WEB APPENDICES: SUPPLEMENTAL MATERIAL

Protocol of the China PEACE (Patient-centered Evaluative Assessment of Cardiac Events) Retrospective Study of Coronary Catheterization and Percutaneous Coronary Intervention

The China PEACE Collaborative Group\textsuperscript{1, 2}

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We intended study hospitals to reflect the diverse sites of care performing coronary catheterization and percutaneous coronary intervention (PCI) in China. We restricted hospitals to those in urban areas, as coronary catheterization and PCI are rarely performed in rural areas. We considered an area urban if it is part of a downtown or suburban area within a directly-controlled municipality (Beijing, Tianjin, Shanghai, Chongqing) or 1 of 283 prefectural-level cities. As financial and medical resources are not identical throughout Mainland China, we separately identified hospitals in each of China’s 3 official economic-geographic regions, i.e. Eastern, Central and Western. As Central and Western urban regions have similar per capita income and health services capacity, as shown below, we combined Central and Western regions into 1 stratum.

<table>
<thead>
<tr>
<th>Population, Economy, and Hospitals in Urban Areas of Different Geographic Strata of Mainland China</th>
<th>Eastern</th>
<th>Central</th>
<th>Western</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population*</td>
<td>336,364,491</td>
<td>150,467,917</td>
<td>144,803,916</td>
</tr>
<tr>
<td>Income per capita (RMB)†</td>
<td>21,547</td>
<td>15,539</td>
<td>15,523</td>
</tr>
<tr>
<td>Number of urban areas in strata‡</td>
<td>121</td>
<td>81</td>
<td>85</td>
</tr>
<tr>
<td>Median # of hospitals per urban area (IQR)¶</td>
<td>Tertiary hospitals</td>
<td>3 (2-6)</td>
<td>2 (1-3)</td>
</tr>
<tr>
<td></td>
<td>Secondary hospitals</td>
<td>5 (3-8)</td>
<td>4 (3-6)</td>
</tr>
</tbody>
</table>

‡Administrative divisions code (October 31, 2011) in China (http://www.stats.gov.cn/tjgb/xzqghdm/t201202015_402777427.htm)
¶Median (interquartile range)

We then identified hospitals separately for 2 study strata: Eastern-urban and Central/Western-urban regions.

We identified cases for study inclusion using a stratified 2-stage cluster sampling design. In the first stage, we identified hospitals using a simple random sampling procedure within each of the 2 study strata. The sampling framework consisted of the highest-level hospitals in each of the predefined urban regions (833 hospitals in 287 urban regions). Hospital level is officially defined by the Chinese government based on clinical resource capacity. For example, secondary hospitals have at least 100 inpatient beds and the capacity to provide acute medical care and preventive care services to populations of at least 100,000, while tertiary hospitals are large referral centers in provincial capitals and major cities. We excluded military hospitals, prison hospitals, specialized hospitals without a cardiovascular disease division, and traditional Chinese medicine hospitals. Since the number of hospitals has remained stable over the past decade, we decided to select representative hospitals from 2011 to reflect current practices and trace this hospital cohort backward to 2006 and 2001 to describe temporal trends.
In the second stage, we drew cases based on the local hospital database for patients who underwent coronary catheterization at each sampled hospital. We ordered each hospital’s list of eligible cases by date of coronary catheterization and selected cases using systematic random sampling with equal probabilities. We selected a case at random, after which we selected every $k$th case based on sample size requirements, where $k$ is the sampling interval.

In each study stratum, we determined the sample size required to achieve a 1.5% precision for describing the rate of in-hospital complications, which we had estimated to be approximately 5%.

The following Equation 1 can be used to define the sample size required ($n$) for a given proportion of the primary outcome ($P$), desired precision ($d$), and specific choice of $\alpha$.

$$ n = \frac{z_\alpha^2 \cdot P(1-P)}{d^2} $$

However, because random cases sampled within the same hospital are likely to be more similar to one another than to random cases from another hospital, the effective sample size is reduced. Consequently, a design effect adjustment should be introduced as follows:

$$ n = \frac{z_\alpha^2 \cdot P(1-P)}{d^2} \times deff $$

Where the design effect ($deff$) is given by

$$ deff = 1 + \delta (\bar{n}^l - 1) $$

where $\delta$ is the intraclass correlation for the statistic in question and $\bar{n}^l$ is the average number of sampled cases within each hospital. $\bar{n}^l$ is also known as the cluster size.

With this framework in mind, to achieve a precision of 1.5% with an $\alpha$ of 0.05 in each stratum, assuming an intraclass correlation of 0.02 and design effect of 2.2, we would need to sample 1750 medical records among hospitals with an average cluster size of 60. These cluster sizes in urban settings appeared reasonable based upon our previous survey of treatment for acute coronary syndromes at more than 1000 hospitals in 2010, which demonstrated that the median PCI volume was approximately 300 cases per year. Assuming a participation rate of 85% among selected hospitals, we approached 35 hospitals for participation in each stratum for a total of 70 hospitals. We doubled cluster sizes for 2011 to improve precision in the description of hospital-level treatment patterns and outcomes.

Consequently, the total expected sample volume with the above assumptions was
approximately 3,500 cases in 2001, 3,500 cases in 2006, and 7,000 cases in 2011.

Reference

### CHINA PEACE-RETROSPECTIVE CATHPCI STUDY ABSOLUTE PRECISION ACHIEVED FOR IN-HOSPITAL COMPLICATIONS IN STUDY STRATA

<table>
<thead>
<tr>
<th>Study Stratum</th>
<th>Sample Size Achieved</th>
<th>Average Cluster Size</th>
<th>deff</th>
<th>Precision Achieved for Proportion of 0.05</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual Data</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central/Western-urban in 2001</td>
<td>519</td>
<td>17</td>
<td>1.3</td>
<td>2.1%</td>
</tr>
<tr>
<td>Central/Western-urban in 2006</td>
<td>1,131</td>
<td>36</td>
<td>1.7</td>
<td>1.6%</td>
</tr>
<tr>
<td>Central/Western-urban in 2011</td>
<td>3,662</td>
<td>118</td>
<td>3.3</td>
<td>1.3%</td>
</tr>
<tr>
<td>Eastern-urban in 2001</td>
<td>925</td>
<td>29</td>
<td>1.6</td>
<td>1.7%</td>
</tr>
<tr>
<td>Eastern-urban in 2006</td>
<td>1,915</td>
<td>60</td>
<td>2.2</td>
<td>1.5%</td>
</tr>
<tr>
<td>Eastern-urban in 2011</td>
<td>4,325</td>
<td>135</td>
<td>3.7</td>
<td>1.3%</td>
</tr>
<tr>
<td><strong>Anticipated Data</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001 or 2006</td>
<td>1,750</td>
<td>60</td>
<td>2.2</td>
<td>1.4%</td>
</tr>
<tr>
<td>2011</td>
<td>3,500</td>
<td>120</td>
<td>3.3</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

* Actual data reflects the absolute precision achieved in describing in-hospital mortality in each stratum during 2001, 2006, and 2011 based upon the actual sample size, actual average cluster size, and associated design effect.

† Anticipated data reflects the anticipated absolute precision that would be achieved in describing in-hospital mortality in each stratum during 2001, 2006, and 2011 based upon the anticipated sample size, anticipated average cluster size, and associated design effect.
CHINA PEACE-RETROSPECTIVE CATHPCI STUDY QUALITY ASSURANCE AND QUALITY CONTROL STRATEGIES IN MEDICAL RECORD SAMPLING

As the China PEACE Retrospective Study of Coronary Catheterization and Percutaneous Coronary Intervention was designed to study a nationally representative hospital cohort, we selected hospitals based on random sampling rather than previous collaboration or longstanding experience with retrospective data collection. As we anticipated that many hospitals would have little previous experience with clinical research, we provided participating sites with substantial support to ensure adherence with multiple quality control strategies for identifying all hospitalizations undergoing coronary catheterization and for randomly selecting eligible hospitalizations for the China PEACE-Retrospective CathPCI Study.

For all participating hospitals, we first held a local investigator meeting to provide in-depth information on study design and operating procedures. We trained sites on how to identify all hospitalizations undergoing coronary catheterization or percutaneous coronary intervention. The sites identified eligible hospitalizations by searching their electronic database or hard-copy log during the specified time periods.

To verify compliance with the search strategy, research staff from the study coordinating center visited 33 study sites to repeat the case finding process and confirm that the list of hospitalizations undergoing coronary catheterization and/or PCI was complete. These 33 sites provided 83% of all hospitalizations undergoing coronary catheterization/PCI from which we sampled cases for the PEACE Retrospective CathPCI Study.

After we sampled cases at each hospital using systematic random sampling and assigned each record a unique study ID, we required local investigators to gather the original record, assign it its study ID, scan it, and transmit the scanned copy to the coordinating center. Upon receipt of the scanned record, coordinating center staff verified the consistency of the hospitalization ID and procedure date with the sampled case, and ensured that the record itself was complete and legible. To facilitate this process, the coordinating center provided each study site with a high-speed scanner. In addition, coordinating center staff provided on-site assistance for 33 study sites that provided approximately 73% of sampled cases.

To ensure transparency in all sampling performed by the NCCD, we have recorded all sampling procedures including the contents of the sampling framework database that contains all eligible cases for sampling in their predefined sequence and the seeds used in random number generation.
Background

Medical record abstraction can be guided by the types of data being abstracted. We have defined as *simple data elements* those elements that can be abstracted directly from the chart without use of professional judgment. Examples include the date of admission, patient sex, patient age, serum creatinine on hospital day 1, etc.

In contrast, *complex data elements* are those that require more advanced medical knowledge for abstraction. Examples of complex data elements include the presence of comorbidities, evidence of pulmonary edema on hospital presentation, development of post-procedural complications such as bleeding or arrhythmia, and so on.

Within the Chinese medical record, simple data elements are found predominantly in the medical record face sheet, section for laboratory testing results and physician orders. Complex elements are found throughout all other sections of the medical record including the admission record, discharge record and diagnostic reports, etc.

Training and Qualification of Abstractors

The abstractors for simple data elements were clerks with experience in medical record abstraction. The abstractors for complex data elements were undergraduate or post-graduate trainees. Most were medical students.

Each abstractor was given a set of training materials about medical record abstraction, including *CHINA PEACE: A Brief Introduction*, *China PEACE: Operation Manual of Medical Record Abstraction*, and 5 standard training medical records.

Each abstractor also underwent the following training courses: (1) Introduction to the China PEACE protocol; (2) Coronary heart disease and its subtypes; (3) Component parts of the inpatient medical record and their contents; (4) China PEACE Retrospective Study of Coronary Catheterization and Percutaneous Coronary Intervention data dictionary; (5) Frequently asked questions in medical record abstraction; (6) Quality assurance and quality control measures in China PEACE; and (7) Intensive guidance in abstracting 5 standard training medical records followed by group discussion and retraining as needed.

Once training was completed, each abstractor reviewed 5 standard training medical records. Supervisors were responsible for evaluating the accuracy of abstraction. Every abstractor needed to achieve greater than 98 percent abstraction accuracy in order to be considered competent.

Quality Control in Medical Record Abstraction

We randomly audit approximately 5% of the abstracted records. If the records have not been abstracted with 98% accuracy, all records in the audited batch are considered unqualified and are re-reviewed by a different abstractor. Discrepancies in abstraction are resolved by review of the original medical record.
To minimize abstraction errors, abstractors start by abstracting only printed medical records. After gaining experience, these individuals are allowed to begin abstracting hand-written records. In addition, a physician is always present in the room with abstractors or is available online to answer questions and address areas of concern as they arise. Common problems have led to updates of the data dictionary and database into which data are directly entered. This database has been additionally customized to expedite the identification of medications that may have more than one trade name. Furthermore, medical records belonging to the same hospital and year are assigned to a broad group of reviewers to avoid potential residual disparities in quality among different abstractors.

**Data Management and Cleaning**

Ongoing data cleaning is performed in a systematic manner. Data is regularly queried for invalid and illogical values as well as for duplicate record entry. Outliers in continuous data distributions are identified as potentially invalid and are further explored. Duplicate records are identified by the presence of identical study identification numbers, hospital identification numbers, medical record identification numbers, and dates of discharge. Once a data query is made, concerns are resolved after tracing and reviewing the relevant records.
CHINA PEACE-RETROSPECTIVE CATHPCI STUDY CASE REPORT FORM, PART I

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Note: The case report form parallels common sections of the Chinese medical record. In certain instances, questions within the case report form have been repeated for different sections of the medical record to maximize the sensitivity of abstraction.
1 Study ID _____【Free Text (F)】

Face Sheet

2.1 Medical Record Number _____【F】

2.2 Hospital Number _____【F】

3 Gender【Single Choice (SC)】
   --Male
   --Female

4 Age _____yrs【F】

5.1 Admission Date _____【Select Date from Calendar (C)】

5.2 Admission Time _____【F】

Discharge Records

6 In-Hospital Death【SC】
   --Yes
   --No

7 In-Hospital Death Date _____【C】

8 Admission Diagnosis (Related to Coronary Heart Disease)【Multiple Choices Permitted (MC)】
   --Coronary Heart Disease
   --Acute Coronary Syndrome
   --Acute Extensive Anterior Myocardial Infarction
   --Acute Myocardial Infarction
   --Acute Anterior Myocardial Infarction
   --Acute Septal Myocardial Infarction
   --Acute Inferior Myocardial Infarction
   --Acute Lateral Myocardial Infarction
   --Acute Posterior Myocardial Infarction
   --Acute Right Ventricular Myocardial Infarction
   --Acute Non ST-Elevation Myocardial Infarction
   --Acute ST-Elevation Myocardial Infarction
   --Subendocardial Myocardial Infarction
   --Acute Myocardial Infarction Suspected
   --Previous (Q-wave) Myocardial Infarction
   --Unstable Angina Pectoris
   --Stable Angina Pectoris
   --Prinzmetal's Angina
   --Angina (Unrecorded Subtype)
None of the Above Is Recorded

9 Admission Diagnosis (Unrelated to Coronary Heart Disease) 【MC】
--Cardiac Arrest
--Cardiogenic Shock
--Ventricular Fibrillation/Ventricular Tachycardia
--Atrial Fibrillation
--Acute Heart Failure
--Chronic Heart Failure
--Heart Failure (Unspecified)
--Acute Pulmonary Edema
--Hemorrhagic Stroke (Cerebral Hemorrhage/Subarachnoid Hemorrhage)
--Ischemic Stroke (Cerebral Infarction/Cerebral Embolism/Cerebral Thrombosis)
--Stroke (Unspecified)
--Pneumonia
--COPD Exacerbation
--Gastrointestinal Bleeding
--Acute Renal Failure
--Chronic Renal Failure
--Dialysis (Hemodialysis/Peritoneal Dialysis)
--Dyslipidemia
--Hypertension
--Diabetes Mellitus
--Diabetic Nephropathy
--Gastroesophageal Reflux
--Oesophagismus
--Cholelithiasis
--Anemia
--None of the Above Is Recorded

10 Summary of In-Hospital Events
【Every Item Has Three Options—Y/N/Unrecorded】
--Repeat/Recurrent Myocardial Infarction
--Repeat/Recurrent Angina
--Cardiac Rupture
--Papillary Muscle Rupture
--Ventricular Septal Perforation
--Cardiac Tamponade
--Pericardial Effusion
--Cardiogenic Shock
--Cardiac Arrest
--Cardiopulmonary Resuscitation (CPR)
--Atrial Fibrillation or Flutter
--Ventricular Tachycardia/Ventricular Fibrillation
--Acute Heart Failure
--Exacerbation of Chronic Heart Failure
--Infection
--Acute Pulmonary Edema
--Gastrointestinal Bleeding
--Genitourinary Bleeding
11 In-Hospital Implantation of Intra-Aortic Balloon Pump (IABP)【SC】
--Yes
--No

12.1 Date of Implantation of Intra-Aortic Balloon Pump (IABP) ____【C】

12.2 Time of Implantation of Intra-Aortic Balloon Pump (IABP) ____【F】

13 Did the Patient Refuse the Following Treatments?
【Every Item Has Three Options—Y/N/Unrecorded】
--Refused Percutaneous Coronary Intervention (PCI)
--Refused Fibrinolysis
--Refused CABG

14 Documented Reasons for Non-prescription of Aspirin in the First 24 Hours【SC】
--No
--Yes--Allergy
--Yes--Other (Specify) ____【F】

15 Documented Reasons for Non-prescription of Beta-blocker in the First
24 Hours 【SC】
--No
--Yes--Allergy
--Yes--Other (Specify) _____【F】

16 Documented Reasons for Non-prescription of Fibrinolysis in the First 24 Hours 【SC】
--No
--Yes--Allergy
--Yes--Other (Specify) _____【F】

17 Documented Reasons for Non-prescription of GP IIB/IIIA Inhibitors 【SC】
--No
--Allergy/Intolerance
--Patient Refused
--Fibrinolytics Given
--Active or Recent (In Past 4 Weeks) Bleeding
--Warfarin/Coumadin as Pre-Arrival Medication
--Other Reason Documented by Physician, Specify _____【F】

18 Documented Reasons for Non-prescription of Heparins 【SC】
--No
--Allergy
--Other (Specify) _____【F】

19 Documented Reasons for Non-prescription of Other Anti-Thrombin Agents (e.g. Bivalirudin/Lepirudin/Argatroban) 【SC】
--No
--Allergy/Intolerance
--Patient Refused
--Stroke or Other Cerebrovascular Event in the Past Year
--Known Intracranial Neoplasm
--Active or Recent (Past 4 Weeks) Internal Bleeding
--Suspected Aortic Dissection
--Recent Surgery
--Severe Uncontrolled Hypertension on Presentation
--Pregnancy
--Trauma
--Other Reasons (Specify) _____【F】

20 Documented Reasons for Non-prescription of Aspirin at Discharge 【SC】
--No
--Yes--Allergy
--Yes--Other (Specify) _____【F】

21 Documented Reasons for Non-prescription of ACE Inhibitor at Discharge 【SC】
--No
--Yes--Allergy
--Yes—Other (Specify) _____ 【F】

22 Documented Reasons for Non-prescription of ARB at Discharge【SC】
--No
--Yes—Allergy
--Yes—Other (Specify) _____ 【F】

23 Documented Reasons for Non-prescription of Beta-blocker at Discharge【SC】
--No
--Yes—Allergy
--Yes—Other (Specify) _____ 【F】

24 Documented Reasons for Non-prescription of Statin at Discharge【SC】
--No
--Yes—Allergy
--Yes—Other (Specify) _____ 【F】

25 Discharge Status【SC】
--Discharge without Transfer to Another Hospital
--Physician Recommends Transfer to Another Hospital
--Patient or Relatives Demand Transfer to Another Hospital
--Patient Left Against Medical Advice
--None of the Above Is Recorded

26 Discharge Diagnosis (Related to Coronary Heart Disease)【MC】
--Coronary Heart Disease
--Acute Coronary Syndrome
--Acute Myocardial Infarction
--Acute Extensive Anterior Myocardial Infarction
--Acute Anterior Myocardial Infarction
--Acute Septal Myocardial Infarction
--Acute Inferior Myocardial Infarction
--Acute Lateral Myocardial Infarction
--Acute Posterior Myocardial Infarction
--Acute Right Ventricular Myocardial Infarction
--Acute Non ST-Elevation Myocardial Infarction
--Acute ST-Elevation Myocardial Infarction
--Subendocardial Myocardial Infarction
--Acute Myocardial Infarction Suspected
--Previous Q-Wave Myocardial Infarction
--Unstable Angina Pectoris
--Stable Angina Pectoris
--Prinzmetal's Angina
--Angina (Unrecorded Subtype)
--Repeated/Recurrent Myocardial Infarction
--Repeated/Recurrent Unstable Angina

27 Discharge Diagnosis of Acute Myocardial Infarction【SC】
--Yes—Answer the Questions Below Marked with an Asterisk (*)
28 Discharge Diagnosis 【MC】
--Cardiac Rupture
--Papillary Muscle Rupture
--Ventricular Septal Perforation
--Cardiac Tamponade
--Pericardial Effusion
--Cardiogenic Shock
--Cardiac Arrest
--Atrial Fibrillation
--Ventricular Tachycardia/Ventricular Fibrillation
--Acute Heart Failure
--Chronic Heart Failure
--Heart Failure (Unspecified)
--Acute Pulmonary Edema
--Gastrointestinal Bleeding
--Genitourinary Bleeding
--Intracranial/Subdural Bleeding
--Retroperitoneal Bleeding
--Access Site Bleeding (Including Hematoma at Access Site)
--Pericardial Bleeding
--Bleeding (Unspecified)
--Hemorrhagic Shock
--Venous Thromboembolism
--Pulmonary Embolism
--Deep Vein Thrombosis
--Ischemic Stroke (Cerebral Infarction/Thrombosis/Cerebral Embolism)
--Hemorrhagic Stroke (Cerebral Hemorrhage/Subarachnoid Hemorrhage)
--Stroke (Unspecified)
--Pneumonia
--Infection
--COPD Exacerbation
--Dyslipidemia
--Hypertension
--Diabetes Mellitus
--Diabetic Nephropathy
--Acute Renal Failure
--Chronic Renal Failure
--Dialysis (Hemodialysis/Peritoneal Dialysis)
--Contrast Reaction (Include Severe Allergic Reaction)
--Contrast-Induced Nephropathy (CIN)
--Thrombocytopenia
--Gastroesophageal Reflux
--Oesophagismus
--Cholelithiasis
--Anemia
--Unrecorded

29 Discharge Suggestions 【MC】
— Dual Anti-Platelet (Aspirin and Clopidogrel) Therapy 【F】
— Regular Blood Lipid Assessment
— Dietary Improvement
— Weight Reduction
— Smoking Cessation
— Regular Exercise
— PCI
— CABG
— None of the Above Is Recorded

30 Specify the Duration of Dual Anti-Platelet Therapy _____ 【F】

31 Medications at Discharge _____ 【Drug Database(D)】

32 Administration 【SC】
— P.O. / Undefined
— I.V. drip/ I.V. gtt (intravenously guttae)
— I.V.
— I.H. (Hypodermic Injection)
— I.D. (intradermal Injection)
— Others

Dose _____ 【F】

Unit 【SC】
— g
— mg
— ml
— u
— piece/ #
— mg/kg
— mg/h
— mg/min
— mg/kg·h
— ml/kg
— ml/h
— ml/min
— ml/kg·min
— u/kg
— u/min
— u/h
— u/kg·h
— ug
— ug/kg
— ug/min
— ug/kg·min
— MU
— BU
— %
— Other
---Unrecorded

**Frequency【SC】**
--Qd/QN
--Bid/q12h
--Tid/q8h
--Q6h
--As Needed
--Other
--Unrecorded

【33-60】Repeat Questions No.31 to 32 for the Other 14 Available Agents

**Admission Records & History of Diseases**

61.1*Ischemic Symptoms Onset Date ____Days Ago【F】

61.2*Ischemic Symptoms Onset Time ____Hours Ago【F】

62.1*Ischemic Symptoms Onset Date ____【C】

62.2*Ischemic Symptoms Onset Time ____【F】

63 *Was the Time of Ischemic Symptom Onset Estimated?【SC】
  --Yes
  --No

64 *Did the Patient Have Chest Discomfort (Chest Pain/Chest Discomfort/Chest Pressure/Other Symptoms in Chest)?【SC】
  --Yes
  --No
  --Unrecorded

65 *Did the Chest Discomfort Last 10 or More Minutes?【SC】
  --Yes
  --No
  --Unrecorded

66 *Did the Patient Have Other Ischemia Symptoms (Shortness of Breath/Pain at Non-chest Sites/Nausea/Vomit/Fatigue)?【SC】
  --Yes
  --No
  --Unrecorded

67 *Did Other Ischemic Symptoms Last 10 or More Minutes?【SC】
  --Yes
  --No
  --Unrecorded
68 CAD Presentation **[MC]**
   -- No Symptoms, No Angina
   -- Symptoms Unlikely to Be Ischemic
   -- Stable Angina
   -- Unstable Angina
   -- Non-STEMI
   -- STEMI

69 *Was Medical Assistance Provided at Outside Facilities Prior to This Hospitalization? **[SC]**
   -- Yes
   -- No
   -- Unrecorded

70 *Treatment Prior to Arrival
   **[Every Item Has Three Options—Y/N/Unrecorded]**
   -- Aspirin
   -- Clopidogrel
   -- Ticlopidine
   -- Antiplatelet Therapy
   -- Fibrinolysis (If Yes, Specify: SK, UK, Rt-PA, Other)
   -- External Defibrillation
   -- CPR/Chest Compression
   -- Temporary Cardiac Pacing

71 Time of Arrival at Your Hospital____ **[F]**

72 Was Time of Arrival at Your Hospital Estimated? **[SC]**
   -- Yes
   -- No
   -- Unrecorded

73 Treatment in Emergency Room Prior to Admission
   **[Every Item Has Three Options—Y/N/Unrecorded]**
   -- Aspirin
   -- Clopidogrel
   -- Ticlopidine
   -- Antiplatelet Therapy
   -- Fibrinolysis (If Yes, Specify: SK, UK, Rt-PA, Other)
   -- External Defibrillation
   -- CPR/Chest Compression
   -- Temporary Cardiac Pacing

74 Cardiogenic Shock at Presentation **[SC]**
   (Sustained (>30 minutes) Episode of Systolic Blood Pressure <90 mm Hg/Cardiac Index <2.2 L/min/m2/Requirement for Parenteral Inotropic or Vasopressor Agents/Mechanical Support [e.g. IABP/Extracorporeal Circulation/Ventricular Assist Devices])
   -- Yes
--No
--Unrecorded

75 Past Medical History (Related to Heart Disease)
【Every Item Has Three Options—Y/N/Unrecorded】
--Coronary Heart Disease
--Angina Pectoris
--Myocardial Infarction
--Prior PCI
--Prior CABG
--Ventricular Tachycardia
--Atrial Fibrillation/Flutter
--Bradycardia
--Heart Failure
--Valvular Heart Disease

76 If Patient Had a Prior PCI, Most Recent PCI Date【SC】
--< 1 Month Ago
--1-5 Months Ago
--6-12 Months Ago
-- 1-2 Years Ago
--> 2 Years Ago
--Unrecorded

77 If Patient Had a Prior CABG, Most Recent CABG Date【SC】
--< 1 Month Ago
--1-5 Months Ago
--6-12 Months Ago
-- 1-2 Years Ago
--> 2 Years Ago
--Unrecorded

78.1 Specify the First Home Medication _____【F】

78.2 Specify the Second Home Medication _____【F】

78.3 Specify the Third Home Medication _____【F】

78.4 Specify the Fourth Home Medication _____【F】

78.5 Specify the Fifth Home Medication _____【F】

79 Features of the Heart Failure
【Every Item Has Three Options—Y/N/Unrecorded】
--Unusual Dyspnea on Light Exertion
--Recurrent Dyspnea Occurring in the Supine Position

80 Past Medical History (Unrelated to Heart Disease)
   Every Item Has Three Options—Y/N/Unrecorded
   --Hypertension
   --Diabetes Mellitus
   --Dyslipidemia
   --Peripheral Vascular Disease (Intermittent Claudication/Lower Limb Arterial Embolism)
   --Ischemic Stroke (Cerebral Embolism/Cerebral Infarction/Cerebral Thrombosis)
   --Hemorrhagic Stroke (Cerebral Hemorrhage/Subarachnoid Hemorrhage)
   --Stroke (Unspecified)
   --Carotid Artery Surgery/Intervention
   --Chronic Lung Disease
     (COPD/Chronic Bronchitis/Emphysema/Asbestosis/Mesothelioma/ Black Lung Disease/Pneumoconiosis/Radiation-induced Pneumonitis/Radiation Fibrosis)
   --Chronic Renal Failure
   --Currently on Dialysis
   --Hepatitis B
   --Hepatitis C
   --Cirrhosis
   --Family History of CAD

81 Drug Allergy _____【F】

Personal History

82 Smoking History【SC】
   --Never
   --Past
   --Current
   --Unrecorded

83 If Current, Duration _____Years _____Months【F】

84 If Past, Duration _____Years _____Months【F】

85 Smoking Frequency _____Cigarettes/Day【F】

Physical Examination

86 Vital Signs【F】
   --Temperature at Presentation to This Facility _____°C
   --Heart Rate at Presentation to This Facility _____bpm
   --Respiratory Rate at Presentation to This Facility _____bpm
   --Systolic Blood Pressure at Presentation to This Facility _____mmHg
   --Diastolic Blood Pressure at Presentation to This Facility _____mmHg
87 Signs of Heart Failure【MC】
【Every Item Has Three Options—Y/N/Unrecorded】
--Jugular Venous Distension
--Rales
--Pulmonary Edema
--Fluid Retention (Lower Extremity Edema)

Auxiliary Examination

88 Was the ECG Performed at Hospital Presentation Available in Medical Record?【SC】
--Yes
--No

89.1 Date of First ECG at Hospital _____【C】

89.2 Time of First ECG at Hospital _____【F】

90 Original Interpretation of ECG【MC】
--Acute MI
--Complete LBBB (Unspecified)
--ST-Elevation
--ST-Depression
--Previous MI (Q Wave)
--Ventricular Fibrillation
--Ventricular Tachycardia
--Atrial Fibrillation
--2nd Degree Atrioventricular Block Type 1
--2nd Degree Atrioventricular Block Type 2
--3nd Degree Atrioventricular Block

91 Was a Second ECG Performed during Hospitalization Available in Medical Record?【SC】
--Yes
--No

92.1 Date of Second ECG at Hospital _____【C】

92.2 Time of Second ECG at Hospital _____【F】

93 Original Interpretation of ECG【MC】
--Acute MI
--Complete LBBB (Unspecified)
--ST-Elevation
--ST-Depression
--Previous MI (Q Wave)
--Ventricular Fibrillation
--Ventricular Tachycardia
94 Was a Third ECG Performed during Hospitalization Available in Medical Record? 【SC】
--Yes
--No
95.1 Date of Third ECG at Hospital _____ 【C】
95.2 Time of Third ECG at Hospital _____ 【F】
96 Original Interpretation of ECG 【MC】
--Acute MI
--Complete LBBB (Unspecified)
--ST-Elevation
--ST-Depression
--Previous MI (Q Wave)
--Ventricular Fibrillation
--Ventricular Tachycardia
--Atrial Fibrillation
--2nd Degree Atrioventricular Block Type 1
--2nd Degree Atrioventricular Block Type 2
--3rd Degree Atrioventricular Block
97 Was CK Tested at the Prior Hospital or in the Emergency Room of Your Hospital? 【SC】
--Yes
--No
98.1 CK Value _____ 【F】
98.2 Unit of CK _____ 【SC】
--IU/L
--ng/ml
--mg/ml
--%
--mg/IU
--ml/IU
98.3 CK Date _____ 【C】
98.4 CK Time _____ 【F】
99 Was CK-MB Tested at the Prior Hospital or in the Emergency Room of Your Hospital? 【SC】
--Yes
--No
100.1 CK-MB Value _____【F】

100.2 Unit of CK-MB _____【SC】
   --IU/L
   --ng/ml
   --mg/ml
   --%
   --mg/IU
   --ml/IU

100.3 CK-MB Date_____【C】

100.4 CK-MB Time_____【F】

101 Was Troponin Tested at the Prior Hospital or in the Emergency Room of Your Hospital? 【SC】
   --Yes
   --No

102.1 Troponin Date _____【C】

102.2 Troponin Time_____【F】

103 The Type of Troponin 【MC】
   --Troponin T
   --Troponin I
   --Troponin (Unspecified)

104 Value for Troponin T? 【SC】
   --Positive
   --Negative
   --Numerical value

105 Troponin T Value _____ng/ml【F】

106 Value for Troponin I?
   --Positive
   --Negative
   --Numerical value

107 Troponin I Value _____ng/ml【F】

108 Value for Troponin (Unspecified)?
   --Positive
   --Negative
   --Numerical value

109 Troponin (Unspecified) Value _____ng/ml【F】
110 Was Routine Blood Test Performed at the Prior Hospital or in the Emergency Room of Your Hospital? 【SC】
--Yes
--No

111.1 White Blood Cell (WBC) Value _____ X 10^9 【F】
111.2 Neutrophil Ratio _____ % 【F】
111.3 Hemoglobin Value _____ g/L 【F】
111.4 Platelet Count Value _____ x10^9 【F】
111.5 Routine Blood Test Date _____ 【C】

112.1 Creatinine Value _____ umol/L 【F】
112.2 Date of Creatinine Test _____ 【C】

113 Was Coagulation Test Performed at the Prior Hospital or in the Emergency Room of Your Hospital? 【SC】
--Yes
--No

114.1 PT Value _____ s 【F】
114.2 APTT Value _____ s 【F】
114.3 INR Value _____ 【F】
114.4 Coagulation Test Date _____ 【C】

Preliminary Diagnosis
115 Admission Diagnosis (Related to Coronary Heart Disease) 【MC】 Same As No.9

116 Admission Diagnosis (Unrelated to Coronary Heart Disease) 【MC】 Same As No.10

117 Killip Classification 【SC】
--I
--II
--III
--IV
--Unrecorded
118 NYHA Classification 【SC】

---I
---II
---III
---IV
---Unrecorded

Daily Records

119 Are Daily Records Filed into This Medical Record? 【SC】

---Yes
---No

120 In-Hospital Events 【Every Item Has Three Options—Y/N/Unrecorded】

---Repeat/Recurrent Myocardial Infarction
---Repeat/Recurrent Angina
---Cardiac Rupture
---Papillary Muscle Rupture
---Ventricular Septal Perforation
---Cardiac Tamponade
---Pericardial Effusion
---Cardiogenic Shock
---Cardiac Arrest
---Cardiopulmonary Resuscitation (CPR)
---Atrial Fibrillation or Flutter
---Ventricular Tachycardia/Ventricular Fibrillation
---Acute Heart Failure
---Exacerbation of Chronic Heart Failure
---Infection
---Acute Pulmonary Edema
---Gastrointestinal Bleeding
---Genitourinary Bleeding
---Intracranial/Subdural Bleeding
---Retroperitoneal Bleeding
---Access Site Bleeding (Including Hematoma at Access Site)
---Pericardial Bleeding
---Bleeding (Unspecified)
---Hemorrhagic Shock
---Venous Thromboembolism
---Pulmonary Embolism
---Deep Vein Thrombosis
---Stent Thrombosis
---Significant Dissection
---Perforation
---Abrupt Vessel Closure in the Catheterization Laboratory
---Side Branch Occlusion
---Distal Embolization
---No Flow/Slow Flow Phenomenon
Did the Patient Refuse the Following Treatment?

【Every Item Has Three Options—Y/N/Unrecorded】
--Refused Percutaneous Coronary Intervention (PCI)
--Refused Fibrinolysis
--Refused CABG

Cardiac Arrest Date _____【C】

Stroke Date _____【C】

Bleeding Date _____【C】

Interventions for Management of Bleeding【MC】
--Local Compression
--Surgery
--Endoscopic
--Transfusion
--Others
--None
--Unrecorded

The Nadir Blood Pressure After Bleeding Event (Lowest Recorded BP On the Day of and the Next Day After Bleeding Onset) _____/_____mm Hg【F】

Hospital-Acquired Infection Site【SC】
--Pulmonary
--Genitourinary
--Gastrointestinal
--Skin
--Surgical site/Access site
--Other, Specify _____【F】
--Unrecorded

In-Hospital Implantation of Intra-Aortic Balloon Pump (IABP)【SC】
129.1 Implantation of Intra-Aortic Balloon Pump (IABP) Date _____【C】

129.2 Implantation of Intra-Aortic Balloon Pump (IABP) Time_____【F】

130 The First Coronary Angiography Status【SC】

--Elective
--Urgent
--Emergency
--Salvage
--Unrecorded

131 The First PCI Status【SC】

--Elective
--Urgent
--Emergency
--Salvage
--Unrecorded

132 The Second Coronary Angiography Status【SC】

--Elective
--Urgent
--Emergency
--Salvage
--Unrecorded

133 The Second PCI Status【SC】

--Elective
--Urgent
--Emergency
--Salvage
--Unrecorded

134 Reasons for Repeat PCI During Hospitalization【SC】

--No Repeat PCI
--Staged Procedure
--Ongoing or recurrent ischemia
--Other
--Unrecorded

135 Documented Reasons for Non-prescription of Aspirin in the First 24 Hour【SC】

--No
--Yes—Allergy
136 Documented Reasons for Non-prescription of Beta-blocker in the First 24 Hours【SC】
--No
--Yes--Allergy
--Yes--Other (Specify) ______【F】

137 Documented Reasons for Non-prescription of Fibrinolytics in the First 24 Hours【SC】
--No
--Yes--Allergy
--Yes--Other (Specify) ______【F】

138 Documented Reasons for Non-prescription of GP IIB/IIIA Inhibitor【SC】
--No
--Allergy/Intolerance
--Patient Refused
--Fibrinolytics Given
--Active or Recent (In Past 4 Weeks) Bleeding
--Warfarin/Coumadin as Pre-Arrival Medication
--Other Reason Documented by Physician, Specify ______【F】

139 Documented Reasons for Non-prescription of Heparins【SC】
--No
--Allergy
--Other (Specify) ______【F】

140 Documented Reasons for Non-prescription of other Anti-Thrombin Agents (e.g. Bivalirudin/Lepirudin/Argatroban)【SC】
--Allergy/Intolerance
--Patient Refused
--Stroke or Other Cerebrovascular Event in the Past Year
--Known Intracranial Neoplasm
--Active or Recent (Past 4 Weeks) Internal Bleeding
--Suspected Aortic Dissection
--Recent Surgery
--Severe Uncontrolled Hypertension on Presentation
--Pregnancy
--Trauma
--Other Reason (Specify) ______【F】

141 Documented Reasons for Non-prescription of Aspirin at Discharge【SC】
--No
--Yes--Allergy
--Yes--Other (Specify) ______【F】

142 Documented Reasons for Non-prescription of ACE Inhibitor at Discharge【SC】
--No
--Yes--Allergy
--Yes--Other (Specify) _____ 【F】

143 Documented Reasons for Non-prescription of ARB at Discharge【SC】
--No
--Yes--Allergy
--Yes--Other (Specify) _____ 【F】

144 Documented Reasons for Non-prescription of Beta-blocker at Discharge【SC】
--No
--Yes--Allergy
--Yes--Other (Specify) _____ 【F】

145 Documented Reasons for Non-prescription of Statin at Discharge【SC】
--No
--Yes--Allergy
--Yes--Other (Specify) _____ 【F】

In-Hospital Device Placement

146 ICD【SC】
--Yes
--No

147 ICD Date _____ 【C】

148 IABP【SC】
--Yes
--No

149.1 IABP Date _____ 【C】

149.2 IABP Time _____ 【F】

Coronary Angiography and PCI Report

150 Diagnostic Catheterization or Diagnostic Coronary Angiography【SC】
--Yes
--No

151.1 Procedure Start Date_____ 【C】

151.2 Procedure Start Time_____ 【F】
152 Arterial Access Site【SC】
   --Femoral Artery
   --Radial Artery
   --Brachial Artery
   --Other

153 Arterial Dominance【SC】
   --Left Coronary Artery
   --Right Coronary Artery
   --Co-dominant
   --Unrecorded

154 If the Patient Has Not Had a CABG, Is Percent Stenosis Available in Each of the Native Vessels?【MC】
   --Left Main Artery (LM)
   --Proximal LAD
   --Mid/Distal LAD/Diag Branches
   --Circ/OMs/LPDA and LPL Branches
   --Ramus
   --RCA/RPDA/RPL/AM Branches
   --None of the Above is Recorded

155 LM Stenosis Percent _____【F】

156 Proximal LAD Stenosis Percent _____【F】

157 Mid/Distal LAD/Diagonal Stenosis Percent _____【F】

158 Circ/OMs/LPDA/LPL Stenosis Percent _____【F】

159 RCA/PRDA/RPL/AM Stenosis Percent _____【F】

160 Ramus Stenosis Percent _____【F】

161 Graft Vessel(s) Used for Previous CABG【MC】
   --LIMA
   --RIMA
   --Radial Artery
   --SVG
   --Unrecorded
   --No CABG History

162 Graft Percent Stenosis【F】
   --Graft to Proximal LAD
   --Graft to Mid/Distal LAD/Diag Branches
   --Graft to Circ/OMs/LPDA and LPL Branches
   --Graft to RCA/RPDA/RPL/AM Branches
--Graft to Ramus
--LIMA
--RIMA
--SVG

163 Intravascular Ultrasound (IVUS) Performed during the Procedure? 【SC】
   --Yes
   --No

164 Left Main Stem Protected? 【SC】
   --Yes
   --No

165 Mechanical Ventricular Support 【SC】
   --None
   --IABP
   --ECMO
   --LVAD

166 If Yes, Timing for IABP Implantation 【SC】
   --In Place at Start of Procedure
   --Inserted During Procedure and Prior to PCI
   --Inserted After PCI has Begun

167 If Yes, Timing for ECMO or LVAD Implantation 【SC】
   --In Place at Start of Procedure
   --Inserted During Procedure and Prior to PCI
   --Inserted After PCI has Begun

168 Recommendation (After Diagnostic Cath) 【MC】
   --None
   --Medical Therapy/Counseling
   --PCI without Planned CABG
   --CABG (Including Planned Hybrid Procedures)
   --Other Cardiac Therapy without CABG or PCI

169 Was PCI Performed Immediately Following Diagnostic Catheterization【SC】
   --Yes
   --No

170.1 PCI Date _____ 【C】

170.2 PCI Start Time _____ 【F】

171 Arterial Access Site 【SC】
--Femoral Artery
--Radial Artery
--Brachial Artery
--Other

172 Cardiogenic Shock at Start of PCI 【SC】
   --Yes
   --No

173.1 Systolic Blood Pressure Prior to PCI _____mmHg 【F】

173.2 Dilated Blood Pressure Prior to PCI _____mmHg 【F】

173.3 Heart Rate Prior to PCI _____bpm 【F】

174 Time of the First Treatment of Lesion
   (AngioJet/Other Thrombectomy/Aspiration Device/Laser/Rotational Atherectomy)
   _____ 【F】

175 Time of the First Balloon Inflation _____ 【F】

176 Lesion Counter _____ 【F】

177 Choose Segments Below in Which Lesion is Located 【MC】
   --Left Main Artery (LM)
   --Proximal LAD
   --Mid/Distal LAD/Diag Branches
   --Circ/OMs/LPDA and LPL Branches
   --Ramus
   --RCA/RPDA/RPL/AM Branches

178 Stenosis Immediately Prior to PCI _____% 【F】

179 Fractional Flow Reserve Ratio Measured during the Procedure _____ 【F】

180 Pre-Procedure TIMI Flow (Lowest TIMI Flow within the Entire Lesion) 【SC】
   --TIMI-0
   --TIMI-1
   --TIMI-2
   --TIMI-3
   --Unrecorded

181 Pre-treated Lesion 【SC】
   --Yes
   --No

182 If Yes, Treated with Stent 【SC】
   --Yes
If Yes, Reasons for PCI at Site of Former Stent

- In-stent Restenosis
- In-stent Thrombosis
- Unrecorded

Was Lesion in Bypass Graft

- Not in Graft
- Vein
- LIMA
- Other Artery
- Unrecorded

If Vein, LIMA, Other, Location in Graft

- Aortic (Proximal Vessel)
- Body (Mid Vessel)
- Distal
- Unrecorded

Lesion Length ______mm

The Characteristics of the Lesion

- Thrombus Present in the Lesion
- Bifurcation Lesion
- Calcified Lesion
- Type A Lesion
- Type B Lesion
- Type C Lesion
- None of the Above Is Recorded

Did Guidewire Cross the Lesion?

- Yes
- No

Time Guidewire Crossed the Lesion _____

Was a Stent Placed

- Yes
- No

If Yes, Time Stent Deployment _____

The First Stent’s Trade Name _____

The Second Stent’s Trade Name _____
192.3 The Third Stent's Trade Name _____ 【D】

193.1 The First Stent’s Diameter _____ 【F】

193.2 The First Stent’s Length _____ 【F】

193.3 The Second Stent’s Diameter _____ 【F】

193.4 The Second Stent’s Length _____ 【F】

193.5 The Third Stent’s Diameter _____ 【F】

193.6 The Third Stent’s Length _____ 【F】

194 Post-Procedural Percent Stenosis for the Treated Lesion _____% 【F】

195 Post-Procedure TIMI Flow (Coded the Lowest TIMI Flow within the Entire Lesion 【SC】

--TIMI-0
--TIMI-1
--TIMI-2
--TIMI-3
--Unrecorded

【196-275】 Repeat Question 176 to 195 for Another 4 Lesions

276 Were Any of the Following Devices Used? 【SC】

--None
--Balloon
--Cutting Balloon
--Rotablator
--Aspiration Catheters
--IVUS
--Pressure Wire
--Flowire
--Brachytherapy
--Distal/Proximal Embolic Protection
--Thrombectomy Device

277 Was Left Ventricular Ejection Fraction Measured during the Procedure 【SC】

--Yes, EF=______% 【F】
--No

278 Type of Contrast Dye Used 【SC】

--Lopamidol
--Lopromide
--Lohexol
--Lodixanol
--Lomeprol
--Loversol
--Other
--Unrecorded

279 Total Volume of Contrast Dye Used _____ml【F】

280 Closure Method【SC】
--Seal (Angioseal/Vasoseal)
--Suture
--Manual Compression
--Other Method
--Unrecorded

281 PCI Complications【MC】
--Ventricular Tachycardia (VT) or Ventricular Fibrillation (V-Fib)
--Significant Dissection
--Perforation
--Abrupt Vessel Closure in the Catheterization Laboratory
--Side Branch Occlusion
--Peripheral Embolization
--Distal Embolization
--No Flow/Slow Flow Phenomenon
--Access Site Occlusion
--Access Site Arteriovenous Fistula
--Access Site Hematoma
--Access Site Dissection
--Access Complication Requiring Surgery/Intervention
--None of the Above

【282-414】Repeat Question 150 to 281 for a Second Coronary Angiogram and/or PCI

CABG Report

415 CABG during Hospitalization?【SC】
--Yes
--No

416 CABG Date _____【C】

Imaging Examination

417 Was Chest X-ray or Other Lung Imaging (Chest CT/MRI) Performed?【SC】
--Yes
418 Was Echocardiography Performed?【SC】
  --Yes
  --No

419 Echocardiography LVEF Value _____%【F】

420 Was a Stress Test Performed?【SC】
  --Yes
  --No

421.1 Stress Test Type【SC】
  --ECG Only
  --Radionuclide
  --Echocardiography
  --Cardiac MRI
  --Unrecorded

421.2 Method of Stress Test【SC】
  --Exercise
  --Pharmacologic
  --Unrecorded

422 Results of Stress Test【SC】
  --Negative
  --Positive
  --Indeterminate
  --Unrecorded

423 Was a Coronary CT Angiogram Performed?【SC】
  --Yes
  --No

424 Coronary Calcium Score _____【F】

In-Hospital ECG

425 Was the ECG Performed at Hospital Presentation Available in Medical Record?【SC】
  --Yes
  --No

426 Original Interpretation of ECG【MC】
  --Acute MI
--New Complete LBBB
--Old Complete LBBB
--Complete LBBB (Unspecified)
--ST-Elevation
--ST-Depression
--Previous MI (Q Wave)
--Ventricular Fibrillation
--Ventricular Tachycardia
--Atrial Fibrillation
--2nd Degree Atrioventricular Block Type 1
--2nd Degree Atrioventricular Block Type 2
--3rd Degree Atrioventricular Block

**Temperature Report**

0.1 Admission Date _____【C】

0.2 Admission Time _____【F】

   Discharge Date _____【C】

   Height _____cm【F】

   Admission Weight _____kg【F】

**Long-term Physician Orders**

Name of Long-term Medications _____【D】

Start Time _____【F】

   **Administration【SC】**
   --P.O. /Undefined
   --I.V. drip/ I.V. gtt (intravenously guttae)
   --I.V.
   --I.H. (Hypodermic Injection)
   --I.D. (Intradermal Injection)
   --Others

   Dose _____【F】

   **Unit _____【SC】**
   --g
   --mg
   --ml
   --U
   --piece/ #
   --mg/kg
--mg/h
--mg/min
--mg/kg·h
--ml/kg
--ml/h
--ml/min
--ml/kg·min
--U/kg
--U/min
--U/h
--U/kg·h
--ug
--ug/kg
--ug/min
--ug/kg·min
--MU
--BU
--Other
--Unrecorded

**Frequency【SC】**
--Qd /QN
--Bid/q12h
--Tid/q8h
--Q6h
--As Needed
--Others
--Unrecorded

**End Date and Time_____【F】**

【434-591】Repeat Questions No.432 to 433 for the Other 79 Available Agents

**Short-term Physician Orders**

592  **Name of Short-term Medications _____【D】**

593  **Start Time_____【F】**

**Administration【SC】**
--P.O. /Undefined
--I.V. drip/ I.V. gtt (intravenously guttae)
--I.V.
--I.H. (hypodermic injection)
--I.D. (intradermal injection)
--Others

**Dose _____【F】**
Unit _____【SC】
--g
--mg
--ml
--U
--Piece/ #
--mg/kg
--mg/h
--mg/min
--mg/kg·h
--ml/kg
--ml/h
--ml/min
--ml/kg·min
--U/kg
--U/min
--U/h
--U/kg·h
--ug
--ug/kg
--ug/min
--ug/kg·min
--MU
--BU
--Other
--Unrecorded

Frequency【SC】
--Qd /QN
--Bid/q12h
--Tid/q8h
--Q6h
--As Needed
--Others
--Unrecorded

【594-791】Repeat Questions No.592 to 593 for the other 99 Available Agents

Discharge Medications

792 Discharge Agent _____【D】

793 Administration【SC】
--I.V. drip/ I.V. gtt (intravenously guttae)
--I.V.
--I.H. (hypodermic injection)
--I.D. (intradermal injection)
--Others
Dose _____【F】

Unit _____【SC】
--g
--mg
--ml
--U
--Piece/ #
--mg/kg
--mg/h
--mg/min
--mg/kg·h
--ml/kg
--ml/h
--ml/min
--ml/kg·min
--U/kg
--U/min
--U/h
--U/kg·h
--ug
--ug/kg
--ug/min
--ug/kg·min
--MU
--BU
--Other
--Unrecorded

Frequency【SC】
--Qd /QN
--Bid/q12h
--Tid/q8h
--Q6h
--As Needed
--Others
--Unrecorded

【794-821】Repeat Questions No.792 to 793 for the other 79 Available Agents
CHINA PEACE-RETROSPECTIVE CATHPCI STUDY CASE REPORT FORM, PART 2

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1 Study ID _____ 【Free Text (F)】

**The Face Sheet of Medical Records**

2 Medical Record Number _____ 【F】

3 Medical Insurance 【Single Choice (SC)】
   --Payment Out-of-Pocket
   --Free Medical Care
   --Urban Residents/Worker Medical Insurance
   --Comprehensive Arrangement for Serious Disease
   --New-Type Rural Cooperative Medical System (CMS)
   --Poverty Assistance Insurance
   --Commercial Medical Insurance
   --Other Social Insurance
   --Unrecorded

4 Gender 【SC】
   --Male
   --Female

5 Age _____ 【F】

6 Marital Status 【SC】
   --Married
   --Single
   --Divorced
   --Widowed
   --Unrecorded

7 Occupation 【SC】
   --Retired
   --Worker (Industrial/Mining/Construction/Other Similar Type of Work)
   --Farmer
   --Office work
   --Cadre
   --Teacher
   --Student
   --Physician
   --Businessman
   --Engineer
   --Policeman or Soldier
   --Freelancers
   --Unemployed
   --Other
   --Unrecorded
8 Ethnicity 【SC】
   --Han
   --Zhuang
   --Man
   --Hui
   --Miao
   --Weiwuer
   --Tuja
   --Yi
   --Menggu
   --Zang
   --Buyi
   --Other
   --Unrecorded

9 Nationality 【SC】
   --China
   --Other
   --Unrecorded

10 Location of Residence 【SC】
   --Urban
   --Rural
   --Overseas
   --Unrecorded

11 Postal Code of Residence _____ 【F】

12 Admission Date _____ 【C】

13 Admission Time _____ 【F】

14 Discharge Date _____ 【C】

15 Department of Admission 【SC】
   --Cardiovascular Department
   --Internal Medicine Department
   --Geriatrics
   --Cadre's Ward
   --Intensive Care Unit (ICU)
   --Coronary Care Unit (CCU)
   --Other
   --Unrecorded

16 Was Patient Transferred from One Department to Another? 【SC】
   --Yes
17 Discharge Department 【SC】
--Cardiovascular Department
--Internal Medicine Department
--Geriatrics
--Cadre's Ward
--Intensive Care Unit (ICU)
--Coronary Care Unit (CCU)
--Other
--Unrecorded

18 Date Diagnosis Was Confirmed _____ 【C】

19 Admission Diagnoses (Related to Coronary Heart Disease) 【Multiple Choices Permitted (MC)】
--Coronary Heart Disease
--Acute Coronary Syndrome
--Acute Myocardial Infarction
--Acute Extensive Anterior Myocardial Infarction
--Acute Anterior Myocardial Infarction
--Acute Septal Myocardial Infarction
--Acute Inferior Myocardial Infarction
--Acute Lateral Myocardial Infarction
--Acute Posterior Myocardial Infarction
--Acute Right Ventricular Myocardial Infarction
--Acute Non ST-Elevation Myocardial Infarction
--Acute ST-Elevation Myocardial Infarction
--Subendocardial Myocardial Infarction
--Acute Myocardial Infarction Suspected
--Previous Q-wave Myocardial Infarction
--Unstable Angina Pectoris
--Stable Angina Pectoris
--Prinzmetal's Angina
--Angina (Unrecorded Subtype)
--None of the Above is Recorded

20 Admission Diagnoses (Unrelated to Coronary Heart Disease) 【MC】
--Cardiac Arrest
--Cardiogenic Shock
--Ventricular Fibrillation/Ventricular Tachycardia
--Atrial Fibrillation
--Acute Heart Failure
--Chronic Heart Failure
--Heart Failure (Unspecified)
--Acute Pulmonary Edema
--Hemorrhagic Stroke (Cerebral Hemorrhage/Subarachnoid Hemorrhage)
--Ischemic Stroke (Cerebral Infarction/Cerebral Embolism/Cerebral Thrombosis)
--Stroke (Unspecified)
--Pneumonia
--COPD Exacerbation
--Gastrointestinal Bleeding
--Acute Renal Failure
--Chronic Renal Failure
--Dialysis (Hemodialysis/Peritoneal Dialysis)
--Dyslipidemia
--Hypertension
--Diabetes Mellitus
--Gastroesophageal Reflux
--Oesophagismus
--Cholelithiasis
--Anemia

21 Discharge Diagnoses【MC】

--Coronary Heart Disease
--Acute Coronary Syndrome
--Acute Myocardial Infarction
--Acute Extensive Anterior Myocardial Infarction
--Acute Anterior Myocardial Infarction
--Acute Septal Myocardial Infarction
--Acute Inferior Myocardial Infarction
--Acute Lateral Myocardial Infarction
--Acute Posterior Myocardial Infarction
--Acute Right Ventricular Myocardial Infarction
--Acute Non ST-Elevation Myocardial Infarction
--Acute ST-Elevation Myocardial Infarction
--Subendocardial Myocardial Infarction
--Acute Myocardial Infarction Suspected
--Previous Q-Wave Myocardial Infarction
--Unstable Angina Pectoris
--Stable Angina Pectoris
--Prinzmetal's Angina
--Angina (Unrecorded Subtype)
--Recurrent/Recurrent Myocardial Infarction
--Recurrent/Recurrent Unstable Angina
--Cardiac Rupture
--Papillary Muscle Rupture
--Ventricular Septum Perforation
--Cardiac Tamponade
--Pericardial Effusion
--Cardiogenic Shock
--Cardiac Arrest
--Atrial Fibrillation
--Ventricular Tachycardia/Ventricular Fibrillation
--Acute Heart Failure
--Chronic Heart Failure
--Heart Failure (Unspecified)
--Acute Pulmonary Edema
--Gastrointestinal Bleeding
--Genitourinary Bleeding
--Intracranial/Subdural Bleeding
--Retroperitoneal Bleeding
--Access Site Bleeding (Including Hematoma at Access Site)
--Pericardial Bleeding
--Bleeding (Unspecified)
--Hemorrhagic Shock
--Venous Thromboembolism
--Pulmonary Embolism
--Deep Vein Thrombosis
--Ischemic Stroke (Cerebral Infarction/Thrombosis/Cerebral Embolism)
--Hemorrhagic Stroke (Cerebral Hemorrhage/Subarachnoid Hemorrhage)
--Stroke (Unspecified)
--Pneumonia
--Infection
--COPD Exacerbation
--Dyslipidemia
--Hypertension
--Diabetes Mellitus
--Diabetic Nephropathy
--Acute Renal Failure
--Chronic Renal Failure
--Dialysis (Hemodialysis/Peritoneal Dialysis)
--Contrast Reaction (Include Severe Allergic Reaction)
--Contrast-Induced Nephropathy (CIN)
--Thrombocytopenia
--Gastroesophageal Reflux
--Oesophagismus
--Cholelithiasis
--Anemia

22 ICD (for Every Diagnosis)【SC】
   --ICD 9
   --ICD 10
   --Unrecorded

23 ICD9 (Specify) _____【F】

24 ICD10 (Specify) _____【F】

25 Nosocomial Infection (Specify) _____【F】

26 Drug Allergy (Specify) _____【F】

27 HBs-Ag【SC】
   --Untested
   --Negative
   --Positive
28 HCV-Ab【SC】
   --Untested
   --Negative
   --Positive

29 HIV-Ab【SC】
   --Untested
   --Negative
   --Positive

30 The First Procedure Date_____【F】

31 Procedures Performed During Hospitalization【MC】
   --PCI
   --CAG
   --PCI+CAG
   --PTCA
   --CABG
   --LVAD
   --IABP
   --ICD
   --Cardiac Resynchronization Therapy
   --CRT-D
   --Pacemaker
   --Other (Specify) ______【F】

32 The Second Procedure Date _____【F】

33 Procedures Performed during Hospitalization【MC】
   --PCI
   --CAG
   --PCI+CAG
   --PTCA
   --CABG
   --LVAD
   --IABP
   --ICD
   --Cardiac Resynchronization Therapy
   --CRT-D
   --Pacemaker
   --Other (Specify) ______【F】

34 Gross Charge _____ Yuan【F】

35 Autopsy【SC】
   --Yes
36 The Type of Blood Transfusion【MC】
--No Blood Transfusion
--Red Blood Cell
--Platelet
--Blood Plasma
--Whole Blood
--Other (Specify)______【F】

Lab Test

37 Unit of Myohemoglobin【SC】
--IU/L
--ng/ml
--mg/ml
--Other

38 Myohemoglobin Upper Limit of Normal (ULN) _____【F】

39 Initial Myohemoglobin Value _____【F】

40 Initial Myohemoglobin Date and Time _____【C】

41 Maximum Myohemoglobin _____【F】

42 Maximum Myohemoglobin Date and Time _____【C】

43 Unit of Creatine Kinase (CK) Level【SC】
--IU/L
--ng/ml
--mg/ml
--%
--mg/IU
--ml/IU

44 Initial CK Upper Limit of Normal (ULN) _____【F】

45 Initial Creatine Kinase (CK) Value _____【F】

46 Initial Creatine Kinase (CK) Date and Time _____【C】

47 Maximum Creatine Kinase (CK) Value _____【F】

48 Maximum Creatine Kinase (CK) Date and Time _____【C】
49 Unit of Creatine Kinase (CK-MB) Level [SC]
   --IU/L
   --ng/ml
   --mg/ml
   --%
   --mg/IU
   --ml/IU

50 Initial CK-MB Upper Limit of Normal (ULN) [F]

51 Initial CK-MB Value [F]

52 Initial CK-MB Date and Time [F]

53 Maximum CK-MB Value [F]

54 Maximum CK-MB Date and Time [C]

55 Unit of Troponin I [SC]
   --ng/ml
   --IU/L or U/L
   --Other

56 Initial Troponin I Value [SC]
   --Positive
   --Negative
   --Trace (+/-)
   --Numerical Value [F]

57 Initial Troponin I Upper Reference Limit (URL) [F]

58 Initial Troponin I Value [F]

59 Initial Troponin I Date and Time [C]

60 Maximum Troponin I Value [F]

61 Maximum Troponin I Date and Time [C]

62 Unit of Troponin T [SC]
   --ng/ml
   --IU/L or U/L
   --Other

63 Initial Troponin T Value [SC]
   --Positive
   --Negative
64 Initial Troponin T Upper Reference Limit (URL) ______【F】
65 Initial Troponin T Value ______【F】
66 Initial Troponin T Date and Time ______【C】
67 Maximum Troponin T Value ______【F】
68 Maximum Troponin T Date and Time ______【C】
69 Unit of Troponin (Unspecified) 【SC】
   --ng/ml
   --IU/L or U/L
   --Other
70 Initial Troponin (Unspecified) Value 【SC】
   --Positive
   --Negative
   --Numerical Value
71 Initial Troponin (Unspecified) Upper Reference Limit (URL) ______【F】
72 Initial Troponin (Unspecified) Value ______【F】
73 Initial Troponin (Unspecified) Date and Time ______【C】
74 Maximum Troponin (Unspecified) value ______【F】
75 Maximum Troponin (Unspecified) Date and Time ______【C】
76 First White Blood Cell (WBC) Value ______ X10^9 【F】
77 Date and Time ______【C】
78 Initial Neutrophil Ratio ______ % 【F】
79 Date and Time ______【C】
80 Initial Hemoglobin Value ______ g/L 【F】
81 Date and Time ______【C】
82 Initial Platelet Count Value ______ x10^9 【F】
83 Date and Time ______【C】
84 Initial HCT Value _____ [F]
85 Date and Time_____ [C]
86 Minimum Platelet Count Value _____ x10^9 [F]
87 Date and Time _____ [C]
88 Lowest Recorded Hemoglobin Value _____ g/L [F]
89 Date and Time _____ [C]
90 Last Hemoglobin Value _____ g/L [F]
91 Date and Time _____ [C]
92 Minimum HCT Value _____ [F]
93 Date and Time _____ [C]
94 Last HCT Value _____ [F]
95 Date and Time _____ [F]
96 Initial Urine Routine Date and Time _____ [C]
97 Urine Protein [SC]
   --Negative
   --Positive/+ 
   --Trace (+/-)
   --++
   --+++ 
   --++++
98 Initial LDH value _____ (U/L;IU/L) [F]
99 Date and Time _____ [C]
100 Units of Glucose
    --mg/ml
    --mmol/L
    --Other
101 Initial GLU Value _____ [F]
102 Glycosylated Hemoglobin (HbA1c) _____ % [F]
103 Initial ALT Value _____ U/L [F]
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<td>Units of Creatinine</td>
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<td>Date and Time</td>
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126 Units of BUN 【SC】
   --mg/dL
   --Mmol/L
   --Other

127 Initial BUN Value _____ 【F】

128 Date and Time _____ 【C】

129 Maximum BUN Value _____ 【F】

130 Date and Time _____ 【C】

131 Units of Lipid 【SC】
   --mg/dl
   --Mmol/L
   --Other

132 Initial Lipid Date and Time _____ 【C】

133 Total Cholesterol Value _____ 【F】

134 HDL Cholesterol Value _____ 【F】

135 LDL Cholesterol Value _____ 【F】

136 Triglycerides Value _____ 【F】

137 Initial Potassium Value _____ (mEq/L; mmol/L) 【F】

138 Date and Time _____ 【C】

139 Last Potassium Value _____ (mEq/L; mmol/L) 【F】

140 Date and Time _____ 【C】

141 Units of BNP/NT-pBNP 【SC】
   --pg/ml
   --ug/L
   --ug/ml
   --Fmol/L
   --Other

142 Initial BNP Value _____ 【F】

143 Date and Time _____ 【C】

144 Initial NT-pBNP Value _____ 【F】
145 Date and Time ______【C】

146 Units of CRP【SC】
--mg/L
--pg/ml
--Other

147 Initial CRP Value ______【F】

148 Units of HsCRP【SC】
--mg/L
--pg/ml
--Other

149 Initial HsCRP Value ______【F】

150 Initial Coagulation Examination Date and Time ______【C】

151 INR Value ______【F】

152 APTT Value _____ s【F】

153 PT Value _____s【F】

154 The Second Coagulation Examination Date and Time _____【C】

155 INR Value ______【F】

156 APTT Value _____s【F】

157 PT Value _____s【F】

158 The Third Coagulation Examination Date and Time _____【C】

159 INR Value ______【F】

160 APTT Value _____s【F】

161 PT Value _____s【F】

162 The Fourth Coagulation Examination Date and Time _____【C】

163 INR Value ______【F】

164 APTT Value _____s【F】

165 Initial PT Value _____ s【F】
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<td>Initial PT Value _____s【F】</td>
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| 174 | HBsAg【SC】
|   | --Positive
|   | --Negative
|   | --Numerical Value _____【F】 |
| 175 | HBsAg Upper Reference Limit (URL) _____【F】 |
| 176 | Anti-HBs/HBs-Ab【SC】
|   | --Positive
|   | --Negative
|   | --Numerical Value _____【F】 |
| 177 | Anti-HBs/HBs-Ab Upper Reference Limit (URL) _____【F】 |
| 178 | HBeAg【SC】
|   | --Positive
|   | --Negative
|   | --Numerical Value _____【F】 |
| 179 | HBeAg Upper Reference Limit (URL) _____【F】 |
| 180 | Anti-HBeAg/HBe-Ab【SC】
|   | --Positive
|   | --Negative
|   | --Numerical Value _____【F】 |
| 181 | Anti-HBeAg/HBe-Ab Upper Reference Limit (URL) _____【F】 |
| 182 | Anti-HBcAg/HBc-Ab【SC】
|   | --Positive
|   | --Negative

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<td>187</td>
<td>HCV-Ab (Unspecified) Upper Reference Limit (URL)</td>
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<td>HCV IgM Upper Reference Limit (URL)</td>
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</table>
Study ID
Coding Instructions: Indicate the identification number for the study.

Medical Record Number
Coding Instructions: Indicate the identification number for this record.

Hospital Number
Coding Instructions: Indicate the identification number for this hospital.

Are Daily Records Included in This Medical Record?
Coding Instructions: Indicate if there are daily records available as a part of this medical record
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definition: (none)
Source: Definition per CORE team

Gender
Coding Instructions: Indicate the gender of the patient.
Selections: (1) Male (2) Female (3) Unrecorded

Age
Coding Instructions: Indicate the age of the patient in years.

Medical Insurance
Coding Instructions: Indicate the patient’s medical insurance status.
Target Value: N/A
Selections:
- Payment Out-of-Pocket
- Free Medical Care
- Urban Residents/ Worker Medical Insurance
- Comprehensive Arrangement for Serious Disease
- New-Type Rural Cooperative Medical System (CMS)
Poverty Assistance Insurance
Commercial Medical Insurance
Other Social Insurance
Unrecorded

Supporting Definitions:

Urban residents/worker medical insurance: the medical insurance provided by the government for people who live in urban areas; also is the type of insurance provided by a company or factory for their employees.

Farmer medical insurance: a new medical insurance type funded by the government for farmers.

Business insurance: Insurance paid for by individuals to insurance companies.

Comprehensive arrangement for serious disease: Insurance for people living in urban areas who are employed by a company or factory. Also may apply to persons who are retired. Specifications vary by city. Covered diseases are different than that covered by urban residents/worker medical insurance.

Poverty assistance insurance: Medical aid provided by the government for poverty-stricken individuals to cover a portion of expenses.

Free medical care: The government provides free medical treatment for a specific group of people such as for disabled members of the armed forces.

Self-paying medical care: Indicated for those without medical insurance or for whom certain diseases are not covered by insurance. Patient will pay for these costs.

Patients may have more than one insurance type at a given time. Abstractor should select all that apply.

Source: Definition per China team.

Height

Coding Instructions: Indicate the patient’s height in centimeters

Note(s): Measurement from the transferring facility is acceptable

Target Value: The first value between arrival at this facility and discharge

Selections: (none)

Supporting Definitions: (none)

Source: Adapted from AHA Get with the Guidelines ACTION registry

Admission Weight
Coding Instructions: Indicate the patient’s weight in kilograms on admission
Note(s): Measurement from the transferring facility is acceptable
Target Value: The first value between first medical contact and discharge
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Marital Status**

Coding Instructions: Indicate the marital status of the patient
Target Value: N/A
Selections:
- Married
- Single
- Divorced
- Widowed
- Unrecorded
Supporting Definitions:
Married – A formal union with a person of the opposite sex, typically as recognized by law, by which they are considered husband and wife.
Single- Never been married.
Divorced – Previous marriage has been legally dissolved by a court or another legal body.
Widowed- A person who has lost his/her spouse to death and has not remarried.
Source: Definition per CORE team; Oxford English Dictionary

**Occupation**

Coding Instructions: Indicate the occupation of the patient
Target Value: N/A
Selections:
- Retired
- Worker (Industrial/Mining/Construction/Other Similar Type of Work)
- Farmer
- Office work
- Cadre
- Teacher
Student
Physician
Businessman
Engineer
Policeman or Soldier
Freelancers
Unemployed
Other
Unrecorded

Supporting Definitions: Documentation of occupation by treating physician
Source: Definition per CORE team; China team

**Ethnicity**

Coding Instructions: Indicate the ethnicity of the patient
Target Value: N/A
Selections:
- Han
- Zhuang
- Man
- Hui
- Miao
- Weiwuer
- Tujia
- Yi
- Menggu
- Zang
- Buyi
- Other
- Unrecorded

Supporting Definitions: The highlighted groups comprise the top 11 ethnicities by population size among 56 ethnic groups within China.
Source: Definition per CORE team; China team

**Nationality**
Coding Instructions: Indicate the nationality of the patient
Target Value: N/A
Selections:
- China
- Other
- Unrecorded

Supporting Definition: Nationality is the status of belonging to a nation by origin, birth, or naturalization
Source: Definition per CORE team; Oxford English Dictionary

Location of Residence
Coding Instructions: Indicate the patient’s location of resident based on the supporting definition.
Target Value: The value on arrival to facility
Selections: (1) Urban (2) Rural (3) Overseas (4) Unrecorded
Supporting Definitions:
Urban residence includes the areas of a city or municipality or Hong Kong, Macao and Taiwan regions.
Rural residence includes the areas belonging to the countryside including associated townships and villages.
Source: Definition per China team

Postal Code of Residence
Coding Instructions: Indicate patient’s postal code of primary residence
Target Value: The value on arrival to facility
Selections: (none)
Supporting Definitions: (none)
Source: Definition per China team

Date of Arrival at Your Hospital
Coding Instructions: Indicate the date the patient arrived at your facility.
Target Value: N/A
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Time of Arrival at Your Hospital**
Coding Instructions: Indicate the time the patient arrived at your facility.
Target Value: N/A
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Was the Time of Arrival at Your Hospital Estimated?**
Coding Instructions: Indicate if the time of arrival at your hospital was estimated.
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team.

**Did The Patient Receive Medical Assistance at an Outside Facility Prior to Arrival?**
Coding Instructions: Indicate if the patient received medical assistance at an outside facility prior to arrival.
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Admission Date**
Coding Instructions: Indicate the date the patient was admitted to your facility
Target Value: N/A
Selections: (none)
Supporting Definitions: (none)
Source: Definition per CORE team

**Admission Time**
Coding Instructions: Indicate the time the patient was admitted to your facility
Target Value: N/A
Selections: (none)
Supporting Definitions: (none)
Source: Definition per CORE team

**Department of Admission**
Coding Instructions: Indicate the department responsible for the patient admission.
Target Value: N/A
Selections: (1) Cardiovascular Department (2) Internal Medicine Department (3) Geriatrics (4) Cadre’s Ward (5) CCU (6) ICU (7) Other (8) Unrecorded
Supporting Definitions: (none)
Source: Definition per China team

**Patient Transferred from One Department to Another**
Coding Instructions: Indicate if the patient was transferred to another department after initial admission.
Target Value: N/A
Selections: (1) Yes (2) No (3) Unrecorded
Supporting Definitions: (none)
Source: Definition per China team

**Discharge Department**
Coding Instructions: Indicate the department responsible for the patient’s discharge.
Target Value: N/A
Selections: (1) Cardiovascular Department (2) Internal Medicine Department (3) Geriatrics (4) Cadre’s Ward (5) CCU (6) ICU (7) Other (8) Unrecorded
Supporting Definitions: (none)
Source: Definition per China team

**Discharge Date**
Coding Instructions: Indicate the date the patient was discharged from your facility.
Target Value: N/A
Selections: (none)
Supporting Definitions: (none)
Source: Definition per CORE team
**Date Diagnosis Was Confirmed**
Coding Instructions: Indicate the date on which the principal discharge diagnosis was confirmed.
Target Value: N/A
Selections: N/A
Supporting Definitions: (none)
Source: Definition per CORE team

**Gross Charge of Hospitalization in Yuan**
Coding Instructions: Indicate total charge for patient hospitalization
Target Value: N/A
Selections: (none)
Supporting Definitions: The entire charge associated with hospitalization.
Source: Definition per China team

**Time since Symptom Onset**
Coding Instructions: How much time has passed since onset of ischemic symptoms?
Target Value: N/A
Selections: (1) ___ Days (2) ___Hours
Supporting Definitions: For patients undergoing elective angiography or PCI, indicate the time passed since ischemic symptoms worsened (for patients with previous ischemic symptoms) or the time since ischemic symptoms began (for patients without previous ischemic symptoms). For those undergoing primary percutaneous coronary intervention in the setting of acute coronary syndromes, indicate the time since the most recent ischemic symptoms began.
Source: Definition per CORE team; China team

**Time of Symptom Onset (precise)**
Coding Instructions: Indicate the time the patient first noted ischemic symptoms that lasted greater than or equal to 10 minutes.
If an estimated symptom onset time is recorded, code 'symptom onset time estimated'.
Target Value: The first time symptoms lasted greater than 10 minutes on the symptom onset date
Selections: (none)
Supporting Definitions: (none)
Note: If the symptom onset time is not specified in the medical record, it may be recorded as 0700 for morning; 1200 for lunchtime; 1500 for afternoon; 1800 for dinnertime; 2200 for evening and 0300 if awakened from sleep.
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Was Symptom Onset Time Estimated?**
Coding Instructions: Indicate if the symptom onset time was estimated.
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Patient Chest Discomfort**
Coding Instructions: Did the patient experience chest symptoms including chest pain, chest discomfort, chest pressure, or other chest symptoms?
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team, adapted from the AHA Get with the Guidelines ACTION registry

**Time of Duration of Chest Discomfort**
Coding Instructions: How long did the patient’s chest discomfort last?
Target Value: N/A
Selections: (1) greater than or equal to 10 minutes; (2) less than 10 minutes; (3) unrecorded
Supporting Definitions: (none)
Source: Definition per CORE team; China team

**Did the Patient Have Ischemic Symptoms Other than Chest Discomfort?**
Coding Instructions: Indicate if there is physician documentation of other ischemic symptoms.
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: Documentation of one or more of these symptoms warrants a “Yes” answer: shortness of breath, pain at non-chest sites, nausea, vomiting, or fatigue
Did Other Ischemic Symptoms Last 10 or More Minutes?
Coding Instructions: How long did other ischemic symptoms last?
Target Value: N/A
Selections: (1) No; (2) Yes; (3) unrecorded
Supporting Definitions: (none)
Source: Definition per CORE team; China team

Admission Diagnosis (Related to Coronary Heart Disease)
Coding Instructions: Indicate the admission diagnosis related to coronary heart disease documented in the medical record.
Note(s): Mark as many of the choices that apply.
Supporting Definition: If none of the above options is noted in the chart, mark "None of the above is recorded".
Source: Definition per CORE team

Admission Diagnosis (Unrelated to Coronary Heart Disease)
Coding Instructions: Indicate the admission diagnosis unrelated to coronary heart disease documented in the medical record.
Note(s): Mark as many of the choices that apply.
Selections: Cardiac Arrest, Cardiogenic Shock, Ventricular Fibrillation/Ventricular Tachycardia, Atrial Fibrillation, Acute Heart Failure, Chronic Heart Failure, Heart Failure (unspecified), Acute Pulmonary Edema, Hemorrhagic Stroke (Cerebral Hemorrhage/Subarachnoid Hemorrhage), Ischemic Stroke (Cerebral Infarction/Cerebral Embolism/Cerebral Thrombosis), Stroke (Unspecified), Pneumonia, COPD Exacerbation, Gastrointestinal Bleeding, Acute Renal Failure,
Chronic Renal Failure, Dialysis (Hemodialysis/Peritoneal Dialysis), Dyslipidemia, Hypertension, Diabetes Mellitus, Diabetic Nephropathy, Gastroesophageal Reflux, Oesophagismus, Cholelithiasis, Anemia, None of the Above Is Recorded.
Supporting Definition: If none of the above options is noted in the chart, mark “None of the above is recorded”.
Source: Definition per CORE team

**Antiplatelet Therapy Prior to Arrival**
Coding Instructions: Indicate whether the patient was given aspirin, clopidogrel, ticlopidine or other antiplatelet therapy by a health provider (EMS, transferring hospital, etc.) prior to arrival at this hospital or if the patient self-administered aspirin after symptom onset.
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Fibrinolysis Prior to Arrival**
Coding Instructions: Indicate whether the patient was given a fibrinolytic by a health provider (EMS, transferring hospital, etc.) prior to arrival at this hospital.
Target Value: N/A
Selections: (1) No (2) Yes. If yes, please specify the name of the fibrinolytic agent that was used.
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**CPR/Chest Compressions Prior to Arrival**
Coding Instructions: Indicate if cardiopulmonary resuscitation (CPR) in any form, including chest compression, was performed for the patient, prior to arrival
Target Value: Any occurrence between first medical contact and arrival to this facility
Selections: (1) No (2) Yes
Supporting Definitions: CPR comprises of a series of interventions performed for patients with sudden cardiac arrest in order to restore the perfusion and oxygenation of vital organs. Chest or abdominal compression, ascertainment of patent airways, rescue breathing, as well as electrical
cardioversion and defibrillation are the cornerstones of CPR. Medications (including epinephrine, lidocaine, amiodarone, and atropine) may or may not be used during CPR.


External Defibrillation Prior to Arrival
Coding Instructions: Indicate if there is documentation of electrical defibrillation by lay responders or EMS personnel prior to arrival
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

Temporary Cardiac Pacing Prior to Arrival
Coding Instructions: Indicate if there is documentation of temporary cardiac transcutaneous or transvenous pacing by EMS personnel prior to arrival
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

Cardiac Arrest Prior to Admission
Coding Instructions: Indicate if the patient had an episode of cardiac arrest prior to admission to this facility.
Note(s): Evaluated by ED personnel and either (1) received attempts at external defibrillation or chest compressions or (2) were pulseless but did not receive attempts to defibrillate or cardiopulmonary resuscitation (CPR).
Target Value: Any occurrence prior to admission to this facility.
Selections: (1) No (2) Yes
Supporting Definitions: ‘Sudden' cardiac arrest is the sudden cessation of cardiac activity so that the victim becomes unresponsive, with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death. Cardiac arrest should be used to signify an event as described above that is reversed, usually by CPR, and/or defibrillation or cardioversion, or cardiac pacing. Sudden cardiac arrest is not the same as sudden cardiac death. Sudden cardiac death describes a fatal event.
Source: ACC/AHA/HRS 2006 Key Data Elements and Definitions for Electrophysiological Studies and Procedures; adapted from AHA Get with the Guidelines ACTION registry

CPR/Chest Compressions in the Emergency Department Prior to Admission
Coding Instructions: Indicate if cardiopulmonary resuscitation (CPR) in any form, including chest compression, was performed for the patient in the emergency department prior to admission
Target Value: Any occurrence between arrival to the ED and admission
Selections: (1) No (2) Yes
Supporting Definitions: CPR comprises of a series of interventions performed for patients with sudden cardiac arrest in order to restore the perfusion and oxygenation of vital organs. Chest or abdominal compression, ascertainment of patent airways, rescue breathing, as well as electrical cardioversion and defibrillation are the cornerstones of CPR. Medications (including epinephrine, lidocaine, amiodarone, and atropine) may or may not be used during CPR.

External Defibrillation in Emergency Department Prior to Admission
Coding Instructions: Indicate if there is documentation of electrical defibrillation in the emergency department prior to admission
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team
Temporary Cardiac Pacing In Emergency Department Prior to Admission
Coding Instructions: Indicate if there is documentation of temporary transcutaneous or transvenous cardiac pacing in the emergency department prior to admission.
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

Fibrinolysis in Emergency Room Prior to Admission
Coding Instructions: Indicate if fibrinolysis was given in the emergency room prior to admission.
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: If the patient received fibrinolysis, indicate the type of agent used (streptokinase, urokinase, reteplase, or other).
Source: Definition per CORE team

Antiplatelet Therapy in the Emergency Department Prior to Admission
Coding Instructions: Indicate whether the patient was given aspirin, clopidogrel, ticlopidine or other antiplatelet therapy by a health provider (EMS, transferring hospital personnel, etc.) in the emergency department prior to admission.
Target Value: Any occurrence between arrival to the ED and admission
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Fibrinolysis in the Emergency Department Prior to Admission
Coding Instructions: Indicate whether the patient was given a fibrinolytic by a health provider (EMS, transferring hospital, etc.) in the emergency department prior to admission.
Target Value: Any occurrence between arrival to the ED and admission
Selections: (1) No (2) Yes. If yes, please specify the name of the fibrinolytic agent that was used.
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry
ACUTE COEXISTING CONDITIONS AT PRESENTATION TO THIS FACILITY

Heart Failure on Presentation to This Facility
Coding Instructions: Indicate if there is physician documentation or report of HF on presentation to this facility
Target Value: Any occurrence between first medical contact and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure, described as: unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention; or the description of rales, jugular venous distension, pulmonary edema on physical exam, or pulmonary edema on chest X-ray presumed to be due to cardiac dysfunction. A low ejection fraction without clinical evidence of heart failure does not qualify as heart failure.
Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 N 30); adapted from AHA Get with the Guidelines ACTION registry

Cardiogenic Shock on Presentation to This Facility
Coding Instructions: Indicate if the patient was in a state of cardiogenic shock on presentation to this facility.
Note(s): Transient episodes of hypotension reversed with IV fluid or atropine do not constitute cardiogenic shock. The hemodynamic compromise (with or without extraordinary supportive therapy) must persist for at least 30 minutes.
Target Value: Any occurrence between first medical contact and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: Cardiogenic shock is defined as a sustained (>30 minutes) episode of systolic blood pressure <90 mm Hg, and/or cardiac index <2.2 L/min/m2 determined to be secondary to cardiac dysfunction, and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, ventricular assist devices) to maintain blood pressure and cardiac index above those specified levels.
Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30); adapted from AHA Get with the Guidelines ACTION registry

Pneumonia on Presentation to This Facility
COPD Exacerbation on Presentation to This Facility
Coding Instructions: Indicate if there is physician documentation or report of exacerbated (acute) COPD on presentation to this facility
Target Value: Any occurrence between first medical contact and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: Exacerbated COPD is defined as physician documentation of exacerbated COPD. Other clinical signs and radiographic findings are non-specific.
Source: Definition per CORE team

Acute Stroke on Presentation to This Facility
Coding Instructions: Indicate if there is physician documentation or report of an acute stroke on presentation to this facility.
Target Value: Any occurrence between first medical contact and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: Acute stroke is defined as physician documentation of an acute stroke
Source: Definition per CORE team

Active Gastrointestinal Bleeding on Presentation to This Facility
Coding Instructions: Indicate if there is physician documentation or report of active gastrointestinal bleeding on presentation to this facility.
Target Value: Any occurrence between first medical contact and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: Active gastrointestinal bleeding is defined as physician documentation of active hematemesis (upper gastrointestinal bleeding), active hematochezia (lower gastrointestinal bleeding), or active melena (upper gastrointestinal bleeding).
Source: Definition per CORE team

**Acute Renal Failure on Presentation to This Facility**
Coding Instructions: Indicate if there is physician documentation or report of acute renal failure on presentation to this facility
Target Value: Any occurrence between first medical contact and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: Acute renal failure is defined as physician documentation of acute renal failure
Source: Definition per CORE team

**NYHA Functional Classification on Arrival**
Coding Instructions: Indicate the physician documentation of New York Heart Association functional class on the patient’s arrival to this facility
Target Value: N/A
Selections:

I – No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath)
II – Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnea.
III – Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea.
IV – Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency present at rest. If any physical activity is undertaken, discomfort is increased.
Unrecorded

Supporting Definitions: The NYHA functional classification system relates symptoms to everyday activities and the patient's quality of life.
**Killip Classification on Arrival**

Coding Instructions: Indicate the physician documentation of Killip classification on the patient’s arrival to this facility

Target Value: N/A

Selections:

I - No rales over the lung fields and no S3.

II - Rales 50% or less over the lung fields or presence of an S3. Includes patients documented as having bibasilar rales.

III - Rales more than 50% of the lung fields/frank pulmonary edema. Includes patients documented as having rales throughout.

IV - Cardiogenic Shock

Unrecorded


Source: Adapted from VIRGO registry

**PAST MEDICAL HISTORY – RELATED TO HEART DISEASE**

**History of Angina or Coronary Heart Disease**

Coding Instructions: Mark “Yes”, if documented history of angina or coronary heart disease is present

Target Value: Any occurrence between birth and arrival at this facility

Selections: (1) No (2) Yes

Supporting Definitions: Indicate if there is physician documentation of history of angina or history of coronary artery disease. Coronary heart disease may be abbreviated as CHD. Presence of at least one of the two warrants a “Yes” answer.

Source: Definition per CORE team

**History of Myocardial Infarction**

Coding Instructions: Indicate if the patient has had at least one documented previous myocardial infarction.

Target Value: Any occurrence between birth and arrival at this facility

Selections: (1) No (2) Yes

Supporting Definitions: A myocardial infarction is evidenced by any of the following:
1. A rise and fall of cardiac biomarkers (preferably troponin) with at least one of the values in the abnormal range for that laboratory [typically above the 99th percentile of the upper reference limit (URL) for normal subjects] together with at least one of the following manifestations of myocardial ischemia:
   a. Ischemic symptoms.
   b. ECG changes indicative of new ischemia (new ST-T changes, new left bundle branch block, or loss of R wave voltage).
   c. Development of pathological Q-waves in 2 or more contiguous leads in the ECG (or equivalent findings for true posterior MI).
   d. Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.
   e. Documentation in the medical record of the diagnosis of acute myocardial infarction based on the cardiac biomarker pattern in the absence of any items enumerated in a-d due to conditions that may mask their appearance (e.g., perioperative infarct when the patient cannot report ischemic symptoms; baseline left bundle branch block or ventricular pacing).

2. ECG changes associated with prior myocardial infarction can include the following (with or without prior symptoms):
   a. Any Q-wave in leads V2-V3 >=0.02 seconds or QS complex in leads V2 and V3.
   b. Q-wave >=0.03 seconds and >=0.1 mV deep or QS complex in leads I, II, aVL, aVF, or V4-V6 in any two leads of a contiguous lead grouping (I, aVL, V6; V4-V6; II, III, and aVF).
   c. R-wave >=0.04 seconds in V1-V2 and R/S >=1 with a concordant positive T-wave in the absence of a conduction defect.

3. Imaging evidence of a region with new loss of viable myocardium at rest in the absence of a non-ischemic cause. This can be manifest as:
   a. Echocardiographic, CT, MR, ventriculographic or nuclear imaging evidence of left ventricular thinning or scarring and failure to contract appropriately (i.e., hypokinesis, akinesis, or dyskinesis).
   b. Fixed (non-reversible) perfusion defects on nuclear radioisotope imaging (e.g., MIBI, thallium).

4. Medical record documentation of prior myocardial infarction.
Family History of CAD

Coding Instructions: Indicate if the patient has a family history of coronary artery disease.

Target Value: Any occurrence between birth and arrival at this facility

Selections: (1) No (2) Yes

Note(s): If the patient is adopted, or the family history is unavailable, code "No".

Supporting Definitions: Family History of Premature CAD Among Direct Relatives:
Family history includes any direct blood relatives (parents, siblings, children) who have had any of the following diagnosed at age less than 55 years for male relatives or less than 65 years for female relatives:
   a. Angina
   b. Acute myocardial infarction
   c. Sudden cardiac death without obvious cause
   d. Coronary artery bypass graft surgery
   e. Percutaneous coronary intervention

Source: Adapted from AHA Get with the Guidelines CATH-PCI registry

History of Heart Failure

Coding Instructions: Indicate if there is a previous history of heart failure.

Note(s): A previous hospital admission with principal diagnosis of heart failure is considered evidence of heart failure history.

Target Value: Any occurrence between birth and arrival at this facility

Selection: (1) No (2) Yes

Supporting Definitions: Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention; or the description of rales, jugular venous distension, pulmonary edema on physical exam, or pulmonary edema on chest X-ray presumed to be cardiac dysfunction. A low ejection fraction without clinical evidence of heart failure does not qualify as heart failure.

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons; adapted from AHA Get with the Guidelines ACTION registry
History of Percutaneous Coronary Intervention
Coding Instructions: Indicate if the patient had a previous percutaneous coronary intervention (PCI) of any type (balloon angioplasty, stent or other).
Note(s): Timeframe does NOT include the current admission.
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: A percutaneous coronary intervention (PCI) is the placement of an angioplasty guide wire, balloon, or other device (e.g. stent, atherectomy, brachytherapy, or thrombectomy catheter) into a native coronary artery or coronary artery bypass graft for the purpose of mechanical coronary revascularization.
Source: Adapted from AHA Get with the Guidelines ACTION registry

If Patient Had a Prior PCI, Most Recent PCI Date
Coding Instructions: Indicate the date of most recent PCI.
Target Value: N/A
Supporting Definitions: (none)
Selections: Choose one of the following:
   a. <1 Month Ago
   b. 1-5 Months Ago
   c. 6-12 Months Ago
   d. 1-2 Years Ago
   e. >2 Years Ago
   f. Unrecorded
Note(s): If month or day are unknown enter 01.
Source: Adapted from AHA Get with the Guidelines CATH-PCI registry

History of Fibrinolysis
Coding Instructions: Indicate if the patient has previously received intravenous fibrinolysis.
Note(s): Timeframe does NOT include the current admission.
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry
History of CABG
Coding Instructions: Indicate whether the patient had a coronary artery bypass graft (CABG).
Note(s): Timeframe does NOT include the current admission.
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

If Patient Had a Prior CABG, Most Recent CABG Date 【SC】
Coding Instructions: Indicate the date of most recent CABG.
Target Value: N/A
Selections:
   a. < 1 Month Ago
   b. 1-5 Months Ago
   c. 6-12 Months Ago
   d. 1-2 Years Ago
   e. > 2 Years Ago
   f. Unrecorded
Supporting Definitions: (none)
Note(s): If month or day are unknown enter 01.
Source: Adapted from AHA Get with the Guidelines CATH-PCI registry

History of Atrial Fibrillation or Flutter
Coding Instructions: Indicate if there is a previous history of atrial fibrillation or flutter
Note(s): Code "No" if patient was first diagnosed with atrial fibrillation or flutter after reperfusion during this admission. If there is no prior documentation of atrial arrhythmias, it is acceptable to code "No"
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

History of Ventricular Tachycardia or Ventricular Fibrillation
Coding Instructions: Indicate if there is a previous history of ventricular tachycardia or ventricular fibrillation.

Note(s): Code "No" if patient was first diagnosed with ventricular tachycardia or fibrillation after reperfusion during this admission. If there is no prior documentation of ventricular arrhythmias, it is acceptable to code "No".

Target Value: Any occurrence between birth and arrival at this facility.

Selections: (1) No (2) Yes

Supporting Definitions: (none)

Source: Definition per CORE team.

**History of Permanent Pacemaker**

Coding Instructions: Indicate if the patient has a history of having a permanent pacemaker.

Target Value: N/A

Selections: (1) No (2) Yes

Supporting Definitions: Permanent pacemaker includes single-chamber, dual chamber, and biventricular pacemakers.

Source: Definition per CORE team.

**History of Bradycardia**

Coding Instructions: Indicate if there is chart documentation for a previous history bradycardia.

Note(s): Code "No" if patient was first diagnosed with bradycardia during this admission. If there is no prior documentation of bradycardia, it is acceptable to code "No".

Target Value: Any occurrence between birth and arrival at this facility.

Selections: (1) No (2) Yes

Supporting Definitions: (none)

Source: Definition per CORE team.

**History of Valvular Heart Disease**

Coding Instructions: Indicate if there is chart documentation for a previous history of valvular heart disease.

Target Value: Any occurrence between birth and arrival at this facility.

Selections: (1) No (2) Yes
Supporting Definitions: Valvular heart diseases include but are not limited to tricuspid stenosis, tricuspid regurgitation, pulmonic stenosis, pulmonic regurgitation, mitral stenosis, mitral regurgitation, aortic stenosis, and aortic regurgitation.
Source: Definition per CORE team

GENERAL PAST MEDICAL HISTORY

History of Hypertension
Coding Instructions: Indicate if the patient has been diagnosed previously with hypertension
Note(s): Code "No" if hypertension was first diagnosed after reperfusion during this admission.
Selections: (1) No (2) Yes
Target Value: Any occurrence between birth and arrival at this facility
Supporting Definitions: Hypertension is defined by any one of the following:
1. History of hypertension diagnosed and treated with medication, diet and/or exercise
2. Prior documentation of blood pressure greater than 140 mm Hg systolic and/or 90 mm Hg diastolic for patients without diabetes or chronic kidney disease, or prior documentation of blood pressure greater than 130 mm Hg systolic or 80 mm Hg diastolic on at least two occasions for patients with diabetes or chronic kidney disease.
3. Currently on pharmacological therapy for the treatment of hypertension.
Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons; adapted from AHA Get with the Guidelines ACTION registry

History of Dyslipidemia
Coding Instructions: Indicate if the patient has a history of dyslipidemia diagnosed and/or treated by a physician.
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: Dyslipidemia is defined by the National Cholesterol Education Program criteria and includes documentation of the following:
1. Total cholesterol greater than 200 mg/dL (5.18 mmol/l); or
2. Low-density lipoprotein (LDL) greater than or equal to 130 mg/dL (3.37 mmol/l); or
3. High-density lipoprotein (HDL) less than 40 mg/dL (1.04 mmol/l).
For patients with known coronary artery disease, treatment is initiated if LDL is greater than 100 mg/dL (2.59 mmol/l), and this would qualify as hypercholesterolemia.
History of Chronic Renal Failure
Coding Instructions: Indicate if the patient has a history of chronic renal failure
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: Chronic renal failure can be coded for any of the following:
1. A documented history of renal failure, and/or
2. A history of creatinine > 2.0 mg/dL, and/or
3. A documented history of chronic renal disease
Prior renal transplant patients are not included unless creatinine has been >2.0 mg/dL since transplantation
Source: Adapted from VIRGO registry

Currently on Dialysis
Coding Instructions: Indicate if the patient is currently undergoing either hemodialysis or peritoneal dialysis on an ongoing basis as a result of renal failure.
Note(s): Code "No" if patient was not on dialysis until after reperfusion during this admission.
Target Value: The value on arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

History of Chronic Lung Disease
Coding Instructions: Indicate if the patient has a history of chronic lung disease.
A history of chronic inhalation reactive disease (asbestosis, mesothelioma, black lung disease or pneumoconiosis) qualifies as chronic lung disease. Radiation induced pneumonitis or radiation fibrosis also qualifies as chronic lung disease. A history of atelectasis is a transient condition and does not qualify.
Notes: Code "No" if patient was first diagnosed with chronic lung disease after reperfusion during this admission.
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: Chronic lung disease can include patients with chronic obstructive pulmonary disease, chronic bronchitis, or emphysema. It can also include a patient who is currently being chronically treated with inhaled or oral pharmacological therapy (e.g., beta-adrenergic agonist, anti-inflammatory agent, leukotriene receptor antagonist, or steroid). Patients with asthma or seasonal allergies are not considered to have chronic lung disease.
Source: Adapted from AHA Get with the Guidelines ACTION registry

**History of Peripheral Vascular Disease**
Coding Instructions: Indicate if there is physician documentation of a history of peripheral vascular disease
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: Mark “Yes” if there is exact mention of “a history of peripheral vascular disease,” or extremity claudication, or history of lower extremity percutaneous or surgical revascularization procedure.
Source: Definition per CORE team

**History of Diabetes Mellitus. History and Risk Factors**
Coding Instructions: Indicate if the patient has a history of diabetes mellitus, regardless of duration of disease or need for antidiabetic agents.
Note(s): Code "No" if the patient was first diagnosed with diabetes mellitus after reperfusion during this admission.
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: Diabetes mellitus is diagnosed by a physician or can be defined as a fasting blood sugar greater than 7 mmol/l or 126 mg/dL. It does not include gestational diabetes. Diabetes mellitus can also be identified by history of pharmacologic treatment for condition.
Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons; adapted from AHA Get with the Guidelines ACTION registry

**History of Hepatitis B Infection**
Coding Instructions: Mark “Yes”, if documented history of hepatitis B infection
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

**History of Hepatitis C Infection**
Coding Instructions: Mark “Yes”, if documented history of hepatitis C infection
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

**History of Liver Cirrhosis**
Coding Instructions: Mark “Yes”, if documented history of liver cirrhosis is present
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

**Prior Carotid Artery Surgery/Intervention**
Coding Instructions: Indicate if the patient has a history of prior carotid artery surgery or stenting
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: Previous carotid artery surgery/ intervention for carotid artery stenosis. This does not include neurological disease processes such as metabolic and/or anoxic ischemic encephalopathy.  
Source: The Society of Thoracic Surgeons; adapted from AHA Get with the Guidelines ACTION registry

**Prior Ischemic Stroke**
Coding Instructions: Indicate if the patient has had an ischemic stroke.
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: A prior stroke is defined as any confirmed neurological deficit of abrupt onset caused by a disturbance in cerebral blood supply that did not resolve within 24 hours.
Source: Adapted from AHA Get with the Guidelines ACTION registry
**Prior Hemorrhagic Stroke**
Coding Instructions: Indicate if the patient has had a hemorrhagic stroke.
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: A prior stroke is defined as any confirmed neurological deficit of abrupt onset caused by a disturbance in cerebral blood supply that did not resolve within 24 hours.
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Prior Stroke, Unknown Subtype**
Coding Instructions: Indicate if the patient has had a stroke, but subtype (ischemic, hemorrhagic) is unknown.
Target Value: Any occurrence between birth and arrival at this facility
Selections: (1) No (2) Yes
Supporting Definitions: A prior stroke is defined as any confirmed neurological deficit of abrupt onset caused by a disturbance in cerebral blood supply that did not resolve within 24 hours.
Source: Adapted from AHA Get with the Guidelines ACTION registry

**PERSONAL HISTORY**
**Smoking History**
Coding Instructions: Indicate the smoking status of the patient
Target Value: N/A
Selections: (1) Never smoked (2) Current Smoker (3) Past Smoker (4) Unrecorded
Supporting Definitions: Past smoker is defined as a person who was a daily smoker in the past and stopped smoking at least three months prior to admission date, or chart documentation of “past smoker”

**Smoking Duration among Current Smokers**
Coding Instructions: Indicate the duration of time since the patient first started smoking
Target Value: N/A
Selections: (none)
Supporting Definitions: Provide the duration in months
Source: Definition per CORE team

**Smoking Duration for Past Smokers**
Coding Instructions: Indicate the duration of time between when the patient first started smoking and the cessation of smoking
Target Value: N/A
Selections: (none)
Supporting Definitions: Provide the duration in months
Source: Definition per CORE team

**Smoking Frequency**
Coding Instructions: Indicate the average number of cigarettes smoked per day
Target Value: N/A
Selections: (none)
Supporting Definitions: Provide the information as cigarettes per day
Source: Definition per CORE team

**PHYSICAL EXAMINATION**

**Heart Rate at Presentation to This Facility**
Coding Instructions: Indicate the first measurement or earliest record of heart rate (in beats per minute).
Note(s): Measurement from EMS or the transferring facility is also acceptable.
Target Value: The first value after arrival at this facility
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Systolic Blood Pressure at Presentation to This Facility**
Coding Instructions: Indicate the first measurement or earliest record of systolic blood pressure (in mm Hg).
Note(s): Measurement from EMS or the transferring facility is also acceptable.
Target Value: The first value after arrival at this facility
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Diastolic Blood Pressure at Presentation to This Facility**
Coding Instructions: Indicate the first measurement or earliest record of diastolic blood pressure (in mm Hg).
Note(s): Measurement from EMS or the transferring facility is also acceptable.
Target Value: The first value after arrival at this facility
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Temperature at Presentation to This Facility**
Coding Instructions: Indicate the first measurement or earliest record of temperature (degrees Celsius).
Note(s): Measurement from EMS or the transferring facility is also acceptable.
Target Value: The first value after arrival at this facility
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Respiratory Rate at Presentation to This Facility**
Coding Instructions: Indicate the first measurement or earliest record of respiratory rate (breaths per minute).
Note(s): Measurement from EMS or the transferring facility is also acceptable.
Target Value: The first value after arrival at this facility
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Specify Home Medications**
Coding Instructions: Indicate the names of medications been taken by patient routinely at home prior to this hospitalization
Note(s): "Routinely" refers to the daily use of medications as prescribed, even if the patient
misses a dose
Target Value: Any occurrence between 2 weeks prior to first medical contact and first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

AUXILIARY EXAMINATION

ECG at Hospital
Coding Instructions: Indicate if an ECG was obtained at the hospital
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: This will be considered for the first 3 ECGs.
Source: Definition per CORE team

Date of ECG at Hospital
Coding Instructions: Indicate the date ECG was obtained at presentation to the hospital
Target Value: N/A
Selections: (none)
Supporting Definitions: This will be considered for the first 3 ECGs.
Source: Definition per CORE team

Time of ECG at Hospital
Coding Instructions: Indicate the time ECG was obtained at presentation to the hospital
Target Value: N/A
Selections: (none)
Supporting Definitions: This will be considered for the first 3 ECGs.
Source: Definition per CORE team

ECG Results
Coding Instructions: Indicate the documented physician interpretation of the ECG
Note(s): Mark as many of the choices that apply.
Target Value: N/A
Selections: (1) acute myocardial infarction  (2) left bundle branch block  (3) ST-elevation myocardial infarction (4) ST-Depression  (5) Q-wave myocardial infarction (6) ventricular fibrillation (7) ventricular tachycardia (8) atrial fibrillation (9) 2nd degree atrioventricular block type 1  (10) 2nd degree atrioventricular block type 2  (11) 3rd degree atrioventricular block
Source: Definition per China team

OTHER DIAGNOSTIC TESTS

Chest X-Ray
Coding Instructions: Indicate whether the patient underwent a chest X-ray or not
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections: (1) No  (2) Yes
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Echocardiography
Coding Instructions: Indicate whether the patient underwent echocardiography or not
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections: (1) No  (2) Yes
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Echocardiography Ejection Fraction (EF) Value
Instructions: Indicate the value of EF in percent documented in the echocardiography report.
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections: (none)
Supporting Definition: LVEF: The left ventricular ejection fraction is the percentage of the blood emptied from the left ventricle at the end of the contraction. The left ventricular ejection fraction can be assessed via invasive (i.e. LV gram) or noninvasive (i.e. Echo, MR, CT or Nuclear) testing.
Source: ACC Clinical Data Standards, The Society of Thoracic Surgeons; adapted from AHA Get with the Guidelines ACTION registry

Stress Testing
Coding Instructions: Indicate whether the patient underwent stress testing or not
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections: (1) No (2) Yes
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines registry

**Type of Stress Test**
Coding Instructions: Indicate the type of stress testing performed
Target Value: N/A
Selections:
1. ECG only
2. With imaging
   a. Nuclear (SPECT/PET)
   b. Echocardiography
   c. Cardiac MRI
   d. Unrecorded
Supporting Definition: (none)
Source: Modified from AHA Get with the Guidelines ACTION registry

**Method of Stress Test**
Coding Instructions: Indicate method of performing stress test
Target Value: N/A
Selections: (1) Exercise (2) Pharmacologic (3) Unknown
Supporting Definition: (none)
Source: Adapted from VIRGO registry

**Stress Test Results**
Coding Instructions: Indicate the results of the stress test.
Target Value: N/A
Selections: (1) Negative (2) Positive (3) Indeterminate (4) Unrecorded
Supporting Definition: (none)
Source: Definition per CORE team.

**Cardiac CT Angiogram**
Coding Instructions: Indicate if the patient received a cardiac CT scan (Cardiac Cat Scan)
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections: (1) No (2) Yes
Supporting Definition: (none)
Source: Adapted from VIRGO registry

**Coronary Calcium Score**
Coding Instructions: Indicate the reported coronary calcium score from the cardiac CT angiogram.
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definition: The score is usually reported in Hounsfield units.
Source: Adapted from VIRGO registry

**LABORATORY TESTS**

**Initial Myohemoglobin Date and Time**
Coding Instructions: Indicate the date and time when the initial myohemoglobin sample was collected (not the date results reported).
Target Value: The first value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Units of Myohemoglobin**
Coding Instructions: Indicate the sample unit of measure of myohemoglobin level.
Target Value: N/A
Selections:
   (1) IU/L
   (2) ng/ml
   (3) mg/mL
   (4) Other
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial Myohemoglobin Value**
Coding Instructions: Indicate myohemoglobin value.
Target Value: The first value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Maximum Myohemoglobin Date and Time**
Coding Instructions: Indicate the date and time of collection of the maximum myohemoglobin value.
Target Value: Any occurrence during the entire hospital stay
Selections: N/A
Supporting Definition: (none)
Source: Definition per CORE team

**Maximum Myohemoglobin Value**
Coding Instructions: Indicate the value of maximum myohemoglobin.
Target Value: Any occurrence during the entire hospital stay
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Initial Creatine Kinase (CK) Value**
Coding Instructions: Indicate the value of the initial CK.
Notes: Initial CK level corresponds to the first sample obtained within the first 24 hours of care. It may also have been collected at the transferring hospital.
Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Unit of Creatine Kinase (CK) Level**
Coding Instructions: Indicate the sample unit of measure of CK level.
Target Value: N/A
Selections:
(1) IU/L
(2) %
(3) (mg/mL)/IU
(4) ng/mL
(5) mg/IU
(6) MI/IU
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial CK Upper Limit of Normal (ULN)**
Coding Instructions: Indicate the ULN of the initial CK sample.
Note(s): If a range is given for ULN values, record the highest number in the range.
Examples: If the reference range given is 0.0-1.5, record ULN as 1.5. If the reference range given is < 1.5, record ULN as 1.5 as well.
The initial sample value refers to the first sample obtained within the first 24 hours of care.
Target Value: N/A
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial Creatine Kinase (CK) Date and Time**
Coding Instructions: Indicate the date and time of collection of the initial CK.
Notes: Initial CK level corresponds to the first sample obtained within the first 24 hours of care. It may also have been collected at the transferring hospital.
Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Maximum Creatine Kinase (CK) Level**
Coding Instructions: Indicate the maximum CK level recorded during hospital stay.
Target Value: Any occurrence during the entire hospital stay.
Maximum Creatine Kinase (CK) Date and Time
Coding Instructions: Indicate the date and time of collection of the maximum CK.
Target Value: Any occurrence during the entire hospital stay
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Initial CK-MB Value
Coding Instructions: Indicate the value of the initial CK-MB.
Notes: If a CK-MB value was not calculated at baseline for normal CPK results, record a value of 0 (zero). Initial CK level corresponds to the first sample obtained within the first 24 hours of care. It may also have been collected at the transferring hospital.
Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Initial CK-MB Date and Time
Coding Instructions: Indicate the date and time of collection of the initial CK-MB.
Notes: Initial CK level corresponds to the first sample obtained within the first 24 hours of care. It may also have been collected at the transferring hospital.
Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Unit of CK-MB Level
Coding Instructions: Indicate the sample unit of measure of CK-MB level.
Initial CK-MB Upper Limit of Normal (ULN)
Coding Instructions: Indicate the ULN of the initial CK-MB sample.
Note(s): If a range is given for ULN values, record the highest number in the range.
Examples: If the reference range given is 0.0-1.5, record ULN as 1.5. If the reference range given is < 1.5, record ULN as 1.5 as well.
The initial sample value refers to the first sample obtained within the first 24 hours of care.
Target Value: N/A
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Initial Troponin I Value
Coding Instructions: Indicate the value of initial troponin I.
Notes: Initial troponin I level corresponds to the first sample obtained within the first 24 hours of care. It may also have been collected at the transferring hospital.
Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility
Selections: (1) Positive (2) Negative (3) Trace (+/-) (4) Numerical value
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Unit of Troponin I
Coding Instructions: Indicate the sample unit of measure of troponin I level.
Target Value: N/A
Selections: (1) ng/mL (2) Other
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial Troponin I Upper Reference Limit (URL)**
Coding Instructions: Indicate the URL of the initial troponin I sample.
Target Value: N/A
Selections: N/A
Supporting Definition: Upper Reference Limit (URL):
Defined as the 99th percentile of troponin levels for a normal reference population.
Source: Joint ESC-ACC-AHA-WHF 2007 Task Force consensus document "Universal Definition of Myocardial Infarction"; adapted from AHA Get with the Guidelines ACTION registry

**Initial Troponin I Date and Time**
Coding Instructions: Indicate the date and time of collection of the initial troponin I.
Notes: Initial troponin I level corresponds to the first sample obtained within the first 24 hours of care. It may also have been collected at the transferring hospital.
Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Maximum Troponin I Level**
Coding Instructions: Indicate the maximum troponin I level recorded during hospital stay.
Target Value: Any occurrence during the entire hospital stay.
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Maximum Troponin I Date and Time**
Coding Instructions: Indicate the date and time of collection of the maximum troponin I.
Target Value: Any occurrence during the entire hospital stay
Selections: N/A
Initial Troponin T Value
Coding Instructions: Indicate the value of initial troponin T.
Notes: Initial troponin T level corresponds to the first sample obtained within the first 24 hours of care. It may also have been collected at the transferring hospital.
Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Unit of Troponin T
Coding Instructions: Indicate the sample unit of measure of troponin T level.
Target Value: N/A
Selections: (1) ng/mL (2) Other
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Initial Troponin Upper Reference Limit (URL)
Coding Instructions: Indicate the URL of the initial troponin T sample.
Target Value: N/A
Selections: N/A
Supporting Definition: Upper Reference Limit (URL):
Defined as the 99th percentile of troponin levels for a normal reference population.
Source: Joint ESC-ACC-AHA-WHF 2007 Task Force consensus document "Universal Definition of Myocardial Infarction"
Source: Adapted from AHA Get with the Guidelines ACTION registry

Initial Troponin T Date and Time
Coding Instructions: Indicate the date and time of collection of the initial troponin T.
Notes: Initial troponin level corresponds to the first sample obtained within the first 24 hours of care. It may also have been collected at the transferring hospital.
Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Maximum Troponin T Level**
Coding Instructions: Indicate the maximum troponin T level recorded during hospital stay.
Target Value: Any occurrence during the entire hospital stay.
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Maximum Troponin T Date and Time**
Coding Instructions: Indicate the date and time of collection of the maximum troponin T.
Target Value: Any occurrence during the entire hospital stay
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Unit of Troponin (Unspecified)**
Coding Instructions: Indicate the unit for measurement of troponin (unspecified).
Target Value: N/A
Selections: (1) Ng/mL, (2) IU/L or U/L (3) Other
Supporting Definition: (none)
Source: Definition per CORE team.

**Initial Troponin (Unspecified) Value**
Coding Instructions: Indicate if the results for the initial troponin (unspecified) test were positive or negative
Target Value: the first troponin collected.
Selections: 1) Positive, 2) Negative 3) Numerical Value
Supporting Definition: (none)
Source: Definition per CORE team.
**Initial Troponin (Unspecified) Value**

Coding Instructions: Indicate the value of initial troponin.

Notes: Initial troponin level corresponds to the first sample obtained within the first 24 hours of care. It may also have been collected at the transferring hospital.

Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility

Selections: N/A

Supporting Definition: (none)

Source: Definition per CORE team

**Initial Troponin (Unspecified) Upper Reference Limit (URL)**

Coding Instructions: Indicate the URL of the initial troponin (unspecified) sample.

Target Value: N/A

Selections: N/A

Supporting Definition: Upper Reference Limit (URL):
Defined as the 99th percentile of troponin levels for a normal reference population.

Source: Joint ESC-ACC-AHA-WHF 2007 Task Force consensus document "Universal Definition of Myocardial Infarction"; adapted from AHA Get with the Guidelines ACTION registry

**Initial Troponin (Unspecified) Date and Time**

Coding Instructions: Indicate the date and time of collection of the initial troponin (unspecified).

Notes: Initial troponin level corresponds to the first sample obtained within the first 24 hours of care. It may also have been collected at the transferring hospital.

Target Value: Any occurrence between first medical contact and 24 hours after arrival at first facility

Selections: N/A

Supporting Definition: (none)

Source: Adapted from AHA Get with the Guidelines ACTION registry

**Maximum Troponin (Unspecified) Level**

Coding Instructions: Indicate the maximum troponin level (unspecified) recorded during hospital stay.

Target Value: Any occurrence during the entire hospital stay.
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Maximum Troponin (Unspecified) Date and Time**
Coding Instructions: Indicate the date and time of collection of the maximum troponin (unspecified).
Target Value: Any occurrence during the entire hospital stay
Selections: N/A
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial Hemoglobin Date and Time**
Coding Instructions: Indicate the date and time when the initial hemoglobin sample was collected (not the date results reported).
Target Value: The first value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial Hemoglobin Value**
Coding Instructions: Indicate hemoglobin value in mg/dL.
Target Value: The first value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Lowest Recorded Hemoglobin Date and Time**
Coding Instructions: Indicate the date and time when the hemoglobin sample with the lowest value was collected (not the date results reported).
Target Value: Any occurrence between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry
**Lowest Recorded Hemoglobin Value**
Coging Instructions: Indicate the lowest hemoglobin value available in mg/dL.
Target Value: Any occurrence between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Last Hemoglobin Date and Time**
Coding Instructions: Indicate the date and time when the last hemoglobin sample during hospital stay was collected (not the date results reported).
Target Value: Last value prior to discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Last Hemoglobin Value**
Coding Instructions: Indicate the last hemoglobin value available in mg/dL.
Target Value: Last value prior to discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Minimum Hematocrit Date and Time**
Coding Instructions: Indicate the date and time of the hematocrit sample that yielded the minimum value (not the date results reported).
Target Value: The minimum value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Minimum Hematocrit Value**
Coding Instructions: Indicate minimum hematocrit value in %.
Target Value: The minimum value between first medical contact and discharge
Last Recorded Hematocrit Date and Time
Coding Instructions: Indicate the date and time when the last hematocrit sample was collected (not the date results reported).
Target Value: Last occurrence between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Last Recorded Hematocrit Value
Coding Instructions: Indicate the last hematocrit value available in %.
Target Value: Last occurrence between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Initial WBC Date and Time
Coding Instructions: Indicate the date and time when the initial WBC count was collected (not the date results reported).
Target Value: The first available value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from VIRGO registry

Initial WBC Value
Coding Instructions: Record the first available WBC count (x10^3/µL)
Target Value: The first available value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from VIRGO registry
**Initial Neutrophil Count Date and Time**
Coding Instructions: Indicate the date and time when the neutrophil count was collected (not the date results reported).
Target Value: The first value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Initial Neutrophil Count Value**
Coding Instructions: Record the initial neutrophil count \(\times 10^3/\mu\text{L}\)
Target Value: The first value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Initial Neutrophil Ratio**
Coding Instructions: Record the initial neutrophil ratio
Target Value: The first value between first medical contact and discharge
Selections: (none)
Supporting Definition: This should be derived from the differentials of the complete blood count (CBC)
Source: Definition per CORE team

**Initial Platelet Count Date and Time**
Coding Instructions: Indicate the date and time when the platelet count was collected (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial Platelet Count Value**
Coding Instructions: Record the first available platelet count \(\times 10^9/\mu\text{L}\)
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Minimum Platelet Count Date and Time**
Coding Instructions: Indicate the date and time when the platelet count with the minimum value was collected (not the date results reported).
Target Value: Lowest value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Minimum Platelet Count Value**
Coding Instructions: Record the lowest available platelet count (x10⁹/µL)
Target Value: Lowest value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Hemoglobin A1c Value**
Coding Instructions: Record the most recent hemoglobin A1c in % obtained in the past 3 months.
Target Value: The most recent value obtained in the past 3 months
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial LDH Date and Time**
Coding Instructions: Indicate the date and time when the initial LDH sample was collected (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry
**Initial LDH Value**
Coding Instructions: Record the first available LDH value (mg/dL)
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial Blood Glucose Value**
Coding Instructions: Record the first available blood glucose value (mg/dL)
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial AST Level Date and Time**
Coding Instructions: Indicate the date and time when the AST levels were collected (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Initial AST level Value**
Coding Instructions: Record the first available AST level. (IU/L)
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Maximum AST Level Date and Time**
Coding Instructions: Indicate the date and time when the maximum AST levels were collected (not the date results reported).
Target Value: Maximum value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Maximum AST level Value**
Coding Instructions: Record the maximum available AST level (IU/L).
Target Value: Maximum value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Minimum AST Level Date and Time**
Coding Instructions: Indicate the date and time when the minimum AST levels were collected (not the date results reported).
Target Value: Minimum value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Minimum AST level Value**
Coding Instructions: Record the minimum available AST level (IU/L).
Target Value: Minimum value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Initial ALT Level Date and Time**
Coding Instructions: Indicate the date and time when the initial ALT levels were collected (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team
**Initial ALT level Value**
Coding Instructions: Record the first available ALT level (IU/L).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Maximum ALT Level Date and Time**
Coding Instructions: Indicate the date and time when the maximum ALT levels were collected (not the date results reported).
Target Value: Maximum value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Maximum ALT level Value**
Coding Instructions: Record the maximum available ALT level (IU/L).
Target Value: Maximum value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Minimum ALT Level Date and Time**
Coding Instructions: Indicate the date and time when the minimum ALT levels were collected (not the date results reported).
Target Value: Minimum value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Minimum ALT Level Value**
Coding Instructions: Record the minimum available ALT level (IU/L).
Target Value: Minimum value between first medical contact and discharge
Selections: (none)
Initial Total Bilirubin Date and Time
Coding Instructions: Indicate the date and time when the initial total bilirubin levels were recorded (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

Initial Total Bilirubin Value
Coding Instructions: Record the first available total bilirubin level (IU/L).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

Initial Direct Bilirubin Date and Time
Coding Instructions: Indicate the initial date and time when the direct bilirubin levels were collected (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

Initial Direct Bilirubin Value
Coding Instructions: Record the first available direct bilirubin level (IU/L).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

Initial Creatinine Date and Time
Coding Instructions: Indicate the date and time when the creatinine levels were recorded (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial Creatinine Value**
Coding Instructions: Record the first available creatinine level (mg/dL).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Maximum Creatinine Date and Time**
Coding Instructions: Indicate the date and time when the creatinine levels with maximum value were collected (not the date results reported).
Target Value: Maximum occurrence between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Maximum Creatinine Value**
Coding Instructions: Record the maximum available creatinine level (mg/dL).
Target Value: Maximum occurrence between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Last Creatinine Date and Time**
Coding Instructions: Indicate the date and time when the last creatinine levels with last value were collected (not the date results reported).
Target Value: Last available value between the first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Last Creatinine Value**

Coding Instructions: Record the last available creatinine level (mg/dL).
Target Value: Last available value between the first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Unit of BUN**

Coding Instructions: indicate the unit of BUN.
Target Value: N/A
Selections: (1) Mgmg/dl (2) mmol/L (3) Other
Supporting Definition: (none)
Source: Definition per CORE team.

**Initial BUN Date and Time**

Coding Instructions: Indicate the date and time when the initial BUN levels were recorded (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial BUN Value**

Coding Instructions: Record the first available BUN level.
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Maximum BUN Date and Time**

Coding Instructions: Indicate the date and time when the maximum BUN levels were collected
(not the date results reported).
Target Value: Maximum value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Maximum BUN Value**
Coding Instructions: Record the maximum BUN value
Target Value: Maximum value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial BNP Date and Time**
Coding Instructions: Indicate the date and time when the BNP levels were collected (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial BNP Value**
Coding Instructions: Record the first available BNP level (pg/ml).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial NT-BNP Date and Time**
Coding Instructions: Indicate the date and time when the initial NT-BNP levels were collected (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Initial NT-BNP Value
Coding Instructions: Record the first available NT-BNP level (pg/ml).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Unit of BNP/NT-proBNP
Coding Instructions: indicate the unit of BNP or NT-proBNP.
Target Value: N/A
Selections: 1) Pg/mL, 2) Ug/L, 3) Ug/mL, 4) Fmol/L, 5) other
Supporting Definition: (none)
Source: Definition per CORE team.

Initial Lipid Panel Date and Time
Coding Instructions: Indicate the date and time the first sample was collected (not the date results reported).
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Unit of Lipids
Coding Instructions: indicate the unit of lipids.
Target Value: N/A
Selections: (1) Mg/dl (2) Mmol/L (3)Other
Supporting Definition: (none)
Source: Definition per CORE team.

Total Cholesterol Value
Coding Instructions: Indicate the total cholesterol value in mg/dL.
Notes: If multiple total cholesterol samples were collected, the first one should be preferentially abstracted.
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**HDL Cholesterol Value**
Coding Instructions: Indicate the HDL cholesterol value in mg/dL.
Notes: If multiple HDL samples were collected, the first one should be preferentially abstracted.
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**LDL Cholesterol Value**
Coding Instructions: Indicate the LDL cholesterol value in mg/dL.
Notes: If multiple LDL samples were collected, the first one should be preferentially abstracted.
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Triglycerides Cholesterol Value**
Coding Instructions: Indicate the triglycerides cholesterol value in mg/dL.
Notes: If multiple triglyceride samples were collected, the first one should be preferentially abstracted.
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Urine Protein Date and Time**
Coding Instructions: Indicate the date and time when the urine protein levels were collected (not the date results reported).
Target Value: Any occurrence between the first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from VIRGO registry
**Urine Protein Value**
Coding Instructions: Indicate the value of urine protein levels.
Target Value: Any occurrence between the first medical contact and discharge
Selections: (1) Positive/ +, (2) Negative, (3) Trace (+/-), (4)++, (5) +++, (6) ++++
Supporting Definition: (none)
Source: Adapted from VIRGO registry

**Initial INR Date and Time**
Coding Instructions: Indicate the date and time when the initial INR levels were collected (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial INR Value**
Coding Instructions: Record the first available INR value.
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial APTT Date and Time**
Coding Instructions: Indicate the date and time when the initial APTT levels were collected (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Initial APTT Value**
Coding Instructions: Record the first available APTT value in seconds.
Target Value: First value between first medical contact and discharge
Selections: (none)
Initial PT Date and Time
Coding Instructions: Indicate the date and time when the initial PT levels were collected (not the date results reported).
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Initial PT Value
Coding Instructions: Record the first available PT value in seconds.
Target Value: First value between first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

HBsAg
Coding Instructions: Indicate if the patient was tested for HBsAg antigen or Pre-S1 protein.
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections: (1) No (2) Yes
If Yes, specify the result:
Negative
Positive
Un collected
Supporting Definition: HBsAg is the surface antigen of the hepatitis B virus (HBV). It indicates current hepatitis B infection.
Source: Definition per CORE team

HBsAb
Coding Instructions: Indicate if the patient was tested for HBsAb.
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections: (1) No (2) Yes
If Yes, specify the result:
Negative
Positive
Un collected
Note: If the numerical value is given, please report it.
Supporting Definition: HBsAb is the antibody directed against the surface antigen of the hepatitis B virus (HBV).
Source: Definition per CORE team

**HBeAg / Anti HBeAg**
Coding Instructions: Indicate if the patient was tested for HBeAg antigen or Anti-HBeAg antibody.
Target Value: Any occurrence between arrival at admitting hospital and discharge.
Selections: (1) No (2) Yes
If Yes, specify the result:
Negative
Positive
Un collected
Supporting Definition: HBeAg is an antigen of the hepatitis B virus indicating active replication of virus in the bloodstream. It indicates current hepatitis B infection.
Source: Definition per CORE team

**HCV-Ab**
Coding Instructions: Indicate if the patient was tested for HCV antibody.
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections: (1) No (2) Yes
If Yes, specify the result:
Negative
Positive
Un collected
Supporting Definition: HCV antibody test helps to detect infection with Hepatitis C virus. If tested for HCV-IgM, HCV-IgG, or both, the answer is Yes.
Source: Definition per CORE team
**HIV Ab**
Coding Instructions: Indicate if the patient was tested for HIV antibody.
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections: (1) No (2) Yes
If Yes, specify the result:
Negative
Positive
Un collected
Supporting Definition: HIV antibody test helps to detect infection with Human Immunodeficiency Virus.
Source: Definition per CORE team

**Initial CRP Date and Time**
Coding Instructions: Indicate the date and time when the initial CRP levels were collected (not the date results reported).
Target Value: First occurrence between the first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Initial CRP Value**
Coding Instructions: Indicate the result of test for initial CRP.
Target Value: First occurrence between the first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

**Unit of CRP/hs-CRP**
Coding Instructions: indicate the unit of CRP or hs-CRP.
Target Value: N/A
Selections: (1) Mg/dl (2) Pg/mL (3) Other
Supporting Definition: (none)
Source: Definition per CORE team
Initial hs-CRP Date and Time
Coding Instructions: Indicate the date and time when the initial hs-CRP levels were collected (not the date results reported).
Target Value: First occurrence between the first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

Initial hs-CRP Value
Coding Instructions: Indicate the result of test for initial hs-CRP.
Target Value: First occurrence between the first medical contact and discharge
Selections: (none)
Supporting Definition: (none)
Source: Definition per CORE team

MEDICATIONS ADMINISTERED
Note: All the information about medications was entered into a central medication database. For each medication, we abstracted name, dose, and route of administration. The following definitions describe specific pre-defined questions pertinent to medication administration for acute myocardial infarction.

Aspirin in the First 24 Hours
Coding Instructions: Indicate if aspirin was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g. transferring facility or EMS).
Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from VIRGO registry

Documented Reasons for Non-prescription of Aspirin in the First 24 Hours
Coding Instructions: If the medication was not prescribed, indicate whether the reason was documented.
Target Value: Any documentation in the chart regarding contraindications for the prescription of
the medication in the first 24 hours.
Selections:
(1) No
(2) Yes – Allergy
(3) Yes – Other (specify)
Source: Definition per CORE team

**Aspirin in the First 24 Hours- Start Date**
Coding Instructions: Indicate the date that aspirin was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact.
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from VIRGO registry

**Aspirin in the First 24 Hours- Start Time**
Coding Instructions: Indicate the time that aspirin was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from VIRGO registry

**Aspirin at Discharge**
Coding Instructions: Indicate if aspirin was continued or prescribed.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Aspirin at Discharge–Dose**
Coding Instructions: Indicate the dose of aspirin prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: The highest value on discharge
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Documented Reasons for Non-Prescription of Aspirin at Discharge**
Coding Instructions: If the medication was not prescribed, indicate whether the reason was documented.
Target Value: Any documentation in the chart regarding contraindications for the prescription of the medication at discharge.
Selections:
(1) No
(2) Yes – Allergy
(3) Yes – Other (specify)
Source: Definition per CORE team

**Warfarin during the First 24 Hours**
Coding Instructions: Indicate if warfarin was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g. transferring facility or EMS).
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from VIRGO registry
**Warfarin at Discharge**
Coding Instructions: Indicate if Warfarin was continued or prescribed.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Clopidogrel in the First 24 Hours**
Coding Instructions: Indicate if clopidogrel was administered, regardless of location of care (e.g. transferring facility or EMS).
Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Clopidogrel in the First 24 Hours- Start Date**
Coding Instructions: Indicate the date the initial dose of clopidogrel was administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact.
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Clopidogrel in the First 24 Hours- Start Time**
Coding Instructions: Indicate the time that clopidogrel was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value for clopidogrel in First 24 Hours Start Date
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Clopidogrel in the First 24 Hours- Dose**
Coding Instructions: Indicate the cumulative dose of clopidogrel.
Target Value: The cumulative dose between first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Clopidogrel at Discharge**
Coding Instructions: Indicate if clopidogrel was continued or prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Clopidogrel at Discharge–Dose**
Coding Instructions: Indicate the dose of clopidogrel prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: The highest value on discharge
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Ticlopidine in the First 24 Hours**
Coding Instructions: Indicate if ticlopidine was administered, regardless of location of care (e.g. transferring facility or EMS).
Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Ticlopidine in the First 24 Hours-Start Date**
Coding Instructions: Indicate the date the initial dose of ticlopidine was administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Ticlopidine in the First 24 Hours- Start Time**
Coding Instructions: Indicate the time that ticlopidine was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Ticlopidine in the First 24 Hours- Dose**
Coding Instructions: Indicate the cumulative dose of ticlopidine.
Target Value: The cumulative dose between first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Ticlopidine at Discharge**
Coding Instructions: Indicate if ticlopidine was continued or prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."

Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Ticlopidine at Discharge –Dose**
Coding Instructions: Indicate the dose of ticlopidine prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: The highest value on discharge
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Prasugrel in the First 24 Hours**
Coding Instructions: Indicate if prasugrel was administered, regardless of location of care (e.g. transferring facility or EMS).
Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Prasugrel in the First 24 Hours- Start Date**
Coding Instructions: Indicate the date the initial dose of prasugrel was administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry
**Prasugrel in the First 24 Hours- Start Time**
Coding Instructions: Indicate the time that prasugrel was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Prasugrel in the First 24 Hours- Dose**
Coding Instructions: Indicate the cumulative dose of prasugrel.
Target Value: The cumulative dose between first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Prasugrel at Discharge**
Coding Instructions: Indicate if prasugrel was continued or prescribed at discharge.  
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Prasugrel at Discharge–Dose**
Coding Instructions: Indicate the dose of prasugrel prescribed at discharge. 
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: The highest value on discharge
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Fibrinolysis in the First 24 Hours**

Coding Instructions: Indicate if fibrinolytics were administered, regardless of location of care (e.g. transferring facility or EMS).

Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact

Selections: (1) No (2) Yes

Supporting Definitions: If fibrinolytics are used, please name the fibrinolytic agent, the Bolus dose (IU), the Second Bolus dose (IU/hour), or Maintenance dose (IU/hour), where applicable, or mark “Unknown” if doses are not documented.

Source: Adapted from VIRGO registry

**Refusal of Fibrinolysis**

Coding Instructions: Indicate if there is documentation of patient refusal for fibrinolysis

Target Value: Any occurrence from the beginning of hospital stay to discharge

Selections: (1) No (2) Yes

Supporting Definitions: (none)

Source: Definition per CORE team

**Fibrinolysis in the First 24 Hours –Start Date**

Coding Instructions: Indicate the date the initial dose of fibrinolytic administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.

Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact

Selections: (none)

Supporting Definitions: (none)

Source: Adapted from AHA Get with the Guidelines ACTION registry

**Fibrinolysis in the First 24 Hours –Start Time**

Coding Instructions: Indicate the time that a fibrinolytic was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g. transferring facility or
EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after
first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Documented Reasons for Non-prescription of Fibrinolysis in the First 24 Hours
Coding Instructions: If the medication was not prescribed, indicate whether the reason was
documented.
Target Value: Any documentation in the chart regarding contraindications for the prescription of
the medication in the first 24 hours.
Selections: (1) No (2) Yes – Allergy (3) Yes – Other (specify)
Source: Definition per CORE team

Fibrinolysis after the First 24 Hours
Coding Instructions: Indicate if fibrinolytics were administered, regardless of location of care
(e.g. transferring facility or EMS).
Target Value: Any occurrence after the first 24 hours from the first medical contact
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Fibrinolysis after the First 24 Hours–Start Date
Coding Instructions: Indicate the date the initial dose of fibrinolytic was administered, regardless
of location of care (e.g. transferring facility or EMS). If administered more than once, code the
first date/time it was administered.
Target Value: The first value after the first 24 hours from the first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Fibrinolysis after the First 24 Hours –Start Time
Coding Instructions: Indicate the time that a fibrinolytic was administered in the first 24 hours
Anticoagulant Use
Coding Instructions: First, please indicate if an anticoagulant is being used or not (YES/ NO). Next, please specify the type of anticoagulant(s) administered, including: unfractionated heparin, low molecular weight heparins (enoxaparin, dalteparin, or fondaparinux), direct thrombin inhibitors (such as lepirudin, bivalirudin, and argatroban), and coumarins. Please indicate the start date and time of first administration of the anticoagulant medication(s).
For anticoagulants that are used in the first 24 hours from first medical contact, depending on the type of the anticoagulant, please also specify:
   (1) Was a bolus used? If yes, provide the date, time and dose.
   (2) Was an infusion used? If yes, provide the date, time and dose.
   (3) Was a subcutaneous injection used? If yes, provide the date, time and dose.
   (4) Provide the number of daily injections where applicable.
Source: Adapted from VIRGO registry

Documented Reasons for Non-prescription of Anticoagulants
Coding Instructions: Indicate if the patient has documented reasons for not being prescribed anti-coagulant medications as described above.
Target Value: N/A
Selections: (1) Yes allergy (2) Yes other (3) No
Supporting Definitions: (none)
Source: Definition per CORE team

Glycoprotein IIb/IIIa Inhibitor Use
Coding Instructions: First, please indicate if glycoprotein IIb/IIIa inhibitors were used (YES/ NO). Next please specify the data and time of first administration and the name of drug being used: abciximab, tirofiban or eptifibatide. If used during the first 24 hours from the time of first medical contact, please indicate the date and time, as well as bolus and maintenance doses.
Documented Reasons for Non-prescription of GP IIB/IIIA Inhibitors
Coding Instructions: Indicate if the patient has documented reasons for not being prescribed of GP IIB/IIIA Inhibitors.
Target Value: N/A
Selections: (1) Yes allergy (2) Yes other (3) No
Supporting Definitions: (none)
Source: Definition per CORE team

Beta-blockers in the First 24 Hours
Coding Instructions: Indicate if a beta-blocker was administered, regardless of location of care (e.g., transferring facility or EMS).
Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Beta-blockers in the First 24 Hours- Start Date
Coding Instructions: Indicate the date the initial dose of beta-blocker was administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Beta Blockers in the First 24 Hours-Start Time
Coding Instructions: Indicate the time that the beta blocker was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g., transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after
Beta Blockers in the First 24 Hours- Route of Administration
Coding Instructions: Indicate if beta blockers were given intravenous, PO, or both.
Target Value: N/A
Selections: (1) IV (2) PO (3) Both
Supporting Definitions: (none)
Source: Definition per CORE team

Documented Reasons for Non-prescription of Beta-blocker in the First 24 Hours
Coding Instructions: Indicate if the patient has documented reasons for not being prescribed Beta-blocker in the first 24 hours.
Target Value: N/A
Selections: (1) Yes allergy (2) Yes other (3) No
Supporting Definitions: (none)
Note(s): Code 'yes' if there is documented reason that the patient was started on an oral form of a beta-blocker within the first 24 hours.
Code 'no' if a there is no documented reason that the patient was given a sublingual, IV, or short acting formula of one of these medications within the first 24 hours.
Source: Adapted from AHA Get with the Guidelines CATH-PCI registry

Beta Blockers at Discharge
Coding Instructions: Indicate if a beta blocker was continued or prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Beta Blockers at Discharge–Dose
Coding Instructions: Indicate the dose of beta blockers prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: The highest value on discharge
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Documented Reasons for Non-prescription of Beta Blockers at Discharge**
Coding Instructions: If the medication was not prescribed, indicate whether the reason was documented.
Target Value: Any documentation in the chart regarding contraindications for the prescription of the medication at discharge.
Selections: (1) No (2) Yes – Allergy (3) Yes – Other (specify)
Source: Definition per CORE team

**Angiotensin Converting Enzyme Inhibitor in the First 24 Hours**
Coding Instructions: Indicate if an angiotensin converting enzyme inhibitor was administered, regardless of location of care (e.g., transferring facility or EMS).
Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Angiotensin Converting Enzyme Inhibitors in the First 24 Hours- Start Date**
Coding Instructions: Indicate the date the initial dose of angiotensin converting enzyme inhibitor was administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact.
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry
**Angiotensin Converting Enzyme Inhibitors in the First 24 Hours- Start Time**
Coding Instructions: Indicate the time that the angiotensin converting enzyme inhibitor was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Angiotensin Converting Enzyme Inhibitors in the First 24 Hours- Route of administration**
Coding Instructions: Indicate if angiotensin converting enzyme inhibitors were given intravenous, PO, or both.
Target Value: N/A
Selections: (1) IV (2) PO (3) Both
Supporting Definitions: (none)
Source: Definition per CORE team

**Angiotensin Converting Enzyme Inhibitors at Discharge**
Coding Instructions: Indicate if an angiotensin converting enzyme inhibitor was continued or prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Angiotensin Converting Enzyme Inhibitors at Discharge –Dose**
Coding Instructions: Indicate the dose of angiotensin converting enzyme inhibitor prescribed at discharge. The name of the agent used should also be mentioned.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to
"Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: The highest value on discharge
Selections: (none)
Supporting Definitions: (none)
Source: Definition per CORE team

**Documented Reasons for Non-prescription of ACE Inhibitors at Discharge**
Coding Instructions: If the medication was not prescribed, indicate whether the reason was documented.
Target Value: Any documentation in the chart regarding contraindications for the prescription of the medication at discharge.
Selections: (1) No (2) Yes – Allergy (3) Yes – Other (specify)
Source: Definition per CORE team

**Angiotensin Receptor Blocker in the First 24 Hours**
Coding Instructions: Indicate if an angiotensin receptor blocker was administered, regardless of location of care (e.g. transferring facility or EMS).
Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact.
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Angiotensin Receptor Blockers in the First 24 Hours- Start Date**
Coding Instructions: Indicate the date the initial dose of angiotensin receptor blocker was administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact.
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Angiotensin Receptor Blockers in the First 24 Hours- Start Time**
Coding Instructions: Indicate the time that the angiotensin receptor blocker was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g., transferring facility or EMS). If administered more than once, code the first date/time it was administered.

Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Angiotensin Receptor Blockers at Discharge –Dose**

Coding Instructions: Indicate the dose of angiotensin receptor blocker prescribed at discharge. The name of the agent used should also be mentioned.

Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."

Target Value: The highest value on discharge
Selections: (none)
Supporting Definitions: (none)
Source: Definition per CORE team

**Angiotensin Receptor Blockers at Discharge**

Coding Instructions: Indicate if an angiotensin receptor blocker was continued or prescribed at discharge.

Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."

Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Documented Reasons for Non-prescription of ARBs at Discharge**

Coding Instructions: If the medication was not prescribed, indicate whether the reason was documented.

Target Value: Any documentation in the chart regarding contraindications for the prescription of
the medication at discharge.
Selections: (1) No (2) Yes – Allergy (3) Yes – Other (specify)
Source: Definition per CORE team

**Statin in the First 24 Hours**
Coding Instructions: Indicate if a statin was administered, regardless of location of care (e.g. transferring facility or EMS).
Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Statins in the First 24 Hours- Start Date**
Coding Instructions: Indicate the date the initial dose of statin was administered, regardless of location of care (e.g. transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact.
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Statins in the First 24 Hours- Start Time**
Coding Instructions: Indicate the time that the statin was administered in the first 24 hours before or after first medical contact, regardless of location of care (e.g., transferring facility or EMS). If administered more than once, code the first date/time it was administered.
Target Value: The first value between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Statins at Discharge**
Coding Instructions: Indicate if a statin was continued or prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Documented Reasons for Non-Prescription of Statin at Discharge**

Coding Instructions: If the medication was not prescribed, indicate whether the reason was documented.

Target Value: Any documentation in the chart regarding contraindications for the prescription of the medication at Discharge.

Selections:

1. No
2. Yes – Allergy
3. Yes – Other (specify)

Source: Definition per CORE team

**Statin at Discharge – Dose**

Coding Instructions: Indicate the dose of statin prescribed at discharge. The agent used should be named, too.

Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."

Target Value: The highest value on discharge
Selections: (none)
Supporting Definitions: (none)
Source: Definition per CORE team

**Non-statin Lipid Lowering Agents in the First 24 Hours**

Coding Instructions: Indicate if a non-statin lipid-lowering drug was administered, regardless of location of care (e.g. transferring facility or EMS).

Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact
Non-statin Lipid Lowering Agents at Discharge
Coding Instructions: Indicate if a non-statin lipid-lowering agent was continued or prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Nitrates in the First 24 Hours
Coding Instructions: Indicate if a nitrate was administered, regardless of location of care (e.g. transferring facility or EMS).
Target Value: Any occurrence between 24 hours before first medical contact and 24 hours after first medical contact
Selections: (1) No (2) Yes - If yes, name the drug.
Supporting Definitions: (none)
Source: Definition per CORE team

Nitrate at Discharge
Coding Instructions: Indicate if a nitrate was continued or prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes - If yes, name the drug and the dose at discharge
Supporting Definitions: (none)
Source: Definition per CORE team

Ranolazine at Discharge
Coding Instructions: Indicate if ranolazine was continued or prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

**Calcium Channel Blockers at Discharge**
Coding Instructions: Indicate if a calcium channel blocker was continued or prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes - If yes, please name the agent being prescribed.
Supporting Definitions: (none)
Source: Definition per CORE team

**Traditional Chinese Medications (TCM) at Discharge**
Coding Instructions: Indicate if a TCM was continued or prescribed at discharge.
Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."
Target Value: Any occurrence on discharge
Selections: (1) No (2) Yes -If yes, please name the drug.
Supporting Definitions: (none)
We will note the following seven categories TCPM (traditional Chinese patent medication) commonly used for AMI in China based on their main ingredient.
1. Danshen or Ginseng or Red Ginseng  
2. Ginkgo  
3. Sanqi (Panax notoginseng)  
4. Hirudin  
5. Erigeron breviscapus Extract (Dengzhan Hua)  
6. Lipid-lowing TCPM (Xuezhikang and Taizhian)  
7. Others (Jiuxinwan and Gegengsu)
Source: Definition per China team

**Proton Pump Inhibitor Use**
Coding Instructions: Indicate if a proton pump inhibitor was administered, regardless of location of care (e.g. transferring facility or EMS).
**Other Drugs at Discharge**

Coding Instructions: Indicate if other drugs continued or prescribed at discharge.

Note(s): Discharge medications do not need to be recorded for patients who were discharged to "Other acute care hospital", "Hospice", or "Left against medical advice (AMA)."

Target Value: Any occurrence on discharge.

Selections: (1) No (2) Yes - If yes, please name the agent.

Supporting Definitions: If multiple “other drugs” are used, please report each, separately

Source: Definition per CORE team

**Drug allergy**

Coding Instructions: Indicate if the patient has any drug allergy

Target Value: N/A

Selections: (1) No (2) Yes

Supporting Definitions: (none)

Source: Definition per CORE team

**CARDIAC CATHETERIZATION AND RELATED COMPLICATIONS**

**Diagnostic Catheterization or Diagnostic Coronary Angiography**

Coding Instructions: Indicate if the patient had a diagnostic coronary angiography procedure.

Target Value: Any occurrence between arrival at first facility and discharge

Selections: (1) No (2) Yes

Supporting Definitions: Diagnostic coronary angiography is defined as the passage of a catheter into the aortic root or other great vessels for the purpose of angiography of the native coronary arteries or bypass grafts supplying native coronary arteries.

Source: NCDR; adapted from AHA Get with the Guidelines ACTION registry

**Reason for Coronary Angiography**

Coding Instructions: Indicate the circumstances or leading to coronary angiography

Target Value: N/A
Selections: (1) Elective (2) Urgent (3) Emergency (4) Salvage (5) Unrecorded
Supporting Definition: This should be performed for 1st 2 occurrences of coronary angiography
Source: Definition per CORE team

**Catheterization Laboratory Arrival Date and Time**

Coding Instructions: Indicate the date the patient arrived to the cath lab, as documented in the medical record, as well as the time of arrival
Target Value: The first value between arrival at this facility and discharge
Selections: (none)
Supporting Definitions: Indicate the time (hours: minutes) using the military 24-hour clock, beginning at midnight (0000 hours). If an arterial sheath is already in place, use the time of the introduction of a catheter or the time the sheath was exchanged.
Source: Adapted from AHA Get with the Guidelines ACTION registry and from VIRGO registry

**Arterial Access Site**

Coding Instructions: Indicate the primary location of percutaneous entry. If more than one entry site was used, choose the site that was used to perform the majority of the procedure.
Target Value: N/A
Selections: Choose one of the following:
   a. Femoral; mark “Femoral” if percutaneous puncture of either femoral artery.
   b. Radial; mark “Radial” if percutaneous radial approach.
   c. Brachial; mark “Brachial” if either a cutdown or percutaneous puncture of either brachial artery.
   d. Other; mark “Other” if percutaneous entry other than femoral, brachial, or radial approaches to the cardiovascular system.
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

**Arterial Dominance**

Coding Instructions: Indicate the dominance of the coronary anatomy (whether the posterior descending artery comes from the right or left vessel system).
Selections: Selection Text Definition
   Left dominance is present when the posterior descending artery (PDA) and posterolateral artery (PLA) arise from the left circumflex artery.
Right dominance is present when the posterior descending artery (PDA) and posterolateral artery (PLA) arises from the right coronary artery.

Co-dominance is present when the right coronary artery supplies the posterior descending artery (PDA) and the circumflex supplies the posterolateral artery (PLA). Thus, there is approximately equal contribution to the inferior surface of the left ventricle from both the left circumflex and right coronary arteries.

If not reported, select “unrecorded”.

Supporting Definitions: (none)
Source: NCDR; Adapted from the CathPCI registry

**Stenosis Percent**

Coding Instructions: Indicate the best estimate of most severe percent stenosis in any coronary artery.

Target Value: The highest value between arrival at first facility and discharge

Selections: Include:

- a. Left Main Artery (LM)
- b. Proximal LAD
- c. Mid/Distal LAD, Diag Branches
- d. CIRC, OMs, LPDA and LPL Branches
- e. RCA, RPDA, RPL, AM Branches
- f. Ramus

Supporting Definitions: Does not include collateral circulation.

Provide the most severe stenosis for the vessel that is primarily providing perfusion to the myocardium in that territory. (Ex. If a patient’s mid LAD is 100% and a graft provides revascularization to that territory of the heart, code the % stenosis of the graft. If the same patient has an open graft, and a 70% stenosis of the 2nd diagonal, code 70% since that is the most severe stenosis % for that territory of the myocardium.) In instances where multiple lesions are present, enter the single highest percent stenosis noted. If no stenosis, then enter 0%.

Stenosis: Stenosis represents the percentage diameter reduction, from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the “normal” reference vessel proximal to the lesion.

Source: NCDR; Adapted from AHA Get with the Guidelines ACTION registry

**Percent stenosis not available**
Coding Instructions: Indicate if best estimate of percent stenosis is not available.
Target Value: as below
Selections: Left Main artery (LM) not available (1) No (2) Yes
   a. Proximal LAD not available (1) No (2) Yes
   b. Mid/Distal LAD, Diag Branches not available (1) No (2) Yes
   c. CIRC, OMs, LPDA and LPL Branches not available (1) No (2) Yes
   d. RCA, RPDA, RPL, AM Branches not available (1) No (2) Yes
   e. Ramus not available (1) No (2) Yes

Graft Percent Stenosis
Coding Instructions: Indicate if the percent stenosis is available for the bypass grafts
Target Value: as below
Selections:
   a. Graft to Proximal LAD
   b. Graft to Mid/Distal LAD, Diag Branches
   c. Graft to Circ, OMs, LPDA and LPL Branches
   d. Graft to RCA, RPDA, RPL, AM Branches
   e. Graft to Ramus
   f. None of the Above is Recorded
   g. LIMA
   h. RIMA
   i. SVG
Source: Definition per CORE team modified from NCDR Cath PCI Registry.

Graft Stenosis Percent
Coding Instructions: Indicate the best estimate of most severe percent stenosis in a graft as determined by angiography. If no stenosis, enter 0%.
Notes: If CABG was performed prior to cardiac catheterization, provide details per each bypass graft. Leave blank if CABG Date is greater than Procedure Date/Time or Prior CABG is "No".
Target value: N/A
Supporting definition: Stenosis: Stenosis represents the percentage diameter reduction, ranging from 0 to 100, associated with the identified vessels. Percent stenosis at its maximal point is estimated to be the amount of reduction in the diameter of the "normal" reference vessel
proximal to the lesion. In instances where multiple lesions are present, enter the single highest percent stenosis noted.
Source: Definition per CORE team modified from NCDR Cath PCI Registry.

**Graft Stenosis Location**
Coding Instructions: Indicate the location of the lesion within the graft.
Target Value: N/A
Selections: (1) Proximal (2) Mid (3) Distal (4) Unrecorded
Supporting Definitions:
Proximal graft site indicates the site of anastomosis closest to the aorta.
Mid-graft site indicates the lesion within the body of the graft.
Distal graft site indicates the site of anastomosis closest to the coronary vessel.
Source: CORE Team

**Is the Left Main Stem Protected?**
Coding Instructions: Indicate if the patient has protected left main stem disease
Target Value: Any occurrence between beginning of procedure and prior to intervention
Selections: (1) No (2) Yes
Supporting Definitions: Protected left main stem disease implies that the patient has at least one patent graft on the left anterior descending artery

**Lesion Length**
Coding Instructions: Indicate the length of the treated lesion in millimeters.
Note(s): Information obtained after the baseline angiogram can be used to help determine lesion length (e.g. for total occlusions where the distal vessel cannot be visualized).
Target Value: Any occurrence on current procedure
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from NCDR CathPCI

**Characteristics of the Lesion**
Coding Instructions: Indicate the characteristics that apply for the lesion.
Target Value: N/A
Selections: (1) Thrombus Present in Lesion (2) Bifurcation Lesion (3) Calcified Lesion (4) Type A Lesion (5) Type B Lesion (6) Type C Lesion (7) None of the Above is Recorded

Supporting Definitions:

Bifurcation Lesion - A significant bifurcation or branch point is a division of a vessel into at least two branches, each of which is >1.5 mm or greater in diameter. In a bifurcation or branch lesion, the plaque extends from at least one of the limbs to the branch point; it need not progress down all the proximal and distal branches. Bifurcations or branch point lesions should be considered one lesion, no matter how many limbs are treated.

Calcified Lesion – Indicate if there is any calcification within the lesion.

Type A lesions include the following characteristics: Discrete (<10 mm length), Concentric, Readily accessible, Non-angulated segment <45 degrees, Smooth contour, Little or no calcification, Less than totally occlusive, Not ostial in location, No major branch involvement, Absence of thrombus

Type B lesions include the following characteristics: Tubular (10-20 mm length), Eccentric, Moderate tortuosity of proximal segment, Moderately angulated segment, 45-90 degrees, Irregular contour, Moderate to heavy calcification, Ostial in location, Bifurcation lesions requiring double guidewires

Some thrombus present, Total occlusion <3 months old

Type C lesions include the following characteristics: Diffuse (length > 2cm), Excessive tortuosity of proximal segment, Extremely angulated segments > 90 degrees, Total occlusions > 3 months old and/or bridging collaterals, Inability to protect major side branches, Degenerated vein grafts with friable lesions

Source: Adapted from NCDR CathPCI

**Type of Contrast Dye Used**

Coding Instructions: Indicate the name of radiographic contrast agent used for angiography.

Target Value: N/A

Selections: Urografin, Iopamidol, Iopromide, Iohexol, Iodixanol, Iomeprol, Ioversol, Other, Unrecorded.

Supporting Definitions: (none)

Source: Adapted from VIRGO registry

**Total Volume of Contrast Dye Used**
Coding Instructions: Indicate the total volume (ml) of contrast dye used during angiography/PCI.
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from VIRGO registry

**Complication- Contrast Reaction**
Coding Instructions: Indicate whether patient experienced a contrast reaction during the cath lab visit or after the lab visit but before discharge.
Target Value: Any occurrence between PCI and discharge
Selections: (1) No (2) Yes
Supporting Definition: Contrast reaction is defined as at least one of the following:
   a. Anaphylaxis-including bronchospasm and/or vascular collapse
   b. Urticaria
   c. Hypotension-prolonged depression of blood pressure below 70mm Hg.
Source: Adapted from VIRGO registry

**Fractional Flow Reserve**
Coding Instructions: Indicate if fractional flow reserve was performed to confirm the percent stenosis. Myocardial fractional flow reserve is a lesion-specific index of stenosis severity.
Target Value: Any occurrence between beginning of procedure and prior to intervention
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from NCDR CathPCI

**Fractional Flow Reserve Ratio**
Coding Instructions: indicate the fractional flow reserve ratio.
Target Value: The lowest value between beginning of procedure and prior to intervention
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from NCDR CathPCI

**Intravascular Ultrasound (IVUS)**
Coding Instructions: Indicate if intravascular ultrasound was performed to confirm the percent stenosis.
Target Value: Any occurrence between beginning of procedure and prior to intervention
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: NCDR CathPCI

Left Ventricular Ejection Fraction Measured During Procedure
Coding Instructions: Indicate whether the left ventricular ejection fraction was measured during the catheterization procedure.
Target Value: N/A
Selections: (1) No (2) Yes, EF = ______%
Supporting Definitions: (none)
Source: Definition per CORE team.

Recommendation (After Diagnostic Catheterization)
Coding Instructions: Indicate the recommendations after diagnostic catheterization.
Target Value: N/A
Selections: (1) Medical therapy/counseling (2) PCI without planned CABG (3) CABG (including planned hybrid procedures) (4) Other cardiac therapy without CABG or PCI (5) None.
Supporting Definitions: (none)
Source: Definition per CORE team

Was PCI Performed Immediately Following Diagnostic Catheterization?
Coding Instructions: Indicate if PCI was performed immediately after diagnostic catheterization.
Target Value: Any occurrence between beginning of procedure and prior to intervention.
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

PCI Date and Time
Coding Instructions: Indicate the date and time the procedure(s) was/were initiated.
Note(s): Indicate the date (mm/dd/yyyy) and time (hours: minutes) using the military 24-hour clock, beginning at midnight (0000 hours).
If an arterial sheath is already in place, use the time of the introduction of a catheter or the time the sheath was exchanged.

Target Value: N/A
Selections: (none)

Supporting Definitions: Time of Procedure: The time the procedure started is defined as the time at which local anesthetic was first administered for vascular access, or the time of the first attempt at vascular access for the cardiac catheterization (use whichever is earlier).

Source: Adapted from NCDR CathPCI

**Blood Pressure Prior to PCI**

Coding Instructions: Indicate the blood pressure prior to the PCI procedure.
Target Value: The last available value prior to the start of the PCI procedure.
Selections: (none)

Supporting Definitions: (none)
Source: Definition per CORE team

**Heart Rate Prior to PCI**

Coding Instructions: Indicate the heart rate recorded prior to the PCI procedure.
Target Value: The last available value prior to the start of the PCI procedure.
Selections: (none)

Supporting Definitions: (none)
Source: Definition per CORE team

**Cardiogenic Shock at the Start of PCI**

Coding Instructions: Indicate if cardiogenic shock was documented at the start of PCI.
Target Value: Any occurrence at the start of the PCI procedure.
Selections: (1) No (2) Yes

Supporting Definitions: Physician documentation of cardiogenic shock.
Source: Definition per CORE team.

**Pre-Procedure TIMI Flow**

Coding Instructions: Indicate the pre-procedure TIMI flow value.
Note(s): If a lesion spans multiple segments with different TIMI flows, code the lowest TIMI flow within the entire lesion.
Selections:
   TIMI - 0 No flow/no perfusion
   TIMI - 1 Slow penetration without perfusion
   TIMI - 2 Partial flow/partial perfusion (greater than TIMI-1 but less than TIMI-3).
   TIMI - 3 Complete and brisk flow/complete perfusion.
   Unknown/not reported

Target Value: Any occurrence on current procedure
Supporting Definitions: (none)
Source: Adapted from NCDR CathPCI

Percutaneous Coronary Intervention (PCI)
Coding Instructions: Indicate if the patient had percutaneous coronary intervention
Target Value: Any occurrence between arrival at this facility and discharge
Selections: (1) No (2) Yes
Supporting Definitions: Percutaneous coronary intervention (PCI) is the placement of an
angioplasty guide wire, balloon, or other device (e.g. stent, atherectomy, brachytherapy, or
thrombectomy catheter) into a native coronary artery or coronary artery bypass graft for the
purpose of mechanical coronary revascularization.
Source: Adapted from AHA Get with the Guidelines ACTION registry

Refusal of Percutaneous Coronary Intervention
Coding Instructions: Indicate if there is documentation of patient refusal for percutaneous
coronary intervention
Target Value: Any occurrence from the beginning of hospital stay to discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

Previously Treated Lesion
Coding Instructions: Indicate if the lesion of interest had been treated before
Target Value: Any occurrence between birth and current procedure.
Selections: (1) No (2) Yes (3) Unknown/not reported
Supporting Definitions: (none)
Source: Adapted from NCDR CathPCI
**Treated with Stent**

Coding Instructions: Indicate if the previously treated lesion was treated with any type of stent in the current or prior episode of care.

Target Value: Any occurrence between birth and current procedure

Selections: (1) No (2) Yes (3) Unknown/not reported

Supporting Definitions: (none)

Source: Adapted from NCDR CathPCI

**Reasons for PCI at the Site of Former Stent**

Coding Instructions: Indicate the reasons for performing PCI at a previously treated site.

Target Value: N/A

Selections: (1) In-Stent Restenosis (2) In-Stent Thrombosis (3) Unrecorded

Supporting Definitions:

In-stent restenosis is defined as a previously stented lesion that has 50% or greater stenosis.

In-stent thrombosis is defined as presence of thrombus in a stent.

Source: CORE Team

**Did Guidewire Cross Lesion?**

Coding Instructions: Indicate if the guidewire successfully crossed the lesion.

Target Value: N/A

Selections: (1) No (2) Yes

Supporting Definitions: (none)

Source: Adapted from NCDR CathPCI

**First Device Activation Date and Time**

Coding Instructions: Indicate the date and time the first device was activated regardless of type of device used.

Note(s): Use the earliest time from the following:

1. Time of the first balloon inflation.
2. Time of the first stent deployment.
3. Time of the first treatment of lesion (AngioJet or other thrombectomy/aspiration device, laser, rotational atherectomy).
4. If the lesion cannot be crossed with a guidewire or device (and thus none of the above apply), use the time of guidewire introduction. This is a process measure about the timeliness of treatment. It is NOT a clinical outcomes measure based on TIMI flow or clinical reperfusion. It does not matter whether the baseline angiogram showed TIMI 3 flow or if the final post-PCI angiogram showed TIMI 0 flow. What is being measured is the time of the first mechanical treatment of the culprit lesion, not the time when TIMI 3 flow was (or was not) restored. Indicate the time (hours:minutes) using the military 24-hour clock, beginning at midnight (0000 hours).

This element is referenced in The Joint Commission AMI Core Measures AMI-8, AMI-8a.
Target Value: N/A
Selections: (none)
Supporting Definitions: Indicate the time (hours: minutes) using the military 24-hour clock, beginning at midnight (0000 hours).
Source: Adapted from AHA Get with the Guidelines CATH-PCI registry

**Time of the First Balloon Inflation**
Coding Instructions: Indicate the date and time of the first balloon inflation during percutaneous coronary intervention
Target Value: N/A
Selections: (none)
Supporting Definitions: Indicate the time (hours: minutes) using the military 24-hour clock, beginning at midnight (0000 hours).
Source: Adapted from VIRGO registry

**Time of the First Stent Deployment**
Coding Instructions: Indicate the date and time of the first stent deployment during percutaneous coronary intervention
Target Value: N/A
Selections: (none)
Supporting Definitions: Indicate the time (hours: minutes) using the military 24-hour clock, beginning at midnight (0000 hours).
Source: Adapted from VIRGO registry
Stent(s) Placed
Coding Instructions: Indicate if a stent or stents were placed in the affected coronary artery.
Target Value: Any occurrence between arrival at this facility and discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Total Number of Stent(s) Placed
Coding Instructions: Indicate the number of stents placed in the affected coronary artery.
Target Value: Any occurrence between arrival at this facility and discharge
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Bare Metal Stent Implanted
Coding Instructions: Indicate if one or more bare metal stents were implanted during PCI.
Target Value: Any occurrence between arrival at this facility and discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Drug Eluting Stent Implanted
Coding Instructions: Indicate if one or more drug eluting stents were implanted during PCI.
Target Value: Any occurrence between arrival at this facility and discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

Use of Mechanical Ventricular Support During Catheterization Procedure
Coding Instructions: Indicate if mechanical ventricular support was used during catheterization.
Target Value: Any occurrence between beginning of procedure and prior to intervention
Selections: (1) Intraaortic balloon pump (IABP) (2) extracorporeal membrane oxygenation (ECMO) (3) Left ventricular assist device (LVAD) (4) None
Note: if mechanical ventricular support was used, indicate if it was started at the start of the catheterization, during the catheterization procedure and prior to PCI, or after PCI began.
Supporting Definitions: (none)
Source: Definition per CORE team

**Post-Procedure TIMI Flow**
Coding Instructions: Indicate the post-procedure TIMI flow value.
Target Value: Any occurrence on current procedure
Note(s): If a lesion spans multiple segments with different TIMI flows, code the lowest TIMI flow within the entire lesion.
Selections: Selection Text Definition
- TIMI - 0 No flow/no perfusion
- TIMI - 1 Slow penetration without perfusion
- TIMI - 2 Partial flow/partial perfusion (greater than TIMI-1 but less than TIMI-3.
- TIMI - 3 Complete and brisk flow/complete perfusion.
Supporting Definitions: (none)
Source: Adapted from NCDR CathPCI

**Devices Deployed During Catheterization Procedure**
Coding Instructions: Indicate if any intracardiac device was deployed.
Target Value: N/A
Selections: (1) None (2) Balloon (3) Cutting Balloon (4) Rotablator (5) Aspiration Catheters (6) IVUS (7) Pressure Wire (8) Flowire (9) Brachytherapy (10) Distal/Proximal Embolic Protection (11) Thrombectomy Device
Supporting Definitions: (none)
Source: Definition per CORE team.

**Closure Method**
Coding Instructions: Indicate the closure method after percutaneous coronary intervention (PCI).
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections:
- a. Seal (Angioseal, Vasoseal)
- b. Suture
- c. Manual Compression
d. Other

e. Unrecorded

Supporting Definition: The closure device is a device used at the arterial access site at the end of the procedure to facilitate hemostasis without need for manual compression.

Source: Adapted from AHA Get with the Guidelines ACTION registry

**PCI Complication-Tamponade**

Coding Instructions: Indicate if the patient experienced a cardiac tamponade associated with the cardiac catheterization/PCI.

Target Value: Any occurrence between PCI and discharge

Selections: (1) No (2) Yes

Supporting Definition: Mark “Yes” if there was fluid in the pericardial space compromising cardiac filling and requiring intervention during the cath lab visit or after lab visit until discharge (or before any subsequent lab visits). This should be documented by either:

a. Echo showing pericardial fluid and signs of tamponade such as right heart compromise; or

b. Systemic hypotension due to pericardial fluid compromising cardiac function.

Source: Adapted from VIRGO registry

**PCI Complication-Peripheral Embolization**

Coding Instructions: Indicate whether patient experienced peripheral embolization after PCI.

Target Value: Any occurrence between PCI and discharge

Selections: (1) No (2) Yes

Supporting Definition: Mark “Yes” if a peripheral embolization occurred distal to the arterial access site during the procedure or after lab visit but before any subsequent lab visits, requiring therapy. Peripheral embolization is defined as a loss of distal pulse, pain and/or discoloration (especially the toes). This can include cholesterol emboli.

Source: Adapted from VIRGO registry

**PCI Complication-Access Site Arteriovenous Fistula**

Coding Instructions: Indicate whether patient experienced access site arteriovenous fistula during the cath lab visit or after lab visit until discharge.

Target Value: Any occurrence between PCI and discharge

Selections: (1) No (2) Yes
Supporting Definition: (none)
Source: Adapted from VIRGO registry

**PCI Complication-Access Complication Requiring Surgery/Intervention**
Coding Instructions: Indicate whether patient experienced access site occlusion at the site of percutaneous entry during the procedure or after lab visit but before any subsequent lab visits.
Target Value: Any occurrence between PCI and discharge
Selections: (1) No (2) Yes
Supporting Definition: Access site occlusion if defined as: Total obstruction of the artery usually by thrombus (but may have other causes) usually at the site of access requiring surgical repair. Occlusions may be accompanied by absence of palpable pulse or Doppler.
Source: Adapted from VIRGO registry

**PCI Complication-Retroperitoneal Bleeding**
Coding Instructions: Indicate whether patient experienced retroperitoneal bleeding after lab visit.
Target Value: Any occurrence between PCI and discharge
Selections: (1) No (2) Yes
Supporting Definition: Mark “Yes” if retroperitoneal bleeding occurred during or after the cath lab visit until discharge. The bleeding should require a transfusion and/or prolong the hospital stay, and/or cause a drop in hemoglobin > 3.0 gm/dl.
Source: Adapted from VIRGO registry

**Repeat PCI**
Coding Instructions: Indicate whether patient had a second PCI during hospital stay
Target Value: Any occurrence after first PCI and before discharge
Selections: (1) No (2) Yes
Supporting Definition: (none)
Source: Adapted from VIRGO registry

**Stent Thrombosis**
Coding Instructions: Indicate whether patient experienced in-stent thrombosis after PCI
Target Value: Any occurrence after the first PCI and before discharge
Selections: (1) No (2) Yes
Supporting Definition: (none)
**Reasons for Repeat PCI**

Coding Instructions: Indicate the reasons for the repeat coronary angiography/PCI during the hospital stay.

Selections:
1. Staged procedure
2. Ongoing or recurrent ischemia
3. Other

Target Value: Any occurrence after first PCI and discharge

Supporting Definition: Mark “Staged procedure” if second PCI was planned during hospitalization for residual stenoses. Mark “Ongoing or recurrent ischemia/angina” if the patient had recurrent symptoms (e.g. angina), signs (e.g. dynamic ECG changes) or biomarker elevation consistent with ischemia.

Source: Definition per CORE team and Adapted from VIRGO registry

**In-Hospital Implantation of a Permanent Pacemaker Device**

Coding Instructions: Indicate if the patient had a permanent pacemaker implanted during the hospital stay.

Target Value: Any occurrence between arrival at admitting hospital and discharge

Selections: (1) No (2) Yes

Supporting Definitions: Permanent pacemaker includes single-chamber, dual chamber, and biventricular pacemakers. It does not include temporary transcutaneous pacemaker.

Source: Adapted from VIRGO registry

**Date of In-Hospital Permanent Pacemaker Device Implantation**

Coding Instructions: Indicate date that permanent pacemaker device was placed.

Target Value: The first value between arrival at first facility and discharge

Selections: N/A

Supporting Definition: (none)

Source: Definition per CORE team

**In-Hospital Implantation of an Automatic Implantable Cardioverter Defibrillator (AICD)**
Coding Instructions: Indicate whether patient received an implantable cardioverter defibrillator at any time during hospital stay.
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from VIRGO registry

Date of In-Hospital Automatic Implantable Cardioverter Defibrillator (AICD) Implantation
Coding Instructions: Indicate date that Automatic Implantable Cardioverter Defibrillator was placed
Target Value: The first value between arrival at first facility and discharge
Selections: N/A
Supporting Definition: (none)
Source: Definition per CORE team

In-Hospital Implantation of a Left-Ventricular Assist Device (LVAD)
Coding Instructions: Indicate whether the patient received an LVAD at any time during the hospital stay
Target Value: Any occurrence between arrival at admitting hospital and discharge
Selections: (1) No (2) Yes
Supporting Definition: (none)
Source: Definition per CORE team

Date of In-Hospital LVAD Implantation
Coding Instructions: Indicate date that LVAD was placed
Target Value: The first value between arrival at first facility and discharge
Selections: N/A
Supporting Definition: (none)
Source: Definition per CORE team

Coronary Artery Bypass Grafting (CABG)
Coding Instructions: Indicate if the patient had a CABG
Target Value: Any occurrence between arrival at this facility and discharge
Selections: (1) No (2) Yes
Refusal of Coronary Artery Bypass Grafting
Coding Instructions: Indicate if there is documentation of patient refusal for coronary artery bypass grafting
Target Value: Any occurrence from the beginning of hospital stay to discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

CABG Date
Coding Instructions: Indicate the date of the coronary artery bypass graft (CABG) surgery.
Target Value: The first value between arrival at this facility and discharge
Selections: (none)
Supporting Definitions: (none)
Source: Definition as per CORE team

SUMMARY OF IN-HOSPITAL EVENTS
In-Hospital Bleeding
Coding Instructions: Indicate if the patient had a bleeding event during hospitalization.
Target Value: Any occurrence mentioned in the chart from arrival to the facility to discharge
Selections: (1) No (2) Yes
Supporting Definitions: If yes, please indicate the time and date.
Source: Definition per CORE team

Location of Bleeding
Coding Instructions: Indicate the location of bleeding.
Target Value: N/A
Selections: (1) Access site (2) Intracranial (3) Intraocular (4) Intraspinal (5) Retroperitoneal (6) Pericardial (7) Gastrointestinal (8) Genitourinary (9) Other (specify)
Supporting Definitions: Access site bleeding is marked when bleeding happens at the site of vascular access. Intracranial bleeding includes intracerebral and subdural bleeding. Please
record each site separately if more than one applies.
Source: Definition per CORE team

**Nadir Blood Pressure After Bleeding Event**
Coding Instructions: Indicate the value of the lowest recorded blood pressure on the day of or the next day after bleeding onset.
Target Value: Lowest occurrence of blood pressure between bleeding onset and the next day
Selections: N/A
Supporting Definition: (none)
Source: Definition per CORE team

**Hypovolemic/hemorrhagic Shock after Bleeding**
Coding Instructions: Indicate if bleeding led to hypovolemic or hemorrhagic shock.
Target Value: Any occurrence during the hospital stay
Selections: (1) No (2) Yes (3) Unknown
Supporting Definitions: In patients who bled during the hospital stay, evidence in the chart may suggest hypovolemic shock:
A) Physician report of hypovolemic shock in the chart
B) Post-bleeding systolic hypotension (peak systolic pressure < 90 mmHg) or a reduction of > 40 mmHg in systolic blood pressure plus evidence of organ hypoperfusion, which is not responsive to administration of plasma expanders or packed RBCs.
Source: Definition per CORE team

**Interventions for Management of Bleeding**
Coding Instructions: Indicate the intervention(s) used to manage bleeding.
Target Value: Any occurrence after the bleeding event.
Selections: (1) whole blood transfusion (2) packed red cell transfusion (3) local compression (4) surgical intervention, including open surgery, closure or endoscopic interventions (5) other (6) none (7) unrecorded.
Supporting Definitions: Access site bleeding is marked when bleeding happens at the site of vascular access. Intracranial bleeding includes intracerebral and subdural bleeding.
Note(s): Please record each intervention separately if more than one was applied.
Source: Definition per CORE team
Blood Transfusion
Coding Instructions: Indicate if the patient was transfused with whole blood or any of its components.
Target Value: Any occurrence between first medical contact and discharge
Selections: (1) No (2) Yes (3) Unrecorded
If Yes, specify:
   - Red blood cell
   - Platelet
   - Blood plasma
   - Whole Blood
   - Other (specify)
Supporting Definition: (none)
Source: Definition per CORE team

Bleeding Date Hb, HCT, Platelet Count, PT, aPTT, and INR
Coding Instructions: Indicate the bleeding date Hb, HCT, Platelet Count, PT, aPTT, and INR.
Target Value: In two separate time points
   A) Last available laboratory tests before the bleeding event happened
   B) Nadir of the aforementioned laboratory tests after the bleeding event
Selections: Varies for each, please refer to the definitions in the laboratory tests section.
Supporting Definitions: Such information should only be collected for patients with bleeding
Source: Definition per CORE team

In-Hospital Dialysis
Coding Instructions: Indicate if the patient received dialysis during the hospital stay
Target Value: Any occurrence from the hospital stay to discharge
Selections: (1) No (2) Yes
Supporting Definitions: Yes includes hemodialysis, peritoneal dialysis, or both.
Source: Adapted from VIRGO registry

In-Hospital Cardiac Tamponade
Coding Instructions: Indicate if cardiac tamponade occurred during the hospital stay
Target Value: Any occurrence from the hospital stay to discharge
Selections: (1) No (2) Yes
Supporting Definitions: A clinical syndrome caused by the accumulation of fluid in the pericardial space, resulting in reduced ventricular filling and subsequent hemodynamic compromise.
Source: Definition per CORE team

**In-Hospital Venous Thromboembolism**

Coding Instructions: Indicate if in-hospital venous thromboembolism (VTE) was diagnosed during the hospital stay
Target Value: Any occurrence from the beginning of the hospital stay to discharge
Selections: (1) No (2) Yes - If yes, please indicate the date

Supporting Definitions: Venous thromboembolism (VTE) is comprised of deep vein thrombosis ([DVT]; i.e. development of blood clots in the deep veins of lower extremity or upper extremity) and pulmonary embolism ([PE]; i.e. migration of the clots to the pulmonary arteries. The clots can clog the pulmonary arteries, impairing the gas exchange in the lungs. PE is associated with symptoms such as dyspnea and chest pain and can be fatal). For any patient that was diagnosed with DVT, or with PE, or with both during the index admission, please mark “Yes”.

Source: Definition per CORE team

**In-Hospital Deep Vein Thrombosis (DVT)**

Coding Instructions: Indicate if in-hospital DVT was diagnosed during the hospital stay
Target Value: Any occurrence from the beginning of the hospital stay to discharge
Selections: (1) No (2) Yes - If yes, please indicate the date

Supporting Definitions: DVT refers to development of blood clots in the deep veins of lower extremity or upper extremity migration of the clots to the pulmonary arteries. The symptoms and signs include extremity pain, warmness, swelling, a palpable venous cord, and tenderness. The diagnosis is made by ultrasonography or venography. Mark “Yes” if there is physician documentation for the diagnosis.

Source: Definition per CORE team

**In-Hospital Pulmonary Embolism (PE)**

Coding Instructions: Indicate if in-hospital PE was diagnosed during the hospital stay
Target Value: Any occurrence from the beginning of the hospital stay to discharge
Selections: (1) No (2) Yes - If yes, please indicate the date

Supporting Definitions: PE refers to a clinical condition resulting from migration of the clots (rarely other material) to the pulmonary arteries. The clots can clog the pulmonary arteries,
impairing the gas exchange in the lungs. PE is associated with symptoms such as dyspnea, hemoptysis and chest pain and can be fatal. The diagnosis could be made by ventilation-perfusion (V/Q) scanning, computed tomography pulmonary angiography, or conventional pulmonary angiography. Mark “Yes” if there is physician documentation for the diagnosis.

Source: Definition per CORE team

**In-Hospital Infection**

Coding Instructions: Indicate if in-hospital infection occurred during the hospital stay

Target Value: Any occurrence from the beginning of hospital stay to discharge

Selections: (1) No (2) Yes If yes, please indicate the date

Supporting Definitions: (none)

Source: Definition per CORE team

**In-Hospital Infection –Site**

Coding Instructions: Indicate the site of in-hospital infection

Target Value: N/A

Selections: (1) Pulmonary (2) Genitourinary (3) Gastrointestinal (4) Skin (5) Surgical site/procedure site (6) Other (7) Site unknown

Supporting Definitions: (none)

Source: Definition per CORE team

**In-Hospital Cardiogenic Shock**

Coding Instructions: Indicate if cardiogenic shock occurred during the hospital stay

Target Value: Any occurrence from the hospital stay to discharge

Selections: (1) No (2) Yes- If yes, please indicate the date and time

Supporting Definitions: Cardiogenic shock is defined as a sustained (>30 minutes) episode of systolic blood pressure <90 mm Hg, and/or cardiac index <2.2 L/min/m2 determined to be secondary to cardiac dysfunction, and/or the requirement for parenteral inotropic or vasopressor agents or mechanical support (e.g., IABP, extracorporeal circulation, ventricular assist devices) to maintain blood pressure and cardiac index above those specified levels.

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), Adapted from AHA Get with the Guidelines ACTION registry

**In-Hospital Cardiac Rupture**
Coding Instructions: Indicate if there is physician documentation of in-hospital cardiac rupture.
Target Value: Any occurrence from the beginning of hospital stay to discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

**In-Hospital Recurrent Angina/Recurrent Myocardial Infarction**
Coding Instructions: Indicate if there is physician documentation of in-hospital recurrent angina or recurrent myocardial infarction.
Target Value: Any occurrence from the beginning of hospital stay to discharge
Selections: (1) No (2) Yes
Supporting Definitions: Physician documentation of recurrent angina, or recurrent myocardial infarction, or both, warrants a “Yes” answer.
Source: Definition per CORE team

**In-Hospital Ventricular Tachycardia/Ventricular Fibrillation**
Coding Instructions: Indicate if there is physician documentation of in-hospital ventricular tachycardia or ventricular fibrillation.
Target Value: Any occurrence from the beginning of hospital stay to discharge
Selections: (1) No (2) Yes
Supporting Definitions: Physician documentation of ventricular tachycardia or ventricular fibrillation, or both, warrants a “Yes” answer.
Source: Definition per CORE team

**In-Hospital Papillary Muscle Rupture**
Coding Instructions: Indicate if there is physician documentation of in-hospital papillary muscle rupture.
Target Value: Any occurrence from the beginning of hospital stay to discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

**In-Hospital Ventricular Septal Perforation**
Coding Instructions: Indicate if there is physician documentation of ventricular septal perforation.
Target Value: Any occurrence from the beginning of hospital stay to discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

**Significant Coronary Artery Dissection**

Coding Instructions: Indicate if a significant coronary artery dissection was observed.

Note(s): Typically, dissections described as type A or B are not considered significant dissections because there is no impairment of flow. Significant dissections are grade C dissections in the presence of ischemia, or grade D-F dissections, all of which are further described as:

- Type C: persisting contrast medium extravasations;
- Type D: spiral filling defect with delayed but complete distal flow;
- Type E: persistent filling defect with delayed antegrade flow;
- Type F: filling defect with impaired flow and total occlusion

The intracoronary device counter is reset back to one for each procedure.

Target Value: Any occurrence on current procedure
Selections: (1) No (2) Yes
Supporting Definitions: Coronary artery dissection is defined as the appearance of contrast materials outside of the expected luminal dimensions of the target vessel and extending longitudinally beyond the length of the lesion.

Source: NCDR CathPCI

**Coronary Artery Perforation**

Coding Instructions: Indicate if angiographic or clinical evidence of coronary artery perforation was observed.

Note(s): This does not include pre-existing AV fistula and other coronary anomalies.

Target Value: Any occurrence on current procedure
Selections: (1) No (2) Yes
Supporting Definitions: A coronary artery perforation occurs when there is angiographic or clinical evidence of a dissection or intimal tear that extends through the full thickness of the arterial wall.

Source: NCDR CathPCI
**Abrupt Vessel Closure in the Catheterization Laboratory**

Coding Instructions: Indicate whether there was total occlusion (TIMI grade 0 or 1 flow) of the dilated coronary artery occurring at any time during the catheterization procedure.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)


**Side Branch Occlusion**

Coding Instructions: Indicate whether reduction in TIMI flow to grade 0 or 1 was observed in the side branch during the catheterization procedure.

Target Value: N/A

Selections: (none)

Supporting Definitions: (none)


**Distal Embolization**

Coding Instructions: Indicate if angiographic evidence of distal embolization was observed.

Target Value: Any occurrence on current procedure

Selections: (1) No (2) Yes

Supporting Definitions: Angiographic distal filling defect with an abrupt cutoff in at least one of distal branches or vessels of the infarct related artery at any point during the procedure.

**No Flow/Slow flow phenomenon**

Coding Instructions: Indicate if angiographic evidence of no flow/ slow flow was observed.

Note(s): This does not include impaired flow due to dissection or thrombus.

Target Value: Any occurrence on current procedure

Selections: (1) No (2) Yes

Supporting Definitions: No flow is defined as cessation of blood flow (or thrombolysis in myocardial infarction grade ≤ 1flow) into the distal coronary artery in the absence of angiographic explanation for impairment of flow.


**Access Site Occlusion**

Coding Instructions: Indicate if access site occlusion was observed.

Target Value: Any occurrence on current procedure

Selections: (1) No (2) Yes

Supporting Definitions: Total obstruction of the artery used as the access site. This is typically due to a thrombus (but may have other causes) and usually requires surgical repair.


**In-Hospital Acute Renal Failure**

Coding Instructions: Indicate if there is physician documentation or report of in-hospital acute renal failure

Target Value: Any occurrence from the beginning of hospital stay to discharge

Selections: (1) No (2) Yes

Supporting Definitions: Acute renal failure is defined as physician documentation of acute renal failure

Source: Definition per CORE team
In-Hospital Peripheral Embolization
Coding Instructions: Indicate if there is physician documentation or report of in-hospital peripheral embolization
Target Value: Any occurrence from the beginning of hospital stay to discharge
Selections: (1) No (2) Yes
Supporting Definitions: Peripheral embolization should not be reflected here.
Source: Definition per CORE team

In-Hospital Death
Coding Instructions: Indicate if the patient died during hospital stay.
Target Value: Any occurrence between arrival at this facility and discharge
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

In-Hospital Death Date
Coding Instructions: Indicate the date of patient’s death.
Target Value: The first value on death date.
Selections: (none)
Supporting Definitions: (none)
Source: Definition per CORE team

Autopsy
Coding Instructions: Indicate if an autopsy of patient was performed after death.
Target Value: N/A
Selections: (1) No (2) Yes (3) Unrecorded
Supporting Definition: Autopsy is a postmortem examination to discover the cause of death or the extent of disease
Source: Definition per CORE team; Oxford English Dictionary

In-Hospital Cardiac Arrest
Coding Instructions: Indicate if the patient experienced an episode of cardiac arrest in your facility.
Target Value: Any occurrence between arrival at this facility and discharge
Selections: (1) No (2) Yes
Supporting Definitions: ‘Sudden’ cardiac arrest is the sudden cessation of cardiac activity so that
the victim becomes unresponsive, with no normal breathing and no signs of circulation. If
corrective measures are not taken rapidly, this condition progresses to sudden death. Cardiac
arrest should be used to signify an event as described above that is reversed, usually by CPR,
and/or defibrillation or cardioversion, or cardiac pacing. Sudden cardiac arrest is not the same
as sudden cardiac death. Sudden cardiac death describes a fatal event.
Source: ACC/AHA/HRS 2006 Key Data Elements and Definitions for Electrophysiological
Studies and Procedures

In-Hospital Cardiac Arrest Date
Coding Instructions: Indicate the date of the cardiac arrest.
Target Value: The first value between arrival at this facility and discharge
Selections: (none)
Supporting Definitions: (none)

In-Hospital Cerebrovascular accident (CVA)/Stroke
Coding Instructions: Indicate if the patient experienced a stroke or (CVA) in your facility.
Target Value: Any occurrence between arrival at this facility and discharge
Selections: (1) No (2) Yes
Supporting Definitions: Stroke: A stroke or Cerebrovascular accident is defined as loss of
neurological function caused by an ischemic or hemorrhagic event with residual symptoms at
least 24 hours after onset or leading to death.
Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30)

In-Hospital Stroke Date
Coding Instructions: Indicate the date of onset of stroke. If a stroke occurs during sleep, last
awake time may be used.
Target Value: The first value between arrival at this facility and discharge
Selections: (none)
Supporting Definitions: (none)
Source: Adapted from AHA Get with the Guidelines ACTION registry

In-Hospital Hemorrhagic Stroke
Coding Instructions: Indicate if the patient experienced a hemorrhagic stroke with documentation on imaging.

Target Value: Any occurrence between arrival at this facility and discharge

Selections: (1) No (2) Yes

Supporting Definitions: Hemorrhagic Stroke: A hemorrhagic stroke requires documentation on imaging (e.g. CT scan or MRI of hemorrhage in the cerebral parenchyma, or a subdural or subarachnoid hemorrhage). Evidence of hemorrhagic stroke obtained from lumbar puncture, neurosurgery, or autopsy can also confirm the diagnosis.

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30)

In-Hospital Unspecified Stroke

Coding Instructions: Indicate if the patient experienced an unspecified stroke with documentation on imaging.

Target Value: Any occurrence between arrival at this facility and discharge

Selections: (1) No (2) Yes

Supporting Definitions: An unspecified stroke can be defined as stroke without documentation on imaging. Evidence of stroke obtained from clinical symptoms.

Source: Definition per CORE team

In-Hospital (New Onset) Heart Failure

Coding Instructions: Indicate if there is physician documentation or report on development of heart failure during hospital stay.

Target Value: Any occurrence between first medical contact and arrival at this facility

Selections: (1) No (2) Yes

Supporting Definitions: Heart failure is defined as physician documentation or report of any of the following clinical symptoms of heart failure described as unusual dyspnea on light exertion, recurrent dyspnea occurring in the supine position, fluid retention; or the description of rales, jugular venous distension, pulmonary edema on physical exam, or pulmonary edema on chest X-ray presumed to be cardiac dysfunction. A low ejection fraction without clinical evidence of heart failure does not qualify as heart failure.

Source: Acute Coronary Syndromes Data Standards (JACC 2001 38: 2114 - 30), The Society of Thoracic Surgeons

In-Hospital Atrial Fibrillation or Flutter
Coding Instructions: Indicate if patient was diagnosed with atrial fibrillation or flutter during this admission.

Target Value: Any occurrence between arrival at this facility and discharge

Selections: (1) No (2) Yes

Supporting Definitions: Fibrillation of > 30 seconds, which presents as supraventricular complexes at an irregular rhythm and no obvious P waves on ECG; or Flutter presents as identically recurring regular sawtooth flutter waves on ECG and evidence of continual electrical activity.

Note(s): Code "No" If there is no documentation of atrial arrhythmias during hospitalization, it is acceptable to code "No"

Source: Adapted from AHA Get with the Guidelines ACTION registry

Smoking Cessation Counseling

Coding Instructions: Indicate if there was documentation in the medical record that smoking cessation advice or counseling was given during this admission.

Note(s): This element is referenced in The Joint Commission AMI Core Measures AMI-4.

Target Value: Any occurrence between arrival at this facility and discharge

Selections: (1) No (2) Yes

Supporting Definitions: (none)

Source: Adapted from AHA Get with the Guidelines ACTION registry

Discharge Suggestions

Coding Instructions: Indicate if there was documentation of the following recommendations at discharge

Target Value: as below

Selections:

a. Dual antiplatelet therapy (aspirin and a thienopyridine) (1) No (2) Yes If yes, specify the duration
b. Regular blood lipid assessment (1) No (2) Yes
c. Dietary improvement (1) No (2) Yes
d. Weight reduction (1) No (2) Yes
e. Smoking cessation (1) No (2) Yes
f. Regular exercise (1) No (2) Yes
g. PCI (1) No (2) Yes
Discharge Diagnosis (Related to Coronary Heart Disease)

Coding Instructions: Indicate the discharge diagnosis mentioned in the chart

Note(s): Marks as many of the choices that apply.


Supporting Definition: If none of the above options is noted in the chart, mark "None of the above Is Recorded".

Source: Definition per CORE team
Discharge Diagnosis (Unrelated to Coronary Heart Disease)
Coding Instructions: Indicate the discharge diagnosis mentioned in the chart
Note(s): Marks as many of the choices that apply.
Selections: Cardiac rupture, papillary muscle rupture, ventricular septal perforation, cardiac tamponade, cardiogenic shock, cardiac arrest, atrial fibrillation/flutter, ventricular tachycardia/fibrillation, heart failure, gastrointestinal bleeding, genitourinary bleeding, intracranial/subdural bleeding, retroperitoneal bleeding, access site bleeding, pericardial bleeding, bleeding (unspecified), hemorrhagic shock, venous thromboembolism, pulmonary embolism, deep vein thrombosis, peripheral embolization, access site arteriovenous fistula, ischemic stroke, hemorrhagic stroke, stroke (unspecified), pneumonia, COPD exacerbation, acute renal failure, chronic renal failure, stroke, dialysis, infection, septicemia, contrast reaction, dyslipidemia, hypertension, diabetes mellitus, diabetic nephropathy, trauma, hepatitis, cirrhosis, anemia.
Supporting Definition: If none of the above options is noted in the chart, mark “None of the above Is Recorded”.
Source: Definition per CORE team

International Classification of Diseases (ICD) Discharge Codes
Coding Instructions: For every diagnosis, record the associated ICD code
Target Value: This should be performed for every diagnosis
Selections: (1) ICD 9; specify value (2) ICD 10; specify value (3) Unrecorded
Supporting Definition: (none)
Source: Definition per CORE team

Date of Hospital Discharge
Coding Instructions: Indicate the date on which the patient was discharged from the hospital
Selections: (none)
Supporting Definitions: (none)
Source: Definition per CORE team

Transferred to Outside Facility
Coding Instructions: Indicate if the patient was transferred to an outside facility after initial presentation to your hospital.
Target Value: N/A
Selections: (1) No (2) Yes
Supporting Definitions: (none)
Source: Definition per CORE team

**Discharge Status (or Disposition)**

Coding Instructions: Indicate the documented nature of the patient's discharge from the hospital.
Target Value: Any value at discharge

Selections:
   (1) Discharge without Transfer to Another Hospital
   (2) Physician Recommends Transfer to Another Hospital
   (3) Patient or Relatives Demand Transfer to Another Hospital
   (4) Patient Left Against Medical Advice
   (5) None of the Above Is Recorded

Supporting Definition: (none)
Source: Definition per China team
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