



STEMI Receiving Center Data Dictionary

Los Angeles County
Emergency Medical Services Agency

*EFFECTIVE
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EMERGENCY MEDICAL
SERVICES AGENCY
LOS ANGELES COUNTY



LANCET TECHNOLOGY
Innovative Data Solutions

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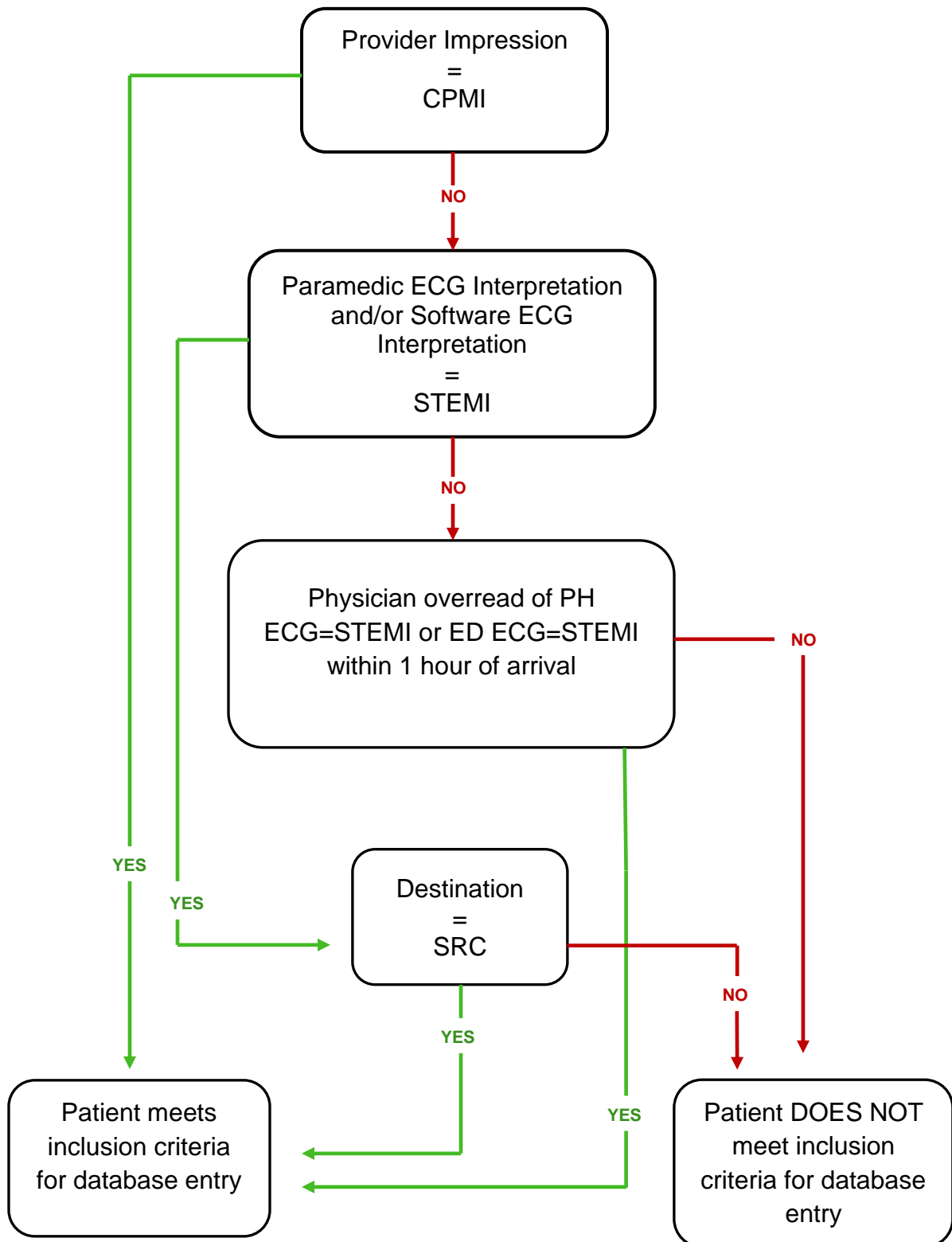
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INCLUSION CRITERIA

- 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:**
 - Identified on an ED ECG within 1 hour of arrival to the SRF **OR**
 - Transported via 911 either to the SRF or from the SRF to the SRC
- 3) Cardiac arrest patients need to meet one of the following:
 - **Patients with Cardiac Arrest identified prehospital by:**
 - Provider Impression of Cardiac Arrest – Non-Traumatic (CANT)
 - Patients age 15 years and older 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 ALGORITHM FOR PATIENTS WITH STEMI IDENTIFIED PREHOSPITAL



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

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 alphanumeric 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.	LY	Filyn Corporation, dba Lynch
AB	AmbuLife Ambulance, Inc.	MA	Mauran Ambulance Service, Inc.
AN	Antelope Ambulance Service	MD	MedTrans, Inc.
AR	American Medical Response of So. Calif.	MI	MedResponse, Inc.
AT	All Town Ambulance, LLC	MR	MedReach, Inc. dba MedReach Ambulance
AU	AmbuServe, Inc.	MY	Mercy Air
AW	Amwest, Inc. dba Amwest Ambulance	PE	Premier Medical Transport, Inc. dba Premier Ambulance
CA	Falck Mobile Health Corp. dba Care Ambulance	PN	PRN Ambulance, Inc.
CL	California Medical Response, Inc. dba Cal-Med Ambulance	RE	REACH Air Medical Service, LLC
CO	College Coastal Care, LLC	RR	Rescue Services International, Ltd. dba Medic-1 Ambulance
EA	Emergency Ambulance Service, Incorporated	RY	Royalty Ambulance Services, Inc.
EX	Explorer 1 Ambulance & Medical Services, LLC	SO	Symbiosis (Di Biassi)
FC	First Rescue Ambulance, Inc.	SY	Symons Emergency Specialties, Inc. dba Symbiosis
FM	Firstmed Ambulance Services, Inc.	VA	Viewpoint Ambulance, Inc.
GU	Guardian Ambulance Service	VI	Vital Care Ambulance
HE	Heart Ambulance Corporation	WE	Westcoast Ambulance, Inc.
JA	Journey via Gurney, LLC., dba Journey Ambulance	WM	Westmed Ambulance, Inc. dba McCormick Ambulance
LE	EastWestProto, Inc. dba Lifeline Ambulance	ZM	Solartricity dba Zoom Medical Transportation

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	DRWN	Submersion/Drowning	NOMC	No Medical Complaint
AGDE	Agitated Delirium	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	GUDD	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		

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

AD	Agitated Delirium
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
- **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
- **MI:** Prior Myocardial Infarction
- **NO:** None
- **PC:** Prior Percutaneous Coronary Intervention (PCI)
- **PV:** Peripheral Vascular Disease
- **SM:** Smoker - current/recent Tobacco (within 1 year)
- **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
- Cerebrovascular disease is defined as history of TIA or stroke
- 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
- Cardiogenic shock is defined as:
 - Sustained (>30 min) episode of systolic blood pressure <90mm Hg **and/or**
 - Cardiac index <2.2L/min/m² 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

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

COVID-19 DIAGNOSIS PRIOR TO HOSPITALIZATION?

Definition

Checkbox indicating whether the patient had a positive COVID-19 PCR test prior to arrival at your facility

Field Values

- **Y:** Yes
- **N:** No
- **U:** Unknown

Additional Information

- Includes PCR, molecular, or rapid test for the virus. Do NOT include antibody testing

Uses

- System evaluation and monitoring

Data Hierarchy

- ED Records
- Other Hospital Records

COVID-19 PCR TEST DURING HOSPITALIZATION?

Definition

Checkbox indicating whether the patient had a COVID-19 PCR test performed while they were hospitalized at your facility

Field Values

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

Additional Information

- Includes PCR, molecular, or rapid test for the virus. Do NOT include antibody testing

Uses

- Provides documentation of care
- System evaluation and monitoring

Data Hierarchy

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

WAS PATIENT VACCINATED PRIOR TO HOSPITALIZATION?

Definition

Checkbox indicating whether the patient had a COVID-19 vaccination prior to hospitalization at your facility

Field Values

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

Uses

- Provides documentation of care
- System evaluation and monitoring

Data Hierarchy

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

HOSPITAL TEST RESULTS

Definition

Checkbox indicating the results of the COVID-19 PCR test performed on the patient while they were hospitalized at your facility, if applicable

Field Values

- **P:** Positive
- **N:** Negative

Uses

- Provides documentation of care
- System evaluation and monitoring

Data Hierarchy

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

DATE HOSPITAL TEST PERFORMED

Definition

Date the patient had a COVID-19 PCR test performed at your facility, if applicable

Field Values

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

Uses

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

Data Hierarchy

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

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 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	Beverly Hospital	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	Lakewood Regional Medical Center	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	West Hills Hospital and 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	Los Alamitos Medical Center		
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
- 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
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ELA	East Los Angeles Doctors Hospital	PLB	College Medical Center
ENH	Encino Hospital Medical Center	PVC	Pomona Valley Hospital Medical Center
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GAR	Garfield Medical Center	QVH	Emanate Health Queen of the Valley Hospital
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KFB	Kaiser Foundation Hospital - Downey	VHH	USC Verdugo Hills Hospital
KFH	Kaiser Foundation Hospital - South Bay	VPH	Valley Presbyterian Hospital
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ORANGE COUNTY 9-1-1 RECEIVING HOSPITALS			
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KHA	Kaiser Foundation Hospital - Anaheim	UCI	University of California, Irvine Medical Center
KFI	Kaiser Foundation Hospital - Irvine	WMC	Orange County Global Medical Center
LAG	Los Alamitos Medical Center		
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

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 admission

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

- “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. 37.0°C)

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 CO₂ UPON ROSC

Definition

1st end tidal CO₂ 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 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 three-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
- 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)
- **CO:** Comorbid disease
- **DN:** DNR
- **EX:** Patient expired
- **IC:** Acute Intracranial bleeding and/or head trauma
- **NF:** Preceding poor neurologic function
- **NO:** None listed
- **PR:** Pregnancy
- **SB:** Active Significant Bleeding
- **UA:** Uncontrolled/recurrent ventricular dysrhythmia

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
- **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

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