus intermedius |
| **1st Diag** | First diagonal branch | **Lat Ramus** | Lateral ramus intermedius |
| **Lat 1st Diag** | Lateral first diagonal branch | **3rd Diag** | Third diagonal branch |
| **2nd Diag** | Second diagonal branch | **Lat 3rd Diag** | Lateral third diagonal branch |
| **Lat 2nd Diag** | Lateral second diagonal branch | **OTH** | Other |
| **LAD SP** | LAD septal perforator | **ND** | Not Documented |
| **pCIRC** | Proximal circumflex artery | | |

**Additional Information**

- If more than one lesion is stented, the lesion in the segment supplying blood to the largest area of myocardium should be considered the culprit lesion

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report
- Progress Notes
- Other Hospital Records

# PT INCURRED INTRA- OR POST-PROCEDURAL STROKE?

**Definition**

Checkbox indicating whether the patient experienced stroke signs or symptoms during or immediately following the PCI procedure that did not resolve within 24 hours

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Additional Information**

- Check “Yes” if symptoms started during the PCI procedure and did not resolve within 24 hours after the procedure

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report
- Progress Notes
- Billing Sheet/ Medical Records Coding Summary Sheet

# PT REQUIRED INTRA- OR POST-PROCEDURE TRANSFUSION?

**Definition**

Checkbox indicating whether the patient experienced a vascular complication requiring transfusion of packed red blood cells (PRBCs)

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report
- Progress Notes
- Billing Sheet/ Medical Records Coding Summary Sheet

# WAS A HEMODYNAMIC SUPPORT DEVICE USED?

**Definition**

Checkbox indicating whether the patient had a hemodynamic support device used

**Field Values**

- **Y:** Yes
- **N:** No

**Additional Information**

- Hemodynamic support devices include Impella, IABP, or ECMO

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# IF YES, WHAT TYPE OF DEVICE?

**Definition**

Checkbox indicating the type of hemodynamic support device that was used, if applicable

**Field Values**

- **EC:** ECMO
- **IA:** Intra-Aortic Balloon Pump (IABP)
- **IM:** Impella
- **OT:** Other

**Additional Information**

- If “Other” is marked, must document reason in ‘Comment to Other’ field
- Enter multiple selections, if applicable, by pressing and holding the “Ctrl” key while making your selections

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# COMMENT TO OTHER

**Definition**

Field provided to specify what “Other” hemodynamic device was used

**Field Values**

- Free-text

**Additional Information**

- Do not enter information into this field unless ‘If Yes, What Type Of Device?” has a value of “Other”

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report

# WHEN WAS THE HEMODYNAMIC SUPPORT DEVICE PLACED?

**Definition**

Checkbox indicating whether the patient had a hemodynamic support device used prior to initiating the PCI procedure, intra PCI procedure or post-PCI procedure.

**Field Values**

- **AP:** After PCI Procedure
- **BP:** Before PCI Procedure
- **HD:** Hemodynamic Support Device Only

**Additional Information**

- If a hemodynamic support device was placed but PCI was not performed, select value “HD: Hemodynamic Device Only”

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# CABG PERFORMED?

**Definition**

Checkbox indicating whether the patient had Coronary Artery Bypass Grafting (CABG) performed during the same hospitalization

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# CABG STATUS

**Definition**

Checkbox indicating the urgency of the CABG

**Field Values**

- **U:** Urgent
- **E:** Emergent
- **S:** Salvage
- **EL:** Elective
- **ND:** Not Documented

**Additional Information**

- Urgent: procedure required during same hospitalization to minimize deterioration
- Emergent: patient has ischemic or mechanical dysfunction that is not responsive to any form of therapy except surgery
- Salvage: last resort to save the patient's life, defined by the presence of CPR en route to the operating room, or prior to induction of anesthesia
- Elective: patient's cardiac function has been stable prior to the operation, procedure can be deferred without risk of compromising cardiac outcome

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Operative Report
- Progress Notes

# CABG DATE

**Definition**

Date the CABG was performed

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Operative Report
- Progress Notes
- Other Hospital Records

# CABG TIME

**Definition**

Time of day the CABG was performed

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Operative Report
- Progress Notes
- Other Hospital Records

# CARDIAC ARREST

# ROSC?

**Definition**

Checkbox indicating whether ROSC occurred, which is defined as restoration of a spontaneous perfusing rhythm. Signs of ROSC include: palpable pulse, breathing (more than an occasional gasp), a measurable blood pressure, and/or a sudden rise in capnography to a normal to high reading

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Additional Info**

- Indicate yes if the patient had ROSC at any time during resuscitation, even if transiently

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- ED Records
- Progress Notes

# SUSTAINED ROSC?

**Definition**

Checkbox indicating whether sustained ROSC occurred, which is defined as persistent signs of circulation, with no chest compressions required, for at least twenty (20) consecutive minutes

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- ED Records
- Progress Notes

# INIT. CARDIAC ARREST DATE

**Definition**

Date of the initial cardiac arrest

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# INIT. CARDIAC ARREST TIME

**Definition**

Time of day of the initial cardiac arrest

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- Enter the time documented by EMS, even if the time does not align with other times documented in the EMS record

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# PRESUMED CARDIAC ARREST ETIOLOGY

**Definition**

Checkbox indicating what likely caused the patient to first go into cardiac arrest

**Field Values**

| | | | | | |
|---|---|---|---|---|---|
| **PC** | Presumed Cardiac Etiology | **EX** | Exsanguination/Hemorrhage (non-traumatic) | **SE** | Sepsis |
| **DS** | Drowning/Submersion | **OD** | Drug Overdose | **OT** | Other |
| **EL** | Electrocution | **RA** | Respiratory/Asphyxia | | |

**Additional Information**

- A non-traumatic cardiac arrest is presumed to be of cardiac etiology unless it is known, or likely to have been, caused by another reason
- Exsanguination/hemorrhage includes GI bleeding, post-surgical complications, etc.
- Respiratory/Asphyxia includes hangings
- Examples of “Other” include end-stage cancer, carbon monoxide poisoning, etc.

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment and transport
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# IF OTHER, PLEASE EXPLAIN

**Definition**

Field provided to specify why “Other” was selected as the presumed cardiac arrest etiology, if applicable

**Field Values**

- Free text

**Additional Information**

- Do not enter information into this field unless ‘Presumed Cardiac Arrest Etiology’ has a value of “Other”

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# INIT. CARDIAC ARREST LOCATION

**Definition**

Checkbox indicating where the patient was when the initial cardiac arrest occurred

**Field Values**

- **Home:** Home/Residence
- **SNF:** Nursing Home/Assisted Living
- **Public:** Public Building/Areas
- **Clinic:** Physician Office/Clinic/Urgent Care
- **Industrial:** Industrial Site
- **ED:** Hospital Emergency Department
- **CL:** Cath Lab
- **Other:** Other
- **ND:** Not Documented

**Uses**

- Provides documentation of assessment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# INIT. CARDIAC ARREST WITNESSED?

**Definition**

Checkbox indicating whether the initial cardiac arrest was witnessed

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of assessment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# INIT. CARDIAC ARREST WITNESSED BY

**Definition**

Checkbox indicating who observed the initial cardiac arrest

**Field Values**

- **C:** Citizen
- **E:** EMS
- **H:** Healthcare Professional
- **ND:** Not Documented

**Additional Information**

- “Healthcare professionals” are defined as medically trained, **on-duty** individuals at a healthcare facility (clinic, doctor’s office, nursing home, ED, etc.)
- “Citizens” are defined as good Samaritans, such as off-duty healthcare professionals, law enforcement officers, and bystanders

**Uses**

- Provides documentation of assessment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# INIT. CARDIAC ARREST RHYTHM

**Definition**

Checkbox indicating the initial cardiac rhythm observed during the initial cardiac arrest

**Field Values**

- **AA:** AED-Analyzed Only
- **AD:** AED-Defibrillated
- **AG:** Agonal
- **ASY:** Asystole
- **IV:** Idioventricular
- **PEA:** Pulseless Electrical Activity
- **VT:** Pulseless Ventricular Tachycardia
- **VF:** Ventricular Fibrillation

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# INIT. CARDIAC ARREST CPR INIT. BY

**Definition**

Checkbox indicating who initiated CPR during the initial cardiac arrest

**Field Values**

- **C:** Citizen
- **E:** EMS
- **H:** Healthcare Professional
- **ND:** Not Documented

**Additional Information**

- “Healthcare professionals” are defined as medically trained, **on-duty** individuals at a healthcare facility (clinic, doctor’s office, nursing home, ED, etc.)
- “Citizens” are defined as good Samaritans, such as off-duty healthcare professionals, law enforcement officers, and bystanders

**Uses**

- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# CPR METHOD

**Definition**

Checkbox indicating the method which was used to perform CPR during the initial cardiac arrest

**Field Values**

- **Manual:** Manual CPR Only
- **Manual to Mechanical:** Manual CPR to Mechanical CPR
- **Mechanical:** Mechanical CPR Only
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# CPR MECHANICAL DEVICE

**Definition**

Checkbox indicating the type of mechanical device used to administer CPR during the initial cardiac arrest

**Field Values**

- **LU:** Lucas
- **AP:** AutoPulse
- **NO:** No Mechanical Device Used
- **OT:** Other

**Uses**

- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# COMMENT TO OTHER

**Definition**

Field provided to specify why “Other” was selected as the CPR mechanical device used to administer CPR during the initial cardiac arrest

**Field Values**

- Free-text

**Additional Information**

- Do not enter information into this field unless ‘CPR Mechanical Device’ has a value of “Other”

**Uses**

- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- ED Records
- Progress Notes
- Other Hospital Records

# PRE-SRC DEFIB?

**Definition**

Checkbox indicating whether defibrillation occurred prior to arrival at the SRC

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# PRE-SRC DEFIB BY

**Definition**

Checkbox indicating who defibrillated the patient prior to arrival at the SRC

**Field Values**

- **AC:** AED Citizen
- **AE:** AED EMS
- **ED:** EMS Defibrillation
- **HP:** Healthcare Professional
- **ND:** Not Documented

**Additional Information**

- Enter multiple selections, if applicable, by pressing down and holding the “Ctrl” key while making your selections
- “Healthcare professionals” are defined as medically trained, **on-duty** individuals at a healthcare facility (clinic, doctor’s office, nursing home, ED, etc.)
- “Citizens” are defined as good Samaritans, such as off-duty healthcare professionals, law enforcement officers, and bystanders

**Uses**

- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# WAS PATIENT IN CA UPON ARRIVAL TO ED?

**Definition**

Checkbox indicating whether the patient was in cardiac arrest upon arrival at the SRC ED

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Progress Notes
- Other Hospital Records

# INIT. ROSC DATE

**Definition**

Date initial ROSC occurred

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Additional Information**

- This is the date that ROSC was first obtained for any length of time

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# INIT. ROSC TIME

**Definition**

Time of day initial ROSC occurred

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Additional Information**

- This is the time of day that ROSC was first obtained for any length of time
- Enter the time documented by EMS, even if the time does not align with other times documented in the EMS record

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# INIT. ROSC LOCATION

**Definition**

Checkbox indicating where the patient was when initial ROSC occurred

**Field Values**

- **PRE:** Pre-SRC
- **SRC:** SRC ED
- **CL:** Cath Lab
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# 1st CARDIAC RHYTHM UPON ROSC

**Definition**

First documented cardiac rhythm observed upon ROSC

**Field Values**

- **AFI:** Atrial Fibrillation
- **AFL:** Atrial Flutter
- **AVR:** Accelerated Ventricular
- **1HB:** 1st Degree Heart Block
- **2HB:** 2nd Degree Heart Block
- **3HB:** 3rd Degree Heart Block
- **JR:** Junctional Rhythm
- **PM:** Pacemaker
- **PST:** Paroxysmal Supraventricular Tachycardia
- **SB:** Sinus Bradycardia
- **SR:** Sinus Rhythm
- **ST:** Sinus Tachycardia
- **SVT:** Supraventricular Tachycardia
- **VT:** Ventricular Tachycardia with Pulses
- **OT:** Other
- **ND:** Not Documented

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# 1st HEART RATE UPON ROSC

**Definition**

First documented heart rate upon ROSC

**Field Values**

- Up to three-digit numeric value
- **ND:** Not Documented

**Additional Information**

- Value cannot be greater than 300

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# 1st SYSTOLIC BLOOD PRESSURE UPON ROSC

**Definition**

First documented systolic blood pressure recorded upon ROSC

**Field Values**

- Up to three-digit numeric value
- **ND:** Not Documented

**Additional Information**

- Value cannot be greater than 300

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# 1st TEMPERATURE UPON ROSC

**Definition**

First documented core temperature, in Celsius, recorded upon ROSC

**Field Values**

- Up to four-digit numeric value
- **ND:** Not Documented

**Additional Information**

- Core temperature is measured via bladder, esophageal, or rectal methods
- Document to the 10th of a degree (e.g. 37.0ºC)

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Base Hospital Form
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# 1st END TIDAL $CO_2$ UPON ROSC

**Definition**

1st end tidal $CO_2$ recorded immediately following ROSC

**Field Values**

- Up to three-digit numeric value
- **ND:** Not Documented

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# 1st $PaO_2$

**Definition**

1st $PaO_2$ value measured in the ED

**Field Values**

- Up to five-digit numeric value
- **ND:** Not Documented

**Additional Information**

- Document to the 10th of a degree (e.g. 7.0)
- Enter the patient's first $PaO_2$ value measured after ED arrival

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Lab Records
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# 1st pH VALUE UPON ROSC

**Definition**

1st pH value resulted within two hours of ROSC

**Field Values**

- Up to three-digit numeric value
- **ND:** Not Documented

**Additional Information**

- Document to the 100th of a degree (e.g. 7.00)
- Value cannot be less than 6.5 or greater than 8

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Lab Records
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# 1st LACTATE VALUE UPON ROSC

**Definition**

1st lactate or lactic acid value resulted within two hours of ROSC

**Field Values**

- Up to four-digit numeric value
- **ND:** Not Documented

**Additional Information**

- Document to the 10th of a degree (e.g. 10.0)
- If a lactic acid or formal lactate level is not drawn, it is acceptable to enter the lactate level from POCT

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Lab Records
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# LACTATE VALUE UNITS

**Definition**

The units associated with the lactate or lactic acid value that is resulted within two hours of ROSC

**Field Values**

- **mmol** mmol/L
- **mg** mg/dl
- **mEQ** mEQ/L

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Lab Records
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# TOTAL GLASGOW COMA SCALE (GCS) UPON ROSC

**Definition**

Checkbox indicating the first documented GCS upon ROSC

**Field Values**

- **3**
- **4**
- **5**
- **6**
- **7**
- **8**
- **9**
- **10**
- **11**
- **12**
- **13**
- **14**
- **15**
- **ND:** Not Documented

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# VASOPRESSORS IVP?

**Definition**

Checkbox indicating whether the patient received epinephrine or vasopressin via intravenous push (IVP) during cardiac arrest

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- ED Records
- Medication Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# VASOPRESSORS VIA CONT. INF.?

**Definition**

Checkbox indicating whether vasopressors via continuous intravenous infusion were initiated post-ROSC in the ED or cath lab

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Additional Information**

- Vasopressors include Dopamine, Epinephrine, Norepinephrine (Levophed), Phenylephrine, and Vasopressin

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Medication Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# ECMO PERFORMED?

**Definition**

Checkbox indicating whether the patient had extracorporeal membrane oxygenation (ECMO) performed

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# ECMO DATE

**Definition**

Date ECMO was initiated

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# ECMO TIME

**Definition**

Time of day ECMO was initiated

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Operative Report
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# CPC SCALE AT DISCHARGE

**Definition**

Checkbox indicating the patient's Cerebral Performance Categories (CPC) scale upon discharge from the acute care unit at your facility

**Field Values**

| **Cerebral Performance Categories Scale** | |
|---|---|
| **1** | Good cerebral performance – conscious, alert, able to work, might have mild neurologic or psychologic deficit. |
| **2** | Moderate cerebral disability – conscious, sufficient cerebral function for independent activities of daily life. Able to work in sheltered environment. |
| **3** | Severe cerebral disability – conscious, dependent on others for daily support because of impaired brain function. Range from ambulatory state to severe dementia or paralysis. |
| **4** | Coma or vegetative state – any degree of coma without the presence of all brain death criteria. Unawareness, even if appears awake (vegetative state) without interaction with environment; may have spontaneous eye opening and sleep/awake cycles. Cerebral unresponsiveness. |
| **5** | Brain death: apnea, areflexia, EEG silence, etc. |

**Additional Information**

- If the patient expired, CPC is "5"
- The CPC Scale at discharge may be performed by a physician, trained RN, or occupational therapist
- SRC Clinical Director/RN data extractor may calculate only if not performed by above personnel

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

# CHANGE IN BASELINE FUNCTIONAL STATUS?

**Definition**

Checkbox indicating whether a CPC scale= 2, 3, or 4 at discharge is a change in the patient's baseline functional status

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Hospital Discharge Summary
- Progress Notes
- Billing Sheet/Medical Records Coding Summary Sheet

# TTM

# TTM INITIATED?

**Definition**

Checkbox indicating whether Targeted Temperature Management (TTM) measures were initiated to actively cool and/or maintain the patient at a temperature of 32-37.5 degrees Celsius

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# TTM APPROACH

**Definition**

Checkbox indicating whether Targeted Temperature Management (TTM) measures were initiated to maintain the patient at a normothermic temperature or an induced hypothermia temperature

**Field Values**

- **NT:** Normothermia
- **IH:** Induced Hypothermia

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# REASONS NORMOTHERMIC TTM WITHHELD (LIST ALL THAT APPLY)

**Definition**

Checkbox indicating why normothermic TTM measures were not initiated

**Field Values**

- **30:** Core temperature < 30 degrees Celsius
- **AR:** Awake/Responsive to verbal commands
- **CO:** Comorbid disease
- **DN:** DNR
- **EX:** Patient expired
- **NF:** Preceding poor neurologic function
- **NO:** None listed

**Additional Information**

- Enter multiple selections, if applicable, by pressing down and holding the “Ctrl” key while making your selections
- Pre-existing coma refers to being in a comatose state prior to cardiac arrest due to a pre-existing condition, neurologic dysfunction (pre-arrest CPC Score of 3 or 4), or severe dementia
- Comorbid disease refers to a known comorbid disease making 180 days survival unlikely
- Preceding poor neurologic function is defined as a Prearrest Cerebral Performance Category (CPC) of 3 or 4

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# REASONS INDUCED HYPOTHERMIA NOT INITIATED (LIST ALL THAT APPLY)

**Definition**

Checkbox indicating why induced hypothermia (Targets below 36° C) measures were not initiated

**Field Values**

- **30:** Core temperature < 30 degrees Celsius
- **80:** Systolic BP<80mmHg
- **AR:** Awake/Responsive to verbal commands
- **AS:** Acute Stroke -Suspected or Confirmed
- **BD:** Known Intrinsic Bleeding Diathesis (e.g. Hemophilia or Von Willebrand)
- **BL:** Active Significant Bleeding
- **CO:** Comorbid disease
- **DC:** Delays > 6 hours from ROSC to cooling
- **DN:** DNR
- **EX:** Patient expired
- **HT:** Major head trauma
- **IC:** Acute Intracranial bleeding and/or head trauma
- **NF:** Preceding poor neurologic function
- **NO:** None listed
- **PO:** Hospital Policy (e.g. normothermia policy)
- **PR:** Pregnancy
- **SB:** Active Significant Bleeding

**Additional Information**

- Enter multiple selections, if applicable, by pressing down and holding the “Ctrl” key while making your selections
- Systolic Bp<80mmHg refers to patients who continue to be hypotensive despite interventions, including IV fluids, vasopressors, or an intra-aortic balloon pump
- Comorbid disease refers to a known comorbid disease making 180 days survival unlikely
- Preceding poor neurologic function is defined as a Prearrest Cerebral Performance Category (CPC) of 3 or 4

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# TTM INITIATED DATE

**Definition**

Date TTM measures were initiated

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# TTM INITIATED TIME

**Definition**

Time of day TTM measures were initiated

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# TTM INITIATED LOCATION

**Definition**

Checkbox indicating where the patient was when TTM measures were initiated

**Field Values**

- **P:** Pre-SRC
- **S:** SRC ED
- **C:** Cath Lab
- **I:** ICU
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# TTM MODALITY USED

**Definition**

Checkbox indicating type(s) of TTM measures initiated

**Field Values**

- **IP:** Ice Packs
- **EC:** ECMO Machine
- **ED:** External Cooling Device
- **CI:** Cold IV fluids
- **CD:** Central Vascular Cooling Device
- **OT:** Other
- **ND:** Not Documented

**Additional Information**

- Enter multiple selections, if applicable, by pressing down and holding the “Ctrl” key while making your selections

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# TARGET TEMPERATURE

**Definition**

Checkbox indicating the desired body temperature to be achieved by TTM measures, as ordered by the physician or per protocol

**Field Values**

- **32:** 32 degrees Celsius
- **33:** 33 degrees Celsius
- **34:** 34 degrees Celsius
- **35:** 35 degrees Celsius
- **36:** 36 degrees Celsius
- **37:** 37 degrees Celsius
- **37.5**: 37.5 degrees Celsius
- **SR:** Specified range
- **ND:** Not Documented

**Additional Information**

- If “Specified Range” is marked, must document range in ‘Target Temperature Range’ field

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# TARGET TEMPERATURE RANGE

**Definition**

Field provided to indicate the range, in Celsius, of desired body temperature to be achieved by TTM measures, if applicable

**Field Values**

- Seven-digit numeric value

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# TARGET TEMPERATURE REACHED?

**Definition**

Checkbox indicating whether the desired body temperature was achieved by TTM measures

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of assessment and/or care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# TARGET TEMPERATURE REACHED DATE

**Definition**

Date that desired body temperature was achieved by TTM measures

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# TARGET TEMPERATURE REACHED TIME

**Definition**

Time of day that desired body temperature was achieved by TTM measures

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# TARGET TEMPERATURE MANAGEMENT DURATION

**Definition**

Duration (in hours) of Targeted Temperature Management

**Field Values**

- Collected as HHMM
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Progress Notes
- Other Hospital Records

# RE-WARMING INITIATED?

**Definition**

Checkbox indicating whether re-warming measures were initiated

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Progress Notes
- Other Hospital Records
- ED Records

# RE-WARMING INIT DATE

**Definition**

Date that re-warming measures were initiated

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Progress Notes
- Other Hospital Records
- ED Records

# RE-WARMING INIT TIME

**Definition**

Time of day that re-warming measures were initiated

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Progress Notes
- Other Hospital Records
- ED Records

# PATIENT DIED DURING RE-WARMING?

**Definition**

Checkbox indicating whether the patient died during the re-warming process

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Progress Notes
- Other Hospital Records
- ED Records

# RE-WARMING ENDED DATE

**Definition**

Date that re-warming measures were terminated

**Field Values**

- Collected as MMDDYYYY
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Progress Notes
- Other Hospital Records
- ED Records

# RE-WARMING ENDED TIME

**Definition**

Time of day that re-warming measures were terminated

**Field Values**

- Collected as HHMM
- Use 24-hour clock
- **ND:** Not Documented

**Uses**

- Establishes care intervals and incident timelines
- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Progress Notes
- Other Hospital Records
- ED Records

# ADVERSE EVENTS DURING TTM

**Definition**

Checkbox indicating whether any of the listed adverse events occurred during TTM – enter all that apply

**Field Values**

- **DY:** Dysrhythmia of VF/VT
- **CG:** Coagulopathy/bleeding
- **DV:** Deep vein thrombosis
- **NO:** None of the above adverse events were specified

**Additional Information**

- Enter multiple selections, if applicable, by pressing down and holding the “Ctrl” key while making your selections

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Progress Notes
- Other Hospital Records
- ED Records

# ECPR

# ECPR ROUTING?

**Definition**

Checkbox indicating whether the patient was routed for ECPR

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports

# ECPR NOTIFICATION?

**Definition**

Checkbox indicating whether notification was received by the SRC ED prior to the patient's arrival

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- SRC Log
- ED Records

# NOTIFICATION DATE

**Definition**

Date of ECPR notification prior to the patient's arrival at the SRC ED

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- SRC Log
- ED Records
- Progress Notes

# NOTIFICATION TIME

**Definition**

Time of day of ECPR notification prior to the patient's arrival at the SRC ED

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- Enter the time documented by EMS, even if the time does not align with other times documented in the EMS record

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- SRC Log
- ED Records
- Progress Notes

# ECPR TEAM ACTIVATED

**Definition**

Checkbox indicating whether the ECPR team was activated

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports

# ECPR PHYSICIAN ARRIVAL DATE

**Definition**

Date ECPR physician arrived to the cannulation location

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- EMS Record
- Base Hospital Form
- SRC Log
- ED Records
- Progress Notes

# ECPR PHYSICIAN ARRIVAL TIME

**Definition**

Time of day of ECPR physician arrived to the cannulation location

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# ECPR CANNULATION

**Definition**

Checkbox indicating whether ECMO cannulation for ECPR was attempted

**Field Values**

- **Y:** Yes
- **N:** No
- **ND:** Not Documented

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Reports
- Progress Notes

# ECPR LOCATION

**Definition**

Patient's location in the hospital when ECMO Cannulation for ECPR was attempted

**Field Values**

- **CL:** Cath Lab
- **ED:** Emergency Department
- **IC:** Intensive Care Unit
- **OR:** Operating Room
- **OT:** Other

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- SRC Log
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# COMMENT TO OTHER

**Definition**

Field provided to specify why “Other” was selected from the ECPR Location field

**Field Values**

- Free-text

**Additional Information**

- Do not enter information into this field unless ‘ECPR Location’ has a Field Value of “Other”

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- SRC Log
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# RATIONALE FOR NOT CANNULATING FOR ECPR

**Definition**

Checkbox indicating the primary reason why ECPR cannulation was not performed

**Field Values**

- **EX:** Patient Expired
- **NC**: Non-Cardiac Etiology
- **PI:** Poor Prognostic Indicator
- **PN:** Poor Neurologic Baseline
- **SR:** Sustained ROSC
- **TI:** Known Terminal Illness
- **OT:** Other

**Additional Information**

- Enter multiple selections, if applicable, by pressing and holding the “Ctrl” key while making your selections
- If the field value Poor Prognostic Indicator is selected, mandatory entry is required in the following Poor Prognostic Indicator field
- If “Other” is marked, must document reason in ‘Comment to Other’ field

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# POOR PROGNOSTIC INDICATOR

**Definition**

Checkbox indicating the prognostic indicators leading to the decision not to initiate ECMO cannulation for ECPR

**Field Values**

- **CO**: EtCO2<10mmHg
- **O2:** O2 sat <85%
- **LA:** Lactate >18mmol/L
- **PA:** PaO2<50mmHg
- **RE:** >60 min of resuscitation
- **OT:** Other

**Additional Information**

- If the field value Poor Prognostic Indicator is selected in field Rationale For Not Cannulating For ECPR, then mandatory entry is required in the Poor Prognostic Indicator field
- Enter multiple selections, if applicable, by pressing and holding the “Ctrl” key while making your selections
- If “Other” is marked, must document reason in ‘Comment to Other’ field

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# COMMENT TO OTHER

**Definition**

Field provided to specify why “Other” was selected from the Poor Prognostic Indicator field

**Field Values**

- Free-text

**Additional Information**

- Do not enter information into this field unless ‘Poor Prognostic Indicator” has a Field Value of “Other”

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- SRC Log
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# PERSISTENT CARDIAC ARREST

**Definition**

Checkbox indicating whether the patient was in persistent cardiac arrest with ongoing resuscitation at the time of ED arrival

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Other Hospital Reports
- Progress Notes

# PT LOCATION WHEN ECPR TEAM ACTIVATED

**Definition**

Patient's location when the ECPR team was activated

**Field Values**

- **Pre-SRC:** Pre-SRC
- **SRC:** SRC ED

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- SRC Log
- Cath Lab Report
- EMS Record

# ECPR TEAM ACTIVATION DATE

**Definition**

Date the ECPR team was activated

**Field Values**

- Collected as MMDDYYYY

**Additional Information**

- If the CL activation was cancelled and then re-activated, enter the date it was re-activated

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Pager
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Records

# ECPR ACTIVATION TIME

**Definition**

Time of day the ECPR team was activated

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Additional Information**

- If the CL activation was cancelled and then re-activated, enter the time it was re-activated

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Pager
- SRC Log
- ED Records
- Cath Lab Report
- Other Hospital Reports

# SHEATH SIZE

**Definition**

Checkbox indicating which size of sheath was placed during ECMO Cannulation for ECPR

**Field Values**

- Up to two-digit numeric value

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Records
- Progress Notes

# SIDE OF CANNULATION

**Definition**

Checkbox indicating the side(s) of the patient where cannulation was performed

**Field Values**

- **Unilateral**
- **Bilateral**

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Reports
- Progress Notes

# DISTAL CATHETER

**Definition**

Checkbox indicating whether a distal catheter was placed

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Reports
- Progress Notes

# US GUIDED

**Definition**

Checkbox indicating whether ultrasonography was used during the EMCO cannulation placement procedure

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Reports
- Progress Notes

# FLUOROSCOPY GUIDED

**Definition**

Checkbox indicating whether fluoroscopy was used during the ECMO cannulation placement procedure

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Reports
- Progress Notes

# ECPR FLOW

**Definition**

Checkbox indicating whether flow was initiated post ECMO cannulation for ECPR

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Reports
- Progress Notes

# NO ECPR CANNULATION FLOW

**Definition**

Checkbox indicating the primary reason why cannulation flow was unable to be established.

**Field Values**

- **SR:** Sustained ROSC during/after cannulation
- **TI:** Technical Issues
- **Other:** Other

**Additional Information**

- If “Other” is marked, must document reason in ‘Comment to Other’ field

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report
- Progress Notes
- ED Records

# COMMENT TO OTHER

**Definition**

Field provided to specify why “Other” was selected as the primary reason why ECPR Cannulation Flow was unable to be established.

**Field Values**

- Free- text

**Additional Information**

- Do not enter information into this field unless ‘Reason For No ECPR Cannulation Flow’ has a value of “Other”

**Uses**

- Provides documentation of assessment
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report
- Progress Notes
- ED Records

# ECPR DATE

**Definition**

Date of ECPR flow successfully initiated

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Records
- Progress Notes

# ECPR TIME

**Definition**

Time of day of ECPR flow successfully initiated

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Records
- Progress Notes

# ECPR DC DATE

**Definition**

Date that ECPR was discontinued

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Records
- Progress Notes

# ECPR DC TIME

**Definition**

Time of day that ECPR discontinued

**Field Values**

- Collected as HHMM
- Use 24-hour clock

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Records
- Progress Notes

# ECPR COMPLICATIONS

**Definition**

Checkbox indicating any complications that arose during the critical illness supported by ECPR

**Field Values**

- **BT:** Blood Transfusion
- **HS:** Hemorrhagic Stroke
- **IN:** Infection
- **IK:** Organ Injury-Kidney
- **IL:** Organ Injury-Liver
- **IS:** Ischemic Stroke
- **LE**: Leg Ischemia
- **TE:** Thromboembolism
- **OT:** Other

**Additional Information**

- Enter multiple selections, if applicable, by pressing and holding the “Ctrl” key while making your selections
- If “Other” is marked, must document reason in ‘Comment to Other’ field

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# COMMENT TO OTHER

**Definition**

Field provided to specify why “Other” was selected from the ECPR Complications field

**Field Values**

- Free-text

**Additional Information**

- Do not enter information into this field unless ‘ECPR Complications” has a Field Value of “Other”

**Uses**

- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- SRC Log
- Cath Lab Report
- Progress Notes
- Other Hospital Records

# PRIOR EJECTION FRACTION MEASURED?

**Definition**

Checkbox indicating whether a prior ejection fraction measurement was documented for the patient

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Reports
- Progress Notes

# PRIOR EJECTION FRACTION

**Definition**

The last ejection fraction measured prior to the cardiac arrest event (if known)

**Field Values**

- Up to three-digit numeric value

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Records
- Progress Notes

# PRIOR EJECTION FRACTION DATE

**Definition**

Date the prior ejection fraction was measured

**Field Values**

- Collected as MMDDYYYY

**Uses**

- Establishes care intervals and incident timelines
- Assists with determination of appropriate treatment
- Provides documentation of care
- System evaluation and monitoring

**Data Source Hierarchy**

- ED Records
- Cath Lab Report
- Other Hospital Records
- Progress Notes

# EJECTION FRACTION AT DISCHARGE

**Definition**

The last ejection fraction measured prior to the patient being discharged

**Field Values**

- Up to three-digit numeric value

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report
- Other Hospital Records
- Progress Notes

# AICD PLACEMENT

**Definition**

Checkbox indicating whether an AICD was placed prior to the patient being discharged

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Cath Lab Report
- Other Hospital Reports
- Progress Notes

# mRS 30

**Definition**

The modified Rankin score at 30 days from the time of hospital admission

**Field Values**

- One-digit numeric value

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Other Hospital Records
- Progress Notes

# mRS 90

**Definition**

The modified Rankin score at 90 days from the time of hospital admission

**Field Values**

- One-digit numeric value

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Other Hospital Records
- Progress Notes

# DONATION

**Definition**

Checkbox indicating whether organ procurement/donation occurred if the patient did not survive

**Field Values**

- **Y:** Yes
- **N:** No

**Uses**

- Provides documentation of care
- Assists with determination of appropriate treatment
- System evaluation and monitoring

**Data Source Hierarchy**

- Other Hospital Reports
- Progress Notes