Please review the following to familiarize yourself with the data entry instructions and each data element definition. This will improve the consistency and accuracy of the Prehospital (PH) and in-hospital data entered into the database. Only enter information that is found in the patient's medical record or within an approved resource document.

DEFINITIONS:

Base Hospital - A Los Angeles County EMS Agency approved hospital with certified mobile intensive care nurses and physicians knowledgeable in EMS Agency policies who provide medical oversight to paramedics in the prehospital setting.

Prehospital 12 L Electrocardiogram (ECG) - A 12 lead ECG that is performed by a paramedic, in a clinic, physician’s office or another Emergency Department prior to arriving at the SRC.

Return of spontaneous Circulation (ROSC) - Following cardiopulmonary arrest, ROSC is the sustained restoration of a spontaneous perfusing rhythm that results in breathing (more than an occasional gasp), coughing, movement, palpable pulse, and/or a measureable blood pressure.

STEMI Patient - A patient who elicits a 12 Lead ECG analysis of an “Acute MI”, “Acute MI Suspected” or other manufacturer’s equipment equivalent of MI, in the prehospital setting or SRC Emergency Department and was brought in by an advance life support (ALS) 9-1-1 provider.

STEMI Referral Facility (SRF) - A non-approved SRC facility. For data entry, a SRF may include any non-SRF facility type with a physician on-site who has the medical authority to diagnose an acute MI, including doctor’s offices, clinics and other EDs.

PATIENTS REQUIRING ENTRY INTO THE DATABASE:

The following 9-1-1 advance life support patients require entry into the database:

- **PH ECG equivalent to MI**
- **PH ECG negative for MI with an ED ECG equivalent to MI prior to admission into the hospital from the emergency room:**
  - First ECG in the ED
  - Subsequent ECG in the ED
- **STEMI patients interfacility transferred** (IFT) to the SRC via a 9-1-1 ALS transport
- **9-1-1 ALS**, non-traumatic, adult, patients with a return of spontaneous circulation (ROSC) in the prehospital setting
- **9-1-1 STEMI patients** transported to the SRC and while in the emergency department then have a cardiac arrest with ROSC (Please enter ROSC data-do not include the patient that has been admitted or has ROSC after an arrest in the cath lab)
Patients receiving therapeutic hypothermia after ROSC

GENERAL INFORMATION
DATA ENTRY DIRECTIONS & DEFINITIONS

APPROVED RESOURCE DOCUMENTS:

Approved resource documents are those forms, records or notes that document the patients care in the prehospital setting or in the hospital and are maintained by the hospital. These documents must be maintained within a chart or have the ability to be accessed electronically, as a resource, for the data validation portion of the SRC re-approval process. The approved PH and in-hospital resource documents are as follows:

- Clinic/Physician Office/Other Emergency Department record including 12 Lead ECG
- Provider EMS Report Form/902M
- Prehospital 12 Lead ECG
- Base Hospital Form (when the SRC is also the base hospital handling the paramedic run)
- ED STEMI/ROSC Log
- Patient Medical Record
- Hospital & ED Patient Logs

DATA ENTRY:

Select the STEMI and/or ROSC/TH Tabs for which you will be entering data. If you forgot or need another tab for data entry after you had previously begun the record, call 562-347-1656 to allow access to the other tab.

PLEASE UTILIZE THE TAB KEY WHEN ENTERING THE DATA. WHEN ENTERING SPECIFIC DATA INTO SELECTED FIELDS AND HITTING THE TAB KEY, THE CURSOR WILL SKIP TO THE NEXT APPROPRIATE FIELD AND MAY AUTO FILL FIELDS DEPENDING ON THE SELECTION.

To clear a field, either highlight or double click the field and hit the delete key on your keyboard, scroll to the blank space above the options and click the blank space, or click the down arrow where the option is entered, then in the drop-down click on the blank space above the options.

SAVE ALL DATA PRIOR TO EXITING EACH TAB & THE DATABASE

The following are true for all sections in the General/STEMI/ROSC/TH tabs:

- Enter the date in the MM/DD/YYYY format; do not enter the slash marks
- Enter the time as Military time in the 00:00 format; do not enter the colon
- Enter the selection that is most true.
  → Not Applicable (NA)-when the selection does not apply in any respect to the data point
  → Not Documented (ND)- when the data cannot be found in an approved resource.

NOTE: Click into date and time field spaces and type Not Applicable (NA) or Not Documented (ND) when NA or ND is the most appropriate choice for the data point.

- Data should be consistent between fields (A date entry of “Not Applicable” should match a time entry of “Not Applicable” (versus a “Not Documented” time entry))

Multiple selections: To enter multiple selections into a field or to list all that apply, scroll to your selection, press and hold the “Ctrl/Control” key, found on the bottom left of your
keyboard, and click your selection. Repeat the same process for your other selections. The selections you chose will appear abbreviated in red next to the title of the data field.

GENERAL INFORMATION
DATA ENTRY DIRECTIONS & DEFINITIONS

Text Fields: The text fields are to be used to clarify data entered into a previous field or to note added information regarding the patient’s care.

When the TAB key is used to maneuver between data fields, the fields following the entry may auto fill if specific criteria is met, in order to minimize data entry key strokes. If the data auto filled is not the data you would like in the field, simply click into the field and make your selection.

Once the data is entered, please ensure the data is saved before exiting the screen(s). The data may be modified on an as needed basis, up to 60 days from the date of incident, by clicking the “Modify” button to the left of the first data entry screen and inputting the Sequence Number of the record being modified.

Depending on what was entered into the database you may see pop-ups that identify that a data point is entered incorrectly or to clarify and entry.

DATA SUBMISSION:

The following is REQUIRED:

- The monthly DATA is due into the database on or before the 15th day of the following month (June’s data is due on or before July 15).
- The monthly TALLY is due to the EMS Agency SRC Program Manager on or before the 15th day of the following month (fax or email)
- The QUARTERLY DATA (Jan-Mar, Apr-Jun, Jul-Sept, Oct-Dec) is due the 30th day after the 3rd month for which it is due (also on page 25). Access to the Quarterly data fields are obtained by selecting the maroon “Quarter Total” button located on the left side of the screen.
  - Total number of all hospital patients with an ICD-9 discharge code of 410
  - Total number of Prehospital STEMI patients who received an actual PCI procedure

The lockout date for a patient’s data to be modified is 60 days from the incident date. If a patient is found after the 60 day period and entered, all data for that patient must be entered at one time. Subsequent access to that patient’s data will be denied due to the 60 day rule.

DATA REVIEW:

All data entered can be reviewed by printing out individual patient screen shots or by running a report for a specific time frame that downloads all data for that time frame into an Excel® format. The review of data is best accomplished by more than one person.

It is the responsibility of the SRC Program Clinical Director to assure the data is complete for all patients, accurate and that all
QI issues identified are addressed in the SRC program’s QI process.

**GENERAL INFORMATION**

1. **Sequence Number (Required to access the database):**
   - Enter the **two (2) alpha, six (6)-10 numeric identifier** found at the top right corner on the Prehospital (PH) EMS Report Form or 902-M. No data entry will be allowed without this **number**.
   - **Note:** The 10 numeric identifier will only be allowed for those few departments (PF, MP & CI) identified by the EMS Agency that currently have the larger Sequence (or booklet) Numbers.

2. **Provider Code**
   - Enter the two alpha provider code, identifying the **9-1-1 Advanced Life Support (ALS)** provider agency responsible for the care of the patient transported to the SRC, (this is **NOT** the Basic Life Support (BLS) ambulance company information that may have transported the patient) that may be found in various areas of the EMS Report Form or 902-M form from LA City Fire Department. Examples of the codes are CI for Los Angeles City Fire Department, GL for Glendale Fire or MO for Montebello Fire Department.
   - Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.

3. **9-1-1 ALS Unit (Number)**
   - Enter the 1-3 numeric provider unit number of the **9-1-1 Advanced Life Support (ALS)** paramedic ambulance that transported the STEMI patient to the SRC. Do not enter and letters associated with the unit number (RA 15 should be entered as 15; S161 should be entered as 161 etc.). The location of this information varies from department to department but usually is identified on the provider form by the use of “A” or “ALS”. If there are choices between BLS/ALS and just ALS, select the ALS unit number.
   - Enter “Not Documented” when there is no unit number documented or there is no acceptable resource to obtain the information.

4. **Patient Age: (up to three (3) numbers)**
   - Enter the patient’s age in years.
   - Enter “Not Documented” when the age is unknown or not documented.

5. **Patient Gender:**
   - Enter “Male” when the patient informs you he is of the male gender.
   - Enter “Female” when the patient informs you she is of the female gender.
   - Enter “Not Documented” for genders unknown or not documented.

6. **Patient’s Race:**
   - Enter “White”; with origins in Europe, Middle East or North Africa; as stated by patient or family.
   - Enter “African American/Black” with origins in Africa. Terms or “Negro” or “Haitian” may also be used; as stated by patient or family.
   - Enter “Asian” with origins in the Far East, Indian subcontinent, or South Asia. People from Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Vietnam, Thailand or the Philippines are examples of this race; as stated by patient or family.
   - Enter “Latino/Hispanic” origins in Cuba, Mexico, Puerto Rico, South or Central America or another Spanish culture; as stated by patient or family.
   - Enter “Pacific Islander/Native Hawaiian” with origins in the Pacific Islands, Guam, Samoa or Hawaiian Islands; as stated by patient or family.
   - Enter “Native American or Alaskan” with original origins of North and South America (including Central America) with tribal affiliation or community attachment; as stated by patient or family.
   - Enter “Not Documented” for races unknown or not documented.
   - Enter “Other” when the race documented is not one of the selections above.
GENERAL INFORMATION

7. Patient’s Chief Complaint: (list up to 3)
   → Enter the patient’s chief complaint codes (2-alpha codes) found on the right side or in the middle of the PH EMS Report Form or 902-M. These codes identify the patient’s complaint(s) and/or whether the patient had a myocardial infarction (STEMI) or cardiac arrest. Enter up to three (3) complaints. A patient may have complained of chest pain “CP”, had an ECG identify STEMI “MI” and then a cardiac arrest “CA”. All three codes should be entered. Enter the most significant codes such as “MI” or “CA” when they apply.
   Examples:
   o “CP”=Chest Pain
   o “MI”=ECG identified a STEMI
   o “CA”=Cardiac Arrest
   o “SY”=SYncope
   o “SB”=Shortness of Breath etc.
   → Enter “Not Documented” when there is no code documented or there is no acceptable resource to obtain the information.

   Note: Only use the “OT”/”OTHER” complaint code when it is the code documented on the EMS Report Form/902-M/BH Form/ED SRC/ROSC Log (if captured). If the “Other” code is used because the patient had an electrical shock, lightning strike or was a hanging, PLEASE enter which of these occurred in the comment section.

8. Bypassed the MAR?
   → Enter “Yes” when the three (3) letter code of the hospital bypassed is identified in the “Divert From” section on the PH ECG/EMS Report Form/902-M indicating that the patient bypassed the Most Accessible Receiving facility and transported to your facility as a SRC.
   → Enter “No” when it is known that your hospital was the MAR as well as the SRC and the “Divert From” area on the PH ECG/EMS Report Form/902-M is left blank.
   → Enter “Not Documented” when the STEMI patient’s transport destination or reason code was unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the patient was an interfacility transfer via the 9-1-1 system from a non-SRC ED to the SRC.

9. Defibrillated By (excludes AIDCs):
   → Enter “AED Citizen” (AKA layperson/bystander or any person who is not responding as part of an organized emergency response/system approach; a nurse, paramedic or physician who happens to be on scene is considered a “Citizen” because they are not part of the system response) when the first shock/defibrillation was delivered with an automated external defibrillator (AED) before EMS arrival.
   → Enter “AED EMS” when the first shock/defibrillation was delivered with an automated external defibrillator (AED) by emergency medical personnel, i.e., EMTs or paramedics.
   → Enter “EMS Personnel” when the first shock/defibrillation was delivered by emergency medical personnel, i.e., EMTs, paramedics, nurse educators or mobile intensive care nurses.
   → Enter “Hospital Healthcare Professional” when the first shock/defibrillation was delivered by healthcare professionals such as a registered nurse, physician, or EMT in an acute care hospital.
   → Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information as to whether the patient was shocked/defibrillated.
   → Enter “Not Applicable” when there was no shock/defibrillation.
10. Initial Prehospital (PH) ECG Date:
   - Enter the “Date” of the initial prehospital ECG. The initial “prehospital” ECG includes ECGs obtained from the first ECG from a PH/Field ECG or the first ECG from a Dr.’s office/Clinic/ other Emergency Department (STEMI Referral Facility) identifying a STEMI.
   - Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information as to the date of the initial prehospital ECG.
   - Enter “Not Applicable” when there was no prehospital ECG was performed.

11. Initial PH ECG Time:
   - Enter the “Time” of the initial prehospital ECG. The initial “prehospital” ECG includes ECGs obtained from the first ECG from a PH/Field ECG or the first ECG from a Dr.’s office/Clinic/ other Emergency Department (STEMI Referral Facility) identifying a STEMI.
   - Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information as to the time of the initial prehospital ECG.
   - Enter “Not Applicable” when there was no prehospital ECG performed.

12. PH ECG Done By:
   - Enter “EMS Personnel” when the initial prehospital ECG was performed by EMS.
   - Enter “Physician’s Office/Clinic” when the prehospital ECG was performed in a physician’s office or clinic.
   - Enter “Other ED” when the prehospital ECG was performed by another emergency department (ED)/ STEMI Referral Facility (SRF).
   - Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   - Enter “Not Applicable” when an ECG was not performed.

13. STEMI Identified on PH ECG?
   - Enter “Yes” when the prehospital ECG analysis interpretation was an ***Acute MI*** or the manufacturer’s equivalent of an Acute MI.
   - A STEMI for the purposes of this data collection will include patients from the prehospital setting with a 12 lead ECG analysis of ***Acute MI***
   - Enter “No” when the prehospital ECG analysis documented something other than an Acute MI (the readout on the ECG did not document an Acute MI).
   - Enter “Not Documented” when the analysis of the initial prehospital ECG was unknown or there is no acceptable resource to obtain the information.
   - Enter “Not Applicable” when NO PH ECG was performed.

14. ED Arrival Date:
   - Enter the “Date” the patient arrived in the emergency department (ED).
   - If the patient bypassed the ED and was transferred directly to the cath lab, document the date the patient arrived in the cath lab. There must be a date and time to auto calculate E2D and D2B time calculations.

15. ED Arrival Time:
   - Enter the “Time” the first documented time the patient entered the emergency department (ED). If the patient bypassed the ED and was transferred directly to the cath lab, document the first time the patient arrived in the cath lab.
   - If the patient bypassed the ED and was transferred directly to the cath lab, document the time the patient
arrived in the cath lab. There must be a date and time to auto calculate E2D and D2B time calculations.

**GENERAL INFORMATION**

16. **Initial ED ECG Date:**
   - Enter the "Date" of the initial ED ECG found in the hospital medical record.
   - Enter "Not Documented" when it is unknown or there is no acceptable resource to obtain the information.
   - Enter "Not Applicable" when there was no confirmation ED ECG performed in the ED.

17. **Initial ED ECG Time:**
   - Enter the “Time” of the initial ED ECG found in the hospital medical record.
   - Enter "Not Documented" when it is unknown or there is no acceptable resource to obtain the information.
   - Enter "Not Applicable" when there was no confirmation ED ECG performed in the ED.

18. **STEMI Identified on Initial ED ECG?**
   - Enter “Yes” when the initial ED ECG confirmed an Acute MI.
     - STEMI for the purposes of this data collection will include only those patients with presumed new ST-segment elevation not resolved within 20 minutes. ST-segment elevation at the J-point in two contiguous ECG leads with the cut off points >=0.2 mV in men or >= 0.15 mV in women in leads V2-V3 and/or >= 0.1 mV in other leads and lasting greater than or equal to 20 minutes. When there is no measurement recorded in the medical record, the documentation of ST-elevation or Q-waves by the physician is acceptable.
   - Enter "No" when the initial ED ECG identified something other than an Acute MI.
   - Enter "Not Documented" when it is unknown or there is no acceptable resource to obtain the information.
   - Enter "Not Applicable" when there was no confirmation/initial ED ECG performed.

19. **STEMI Identified on Subsequent ED ECG Date:**
   - Enter the “Date” when a subsequent ED ECG confirmed a STEMI.
   - Enter "Not Documented" when the date is unknown or there is no acceptable resource to obtain the information.
   - Enter "Not Applicable" when there was no subsequent ED ECG identifying STEMI.

20. **STEMI Identified on Subsequent ED ECG Time:**
   - Enter the “Time” when a subsequent ED ECG confirmed a STEMI.
   - Enter "Not Documented" when the time is unknown or there is no acceptable resource to obtain the information.
   - Enter "Not Applicable" when there was no subsequent ED ECG identifying STEMI.

21. **Patient Cath Lab Arrival Date:**
   - Enter the “Date” the patient arrived (cath lab door date) in the cath lab.
   - Enter "Not Documented" when the date the patient arrived in the cath lab is unknown or there is no acceptable resource to obtain the information.
   - Enter "Not Applicable" when the patient did not proceed to the cath lab.

22. **Patient Cath Lab Arrival Time:**
   - Enter the “Time” the patient first arrived (cath lab door time) in the cath lab.
   - Enter "Not Documented" when the first time the patient arrived in the cath lab is unknown or there is no acceptable resource to obtain the information.
   - Enter "Not Applicable" when the patient did not proceed to the cath lab.

23. **Hospital Discharge Date:**
   - Enter the “Date” the patient was discharged from the hospital; or the date the patient expired.
   - Enter "Not Documented" when discharge date is unknown or there is no acceptable resource to obtain the information.
24. **Patient Discharge Outcome:**
   - Enter “Lived” when the patient did not expire and was discharged from the hospital.
   - Enter “Died in ED” if patient expired in the ED.
   - **If the patient died in the ED enter the time the patient expired.**
   - Enter “Died in Cath Lab” if patient expired in the cath lab.
   - Enter “Died in Other” if patient expired prior to discharge from anywhere in the hospital other than the ED or Cath Lab.
   - Enter “Not Documented” when the patient discharge outcome is unknown or there is no acceptable resource to obtain the information.

25. **Discharged To:**
   - Enter “Home/Residence” when the patient returned back to his home or previous place of residence after discharge.
   - Enter “Extended Care/SNF” when the patient was discharged to one of these facilities.
   - Enter “Sub Acute/Transitional Care/Rehabilitation Care Facility” when the patient was discharged to one of these facilities.
   - Enter “Other Acute Care Facility” when the patient was transferred to another acute care facility.
   - Enter “Morgue/Mortuary” when the patient expired and the patient was discharged to the morgue or mortuary.
   - Enter “Left Against Medical Advice/Eloped” when the patient left against medical advice.
   - Enter “Other” when the patient was to someplace not mentioned in the above options.
   - Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.

26. **Risk Stratifying Deaths (Select all that apply) ONLY ON PATIENTS THAT EXPIRED**
   - Enter “Cardiogenic Shock” when it requires one or more below to maintain blood pressure and cardiac index above those specified levels. The hemodynamic compromise (with or without extraordinary supportive therapy) must persist for at least 30 minutes. One or more required:
     - Sustained (>30 minutes) episode of systolic blood pressure <90 mm Hg, and/or
     - Cardiac index <2.2L/min/m2 determined to be secondary to cardiac dysfunction, and/or
     - Requires parenteral inotropic or vasopressor agents or
     - Requires mechanical support (e.g., Intra aortic balloon pump (IABP), extracorporeal circulation, ventricular assist devices)
   
   **Note:** Transient episodes of hypotension reversed with IV fluid or atropine do not constitute cardiogenic shock.
   
   - Enter “Sepsis” when a patient exhibits at least two of the following symptoms to be diagnosed with sepsis.
     Two or more required:
     - Fever above 101.3 F (38.5 C) or below 95 F (35 C)
     - Heart rate higher than 90 beats a minute
     - Respiratory rate higher than 20 breaths a minute
     - Probable or confirmed infection
   
   - Enter “Cardiac Arrest” when the patient has had a cardiac arrest within 24 hours of ED admission
   
   - Enter “DNR/Family” when the patient had a DNR or the family requested comfort measures only.
   
   - Enter “Death within 30 Days” when the patient expired within 30 days of ED admission.
   
   - Enter “1-2 Co-morbidities” when the patient had 1-2 co-morbidities.

Examples **PER ACC AND MAY INCLUDE BUT NOT LIMITED TO:**
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→ Enter “3 or More Co-morbidities” when the patient had 3 or more co-morbidities as above.
→ Enter “Not Documented” when it is unknown or there is no documentation on the medical record as to why the patient expired.
→ Enter “Not Applicable” when the patient did not expire or there were no known risk factors or co-morbidities associated with the cause of death.

27. Made a DNR During Hospital Stay? ALLPATIENTS
→ Enter “Yes” if the patient was brought in to the hospital without a DNR and then made a DNR anytime during the hospital stay.
→ Enter “No” if the patient was brought into the hospital without a DNR and never made a DNR anytime during the hospital stay.
→ Enter “Not Documented” when it is unknown or there is no documentation on the medical record as to the patient’s DNR status.
→ Enter “Not Applicable” if the patient was brought in to the hospital with a DNR.
1. **PH STEMI ECG Transmitted?**
   → Enter “Yes” when the initial prehospital STEMI ECG was transmitted from an ALS unit.
   → Enter “No” when the initial prehospital STEMI ECG was NOT transmitted from an ALS unit.
   → Enter “Not Applicable” when the initial STEMI prehospital ECG was not transmitted from an ALS unit because:
     - the provider did not have the capability to transmit
     - the patient’s initial ECG was performed by a Physician’s Office/Clinic or another ED
     - the patient’s prehospital ECG was NOT a STEMI
     - no PH ECG was performed

2. **First Door Date if STEMI Identified at the STEMI REFERRAL FACILITY (SRF):**
   → Enter the “Date” the patient arrived at the STEMI Referral Facility/non STEMI Emergency Department, Physician’s Office or Clinic.
   → Enter “Not Documented” when the information is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the patient was not initially seen by a SRF/Physician’s Office/Clinic.

3. **First Door Time if STEMI Identified at the STEMI REFERRAL FACILITY (SRF):**
   → Enter the “Time” the patient arrived at the STEMI Referral Facility/non STEMI Emergency Department Physician’s Office or Clinic.
   → Enter “Not Documented” when the information is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the patient was not initially seen by a SRF/Physician’s Office/Clinic.

4. **STEMI ECG Date at SRF:**
   → Enter the “Date” of the first ECG identifying STEMI performed at the non-SRC ED, Physician’s office or clinic.
   → Enter “Not Documented” when the information is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the patient was not initially seen by a SRF/Physician’s Office/Clinic.

5. **STEMI ECG Time at SRF:**
   → Enter the “Time” of the first ECG identifying STEMI performed at the non-SRC ED, Physician’s office or clinic.
   → Enter “Not Documented” when the information is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the patient was not initially seen by a SRF/Physician’s Office/Clinic.

6. **Cath Lab TEAM Activation Date:**
   → Enter the “Date” the cath lab team was activated **AND** the patient was transported to the cath lab.
   → Enter “Not Documented” when the date of the cath lab team activation is not documented or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the cath lab team was not activated.
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7. Cath Lab TEAM Activation Time:
   → Enter the “Time” the cath lab team was activated AND the patient was transported to the cath lab.
   → Enter “Not Documented” when the time of the cath lab team activation is not documented or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the cath lab team was not activated.

8. Patient Location When Cath Lab Activated:
   → Enter “PH” if cath lab team was activated while patient was in the Prehospital setting/field.
   → Enter “ED” if the cath lab team was activated after the patient arrived in the ED.
   → Enter “Not Documented” when the information regarding the initiation of the cath lab activation is not documented or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when cath lab was not activated.

9. Cath Lab Canceled Date:
   → Enter the “Date” the cath lab team activation was canceled.
   → Enter “Not Documented” when the cath lab canceled date is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the cath lab was NOT activated or NOT canceled.

10. Cath Lab Canceled Time:
    → Enter the “Time” the cath lab team activation was canceled.
    → Enter “Not Documented” when the cath lab canceled time is unknown or there is no acceptable resource to obtain the information.
    → Enter “Not Applicable” when the cath lab was NOT activated or NOT canceled.

11. Reason Cath Lab Not Activated/Canceled:
    → Enter “Age” when this was the main cause the cath lab not activated or canceled.
    → Enter “Allergic to Contrast” when this was the main cause the cath lab not activated or canceled.
    → Enter “CABG” when this was the main cause the cath lab not activated or canceled.
    → Enter “Cath Lab Not Available” when this was the main cause for cath lab not activated or canceled.
    → Enter “DNR” when this was the main cause the cath lab not activated or canceled.
    → Enter “Discordant ECG” when this was the main cause the cath lab not activated or canceled AND there was a positive prehospital 12-Lead ECG monitor analysis and a negative ED 12-Lead ECG monitor analysis (the analysis is from the monitor’s printed interpretation, NOT a physician’s interpretation or over-read). Enter the main reason/cause/discordance the cath lab was not activated or canceled in following field (Enter the Reason for the Discordant ECG in #12).
    → Enter “Early Repolarization” when this was the main cause for the cath lab not activated or canceled.
    → Enter “Medical Condition” when an illness(es) was the main cause for the cath lab not activated or canceled.
    Examples:
    ● End stage cancer/liver disease
    ● Multiple co-morbidities
    ● Unstable patient
    → Enter “Multi-vessel Disease” when this was the main cause for the cath lab not activated or canceled.
→ Enter "Patient Expired" when this was the main cause for the cath lab not activated or canceled.
→ Enter "Physician Decision" when this was the main cause for the cath lab not activated or canceled.

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→ Enter "Transferred to Another Facility" when this was the main cause for the cath lab not activated or canceled.
→ Enter "Treatment Refused" when this was the main cause for the cath lab not activated or canceled.
→ Enter "Vasospasm Relieved" when this was the main cause for the cath lab not activated or canceled.
→ Enter "Other" when there is another cause the cath lab was not activated or canceled.
→ Enter "Not Documented" when the main cause is unknown or there is no acceptable resource to obtain the information.
→ Enter "Not Applicable" when the patient went to the cath lab for an intervention.

12. **Reason for Discordant ECG:** (Refers only to the Discordant ECG selected in #11 Above; otherwise should be NA)

→ Enter "Poor Quality PH ECG" when the PH ECG was due to a wavy baseline, artifact, missed or wrong lead placement.
→ Enter "Medical Condition" when the PH ECG mimicks a STEMI due to an underlying medical condition.
   Examples:
   - Pericarditis
   - Brugada Syndrome
   - Tako-Tsubo Syndrome
   - Hyperkalemia
→ Enter "Dysrhythmia" when the discordance was due to a dysrhythmia or paced rhythm.
   Examples:
   - Atrial Tachycardias
   - Atrial Fibrillation
   - Atrial Flutter
   - Bundle Branch Blocks
   - Paced Rhythm
   - Ventricular Tachycardia
→ Enter "Not Documented" when the discordance between the PH and ED ECGs cannot be determined or there is no acceptable resource to obtain the information.
→ Enter "Not Applicable" when there was no discordance.

13. **Reason Pt went to CL with NO STEMI Identified on the Initial ED ECG:**

→ Enter "Physician Over-read" when a physician (ED MD or Cardiologist) interpreted the ECG analysis as a STEMI.
→ Enter "Subsequent ECG is STEMI" when the 1st ED ECG did not confirm a STEMI but a subsequent ED ECG confirmed STEMI.
→ Enter "Ischemic ECG" when ED ECG demonstrates ST-T wave changes, including ST depression (may be transient), minimal ST elevation or presumed or new Left Bundle Branch Blocks.
   "Ischemic ECG" for the purposes of this data base will include the new or presumed new LBBB ECG and not included in the "STEMI" definition described above. For the patient without ST elevation, this option will clarify why a patient may have been transported to the cath lab.
→ Enter "Laboratory Findings" when the patient is diagnosed or is transported to the cath lab based on Lab/Troponin values.
   Laboratory findings for the purpose of this database are cardiac biomarkers exceeding the upper limit of normal, according to the hospital lab parameters; are consistent or suggestive of ischemia but as a result from the lab value; not from the LBBB. For the patient without ST elevation, this option will clarify why a patient may have been transported to the cath lab.
→ Enter "Not Documented" when the reason the patient went to the cath lab is unknown or there is no acceptable resource to obtain the information.
→ Enter "Not Applicable" when the patient did NOT go to the cath lab or had an initial ED ECG positive for STEMI.

**STEMI PATIENT INFORMATION**

14. **Initial PCI Date:** *(Patient went directly from the ED to the CL for Emergent STEMI PCI)*
   → Enter the "Date" the first device (excluding guide wire) was used to intervene at the culprit lesion during the first PCI. The patient must have had an intervention.
   → PCI is defined as the dilation of coronary, heart, arterial obstruction by means of a balloon catheter, stent, atherectomy, brachytherapy, angiojet, or thrombolectomy device inserted into a narrow blood vessel and inflated, to flatten plaque against the artery wall - JACHO Definition
   → Enter "Not Documented" when the PCI date is unknown or there is no acceptable resource to obtain the information.
   → Enter "Not Applicable" when the cath lab was never activated, canceled or no PCI was performed.

15. **Initial PCI Time:**
   → Enter the “Time” the first device (excluding guide wire) was used to intervene at the culprit lesion during the first PCI. The patient must have had an intervention.
   → Enter "Not Documented" when the PCI time is unknown or there is no acceptable resource to obtain the information.
   → Enter "Not Applicable" when the cath lab was never activated, canceled or no PCI was performed.

16. **Reason PCI Not Performed:**
   → Enter “Candidate CABG/IABP” when this was the main reason PCI was not performed.
   → Enter "Difficult Cath" when the intervention was a difficult cath due to the physician being unable to cannulate the vessel, dilate the vessel, cross the lesion or locate the vessel; therefore, no PCI was performed.
   → Enter “Multi-vessel Disease” when this was the main reason PCI was not performed.
   → Enter “No Lesions Found/Normal Coronaries” when the coronaries were normal and no lesions were found and no PCI was performed.
   → Enter “Patient Expired/Arrested in Cath Lab” when the patient expired or arrested in the cath lab or on the cath lab table prior to a procedure and no PCI was performed.
   → Enter "Vessel Spasm" when this was the main reason PCI was not performed.
   → Enter “Other” when there is another reason why PCI was not performed or not an option listed above (add the reason in the comment section). If this option is selected, go to #17 and write out the reason in the space provided.
   → Enter “Not Documented” when the reason an intervention was not performed or there is no acceptable resource to obtain the information.
   → Enter "Not Applicable” when the cath lab was never activated, canceled or an intervention was performed.

17. **Comment to “Other” Identified in 16.**
   → Type out the reason why “Other” was selected an option in number 16 above.
   → Not Applicable when an intervention was performed or another choice was selected in number 16 above.

18. **Fibrinolytic Infusion Date:**
   → Enter the “Date” fibrinolytics were administered.
   → Enter "Not Documented" when the date is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the patient did not receive fibrinolytics.

19. **Fibrinolytic Infusion Time:**
→ Enter the “Time” fibrinolytics were administered/infusion began.
→ Enter “Not Documented” when the time is unknown or there is no acceptable resource to obtain the information.
→ Enter “Not Applicable” when the patient did not receive fibrinolytics.

**STEMI PATIENT INFORMATION**

20. **Patient Achieved TIMI Grade III Flow?**
   → Enter “Yes” when the patient achieved TIMI Grade III Flow after intervention of the CULPRIT VESSEL/lesion. TIMI III Flow MUST BE REFLECTED in the medical record.
   → Enter “No” when the patient did not achieve TIMI Grade III Flow.
   → Enter “Not Documented” when there is no documentation of the patient achieving TIMI Grade III Flow found in the medical record.
   → Enter “Not Applicable” when no PCI was performed.

21. **Emergent CABG Date:**
   → Enter the “Date” if the patient received emergent coronary artery bypass grafting (within 24 hours from the start of the PCI procedure).
   → Enter “Not Documented” when the date of CABG is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the patient did not receive an emergent CABG.

22. **Emergent CABG Time:**
   → Enter the “Time” if the patient received emergent coronary artery bypass grafting (within 24 hours from the start of the PCI procedure).
   → Enter “Not Documented” when the time of CABG is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the patient did not receive an emergent CABG.

23. **Patient Incurred a Peri-procedure Cerebrovascular Accident?**
   → Enter “Yes” when the patient incurred a peri-procedure Cerebrovascular Accident, and neuro deficits do not resolve within 72 hours.
   → Enter “No” when the patient did not incur a peri-procedure Cerebrovascular Accident.
   → Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when no PCI was performed.

24. **Patient Incurred PCI Vascular Complication** (within 24 hours from the start of the PCI procedure):
   → Enter “No” when the patient did not incur a vascular complication.
   → Enter “PCI Site” if a complication i.e. access site occlusions, peripheral embolizations, dissections or pseudo aneurysm and/or AV fistulas occurred at the femoral or PCI site.
   → Enter “Hematoma Requiring Transfusion” if complication required a blood transfusion.
   → Enter “Required Operative Intervention” if the complication required surgical intervention.
   → Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when no PCI was performed.
1. First Cardiac Arrest Date:
   → Enter the “Date” of the first cardiac arrest in the prehospital or ED setting.
   → Enter “Not Documented” when the date of the first cardiac arrest is unknown or there is no acceptable resource to obtain the information.

2. First Cardiac Arrest Time:
   → Enter the “Time” of the first cardiac arrest in the prehospital or ED setting.
   → Enter “Not Documented” when the date of the first cardiac arrest is unknown or there is no acceptable resource to obtain the information.

3. First Cardiac Arrest Location:
   → Enter “Home/Residence” when this is the most appropriate location where the first cardiac arrest occurred.
   → Enter “Nursing Home/Assisted Living” when this is the most appropriate location where the first cardiac arrest occurred.
   → Enter “Public Building” when this is the most appropriate location where the first cardiac arrest occurred.
   Examples:
   - Airport
   - Casino
   - Courthouse
   - Department of Motor Vehicles
   - Fire Station
   - Office Buildings
   - Police Department
   → Enter “Physician Office/Clinic” when this is the most appropriate location type where the first cardiac arrest occurred.
   → Enter “Hospital/Emergency Department” when this is the most appropriate location where the first cardiac arrest occurred.
   → Enter “Industrial Site” when this is the most appropriate location type where the first cardiac arrest occurred.
   Examples:
   - Construction Sites
   - Sites with Large Machinery
   - Sites with Heavy Equipment
   → Enter “Other” when the location of the first cardiac arrest does not correspond to any of the options above.
   → Enter “Not Documented” when the location of the first cardiac arrest was unknown or there is no acceptable resource to obtain the information.

4. First Cardiac Arrest Witnessed By:
   → Enter “Citizen” (AKA layperson/bystander) when the first cardiac arrest was witnessed by a person who is not responding as part of an organized emergency response/system approach; a nurse, paramedic or physician who happens to be on scene is considered a “Citizen” because they are not part of the system response).
   → Enter “EMS” when the cardiac arrest was witnessed by emergency medical personnel, i.e., EMTs, paramedics, nurse educators or mobile intensive care nurses.
   → Enter “Hospital Healthcare Professional” when the cardiac arrest was witnessed by healthcare professionals such as a registered nurse, physician, or EMT in an acute care hospital.
   → Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when there was no witness to the cardiac arrest.
5. **First Cardiac Arrest Rhythm:**
   - Enter “AED-Analyzed Only (AA)” when this is the most appropriate initial rhythm for the first cardiac arrest. Or when an AED was used and NO shock was delivered.
   - Enter “AED-Defibrillated (AD)” when this is the most appropriate initial rhythm for the first cardiac arrest. Or when an AED was used and a shock was delivered.
   - Enter “Agonal (AG)” when this was the initial rhythm identified for the first cardiac arrest.
   - Enter “Asystole (ASY)” when this was the initial rhythm identified for the first cardiac arrest.
   - Enter “Idioventricular (IV)” when this was the initial rhythm identified for the first cardiac arrest.
   - Enter “Pulseless Electrical Activity (PEA)” when this was the initial rhythm identified for the first cardiac arrest.
   - Enter “Ventricular Tachycardia (VT)” when this was the initial rhythm identified for the first cardiac arrest.
   - Enter “Ventricular Fibrillation (VF)” when this was the initial rhythm identified for the first cardiac arrest.
   - Enter “Not Documented” when the first rhythm of the cardiac arrest was unknown or there is no acceptable resource to obtain the information.

6. **First Cardiac Arrest CPR Initiated By:**
   - Enter “Citizen” (AKA layperson/ bystander) when cardiopulmonary resuscitation (CPR), for the first cardiac arrest, was initiated/performed by a person who is not responding as part of an organized emergency response/system approach; a nurse, paramedic or physician who happens to be on scene is considered a “Citizen” because they are not part of the system response).
   - Enter “EMS” when CPR, for the first cardiac arrest, was initiated/performed by emergency medical personnel, i.e., EMTs, paramedics, nurse educators or mobile intensive care nurses.
   - Enter “Hospital Healthcare Professional” when CPR, for the first cardiac arrest, was initiated/performed by healthcare professionals such as a registered nurse, physician, or EMT in an acute care hospital.
   - Enter “Not Documented” when it is unknown who initiated/performed the first cardiac arrest CPR or there is no acceptable resource to obtain the information
   - Enter “Not Applicable” when there was no CPR and the patient had a ROSC after a precordial thump, defibrillator (internal external) or AED shock was delivered.

7. **First Return of Spontaneous Circulation (ROSC) Date:**
   - Enter the “Date” the patient had ROSC after the first cardiac arrest.
   - Enter “Not Documented” when the date of ROSC after the first cardiac arrest is unknown or there is no acceptable resource to obtain the information.

8. **First Return of Spontaneous Circulation (ROSC) Time:**
   - Enter the “Time” the patient had ROSC after the first cardiac arrest.
   - Enter “Not Documented” when the Time of ROSC after the first cardiac arrest is unknown or there is no acceptable resource to obtain the information.

9. **First ROSC Location:**
   - Enter “Prehospital” (PH) when the location of the first ROSC was in the prehospital setting.
   - Enter “Emergency Department” (ED) when the location of the first ROSC was in the ED.
   - Enter “Not Documented” when the location of the first ROSC is unknown or there is no acceptable resource to obtain the information.
10. First ROSC Cardiac Rhythm:  
**NOTE:** Enter the cardiac rhythm first documented on the EMS or hospital medical record after the first cardiac arrest.  
- Enter "Atrial Fibrillation (AFI)" when this is the first documented rhythm.  
- Enter "Atrial Flutter (AFL)" when this is the first documented rhythm.  
- Enter "Accelerated Ventricular (AVR)" when this is the first documented rhythm.  
- Enter "1° Heart Block (1HB)" when this is the first documented rhythm.  
- Enter "2° Heart Block (2HB)" when this is the first documented rhythm.  
- Enter "3° Heart Block (3HB)" when this is the first documented rhythm.  
- Enter "Idioventricular (IV)" when this is the first documented rhythm.  
- Enter "Junctional Rhythm (JR)" when this is the first documented rhythm.  
- Enter "Pacemaker(PM)" when this is the first documented rhythm.  
- Enter "Paroxysmal Supraventricular Tachycardia (PST)" when this is the first documented rhythm.  
- Enter the "Pulseless Electrical Activity (PEA)" when this is the first documented rhythm.  
- Enter "Sinus Bradycardia (SB)" when this is the first documented rhythm.  
- Enter "Sinus Rhythm (SR)" when this is the first documented rhythm when this is the first documented rhythm.  
- Enter "Supraventricular Tachycardia (SVT)" when this is the first documented rhythm.  
- Enter "Ventricular Tachycardia (VT)" when this is the first documented rhythm.  
- Enter "Ventricular Fibrillation (VF)" when this is the first documented rhythm.  
- Enter "Other" when the patient's cardiac rhythm in the PH setting or emergency room after the first ROSC is not listed in the options above.  
- Enter "Not Documented" when the patient's cardiac rhythm in the emergency room after the first ROSC is unknown or there is no acceptable resource to obtain the information.  

11. First ROSC Heart Rate: (up to 3 digits may be entered) 
- Enter the “Heart Rate” first documented on the EMS or medical record after the first cardiac arrest. If ROSC occurred in the PH setting and the information was not documented on the EMS Report Form/902M or Base Hospital Form, document the first heart rate from the patient’s medical record.  

12. First ROSC Blood (Systolic) Pressure: (Up to 3 digits can be entered).  
- Enter the “Blood Pressure” (systolic) first documented on the EMS or medical record after the first cardiac arrest. If ROSC occurred in the PH setting and the information was not documented on the EMS Report Form/902M or Base Hospital Form, document the first systolic blood pressure from the patient's medical record.  

13. First ROSC Spontaneous Respiratory Rate: (Up to 2 digits can be entered)  
- Enter the “Spontaneous Respiratory Rate” first documented on the EMS or medical record after the first cardiac arrest. If ROSC occurred in the PH setting and the information was not documented on the EMS Report Form/902M or Base Hospital Form, document the first spontaneous respiratory rate from the patient’s medical record.  
- Enter “Not Applicable” when the patient is being manually/mechanically ventilated.  

14. First ROSC End Tidal CO2: (Up to 2 digits can be entered)  
- Enter the End Tidal Carbon Dioxide” value first documented on the EMS or medical record after the first cardiac arrest. If ROSC occurred in the PH setting and the information was not documented on the EMS Report Form/902M or Base Hospital Form, document the first End Tidal CO2 from the patient’s medical record.  
- Enter “Not Documented” when the end tidal carbon dioxide value was not measured &/or not documented.
ROSC/ TH INFORMATION

15. First ROSC Total GCS: (Only values from 3-15 apply)

NOTE: Enter the Glasgow Coma Scale first documented on the EMS or hospital medical record after the first cardiac arrest.

→ Enter “3” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “4” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “5” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “6” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “7” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “8” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “9” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “10” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “11” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “12” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “13” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “14” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter “15” when this is the first documented Glasgow Coma Scale after the first cardiac arrest.
→ Enter ”Not Documented” when the patient’s Glasgow Coma Scale is unknown or there is no acceptable resource to obtain the information.

16. Vasopressors Received?

→ Enter “Yes” when the patient received a vasopressor in the prehospital or ED setting. Examples of vasopressors are:
  - Dopamine
  - Dobutamine
  - Epinephrine
  - Nor-epinephrine
  - Phenylephrine
  - Vasopressin
→ Enter “No” when the patient received no vasopressors.
→ Enter “Not Documented” when vasopressor administration is unknown or there is no acceptable resource to obtain the information.

17. Initial PCI Date:

→ Enter the “Date” the first device (excluding guide wire) was used to intervene at the culprit lesion during the first PCI. The patient must have had an intervention. PCI in the ROSC patient differs from that of the emergent PCI STEMI patient. PCI may be performed emergently without knowledge of a STEMI or many days after admission.

PCI is defined as the dilation of coronary, heart, arterial obstruction by means of a balloon catheter, stent, atherectomy, brachytherapy, angioplasty, or thrombectomy device inserted into a narrow blood vessel and inflated, to flatten plaque against the artery wall -JACHO Definition

→ Enter ”Not Documented” when the PCI date is unknown or there is no acceptable resource to obtain the information.
→ Enter ”Not Applicable” when the cath lab was never activated, canceled or not performed.
18. Initial PCI Time:
   → Enter the "Time" the first device (excluding guide wire) was used to intervene at the culprit lesion during the first PCI. The patient must have had an intervention. PCI in the ROSC patient differs from that of the emergent PCI STEMI patient. PCI may be performed emergently without knowledge of a STEMI or many days after admission.PCI is defined as the dilation of coronary, heart, arterial obstruction by means of a balloon catheter, stent, atherectomy, brachytherapy, angiojet, or thrombolectomy device inserted into a narrow blood vessel and inflated, to flatten plaque against the artery wall -JACHO Definition
   → Enter "Not Documented" when the PCI time is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when the cath lab was never activated, canceled or not performed.

19. ROSC Care Terminated Date:
   → Enter the “Date” when care for the patient was terminated. Care may be terminated at any time during the patient’s stay, before or after therapeutic hypothermia. It does not always mean that the patient expired; the patient may have been made a DNR and remains in the hospital, then discharged at a later date.
   → Enter "Not Documented" when the date care was terminated was unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” if care continued and the patient was discharged from the hospital.

20. ROSC Care Terminated Time:
   → Enter the “Time” when care for the patient was terminated. Care may be terminated at any time during the patient’s stay, before or after therapeutic hypothermia. It does not always mean that the patient expired; the patient may have been made a DNR and remains in the hospital, then discharged at a later date.
   → Enter "Not Documented" when the time care was terminated was unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” if care continued and the patient was discharged from the hospital.

21. ROSC Care Terminated Location:
   → Enter “ED” when care for the patient ended in the emergency room.
   → Enter “Cath Lab” when care for the patient ended in the cath lab.
   → Enter “Inpatient” when care for the patient ended once the patient was admitted to the floor (ICU, Telemetry, or ward).
   → Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when care for the patient was NOT terminated and continued.

22. ROSC Care Terminated Reason:
   → Enter “Poor Response to Treatment” when care was terminated because the patient did not respond to treatment.
   → Enter “DNR” when care was terminated because the patient was or made a “Do Not Resuscitate” by a physician.
   → Enter “Expired” when care was terminated because the patient expired.
   → Enter “Not Documented” when is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when care for the patient continued.
**ROSC/TH INFORMATION**

23. **Reason Therapeutic Hypothermia (TH) Not Initiated (Exclusions-List all that apply)**
   - Enter “Age less than 18 (18)” when this was a reason TH was not initiated.
   - Enter “Active Bleeding (BL)” when this was a reason TH was not initiated. Includes:
     - Gastrointestinal
     - Inner cranial hemorrhage
     - Know Bleeding Diathesis
   - Enter “Awake/Responsive to Verbal commands (AR)” when this was a reason TH was not initiated.
   - Enter “Chronic Renal Disease (RD)” when this was a reason TH was not initiated.
   - Enter “Coma Prior to Arrest from Drug Intoxication (CD)” when this was a reason TH was not initiated.
   - Enter “Coma Prior to Arrest from Preexisting Condition (CP)” when this was a reason TH was not initiated.
   - Enter “Coma prior to Arrest from Neurological Dysfunction/Dementia (CD)” when this was a reason TH was not initiated.
   - Enter “Core Temperature <35 degrees Celsius (35)” when this was a reason TH was not initiated.
   - Enter “DNR (DN)” when this was a reason TH was not initiated.
   - Enter “End Stage Terminal Illness (TI)” when this was a reason TH was not initiated.
   - Enter “Greater than 60 minutes from Cardiac Arrest to ROSC (60)” when this was a reason TH was not initiated.
   - Enter “Initiated in Greater than 6 Hours After ROSC (GT)” when this was a reason TH was not initiated.
   - Enter “Major Head Trauma (HT)” when this was a reason TH was not initiated.
   - Enter “Major Surgery within 14 days (MS)” when this was a reason TH was not initiated. Including:
     - Cardiac
     - Vascular
     - Thoracic
     - Abdominal
     - Peripheral
     - Other Surgical Procedures
   - Enter “Patient Expired” (PE) when this was a reason TH was not initiated.
   - Enter “Persistent Hypotension (PH)” when this was a reason TH was not initiated.
   - Enter “Post Cardiac Arrest with Rhythm Other Than VT/VF (VF)” when this was a reason TH was not initiated.
   - Enter “Pregnancy (PG)” when this was a reason TH was not initiated.
   - Enter “ROSC Care Terminated” (RC) when this was a reason TH was not initiated.
   - Enter “Septic Shock (SS)” when this was a reason TH was not initiated.
   - Enter “Severe Bradycardia (SB)” when this was a reason TH was not initiated.
   - Enter “Uncontrolled Ventricular Arrhythmia (UA)” when this was a reason TH was not initiated.
   - Enter “Other” when there was an exclusion not listed in the options above.
   - Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   - Enter “Not Applicable” when TH was initiated.

24. **Reason Therapeutic Hypothermia (TH) Initiated (Inclusions-List all that apply)**
   - Enter “Age is Greater Than 18 yrs (18)” when this is the reason TH was initiated.
   - Enter “Core Temperature > 35 Degrees Celsius (35)” when this is the reason TH was initiated.
   - Enter “Hemodynamically Stable (HS)” or SBP≥ 90 mmHg or MAP >70mmHg with or without external means when this is the reason TH was initiated.
   - Enter “Initiated in Less Than 6 Hours of ROSC (LT)” when this is the reason TH was initiated.
   - Enter “Less than 60 min from Cardiac arrest to ROSC (60)” when this is the reason TH was initiated.
ROSC/ TH INFORMATION

- Enter “Unresponsive (GCS < 8) (UN)” when this is the reason TH was initiated.
- Enter “Other” when there was an inclusion not listed in the options above.
- Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
- Enter “Not Applicable” when ROSC care was terminated or the patient expired and/or TH was not initiated.

25. TH Initiated Date:
- Enter the “Date” the cooling began with the first modality.
- Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
- Enter “Not Applicable” when ROSC care was terminated or the patient expired and TH was not initiated.

26. TH Initiated Time:
- Enter the “Time” the cooling began with the first modality.
- Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
- Enter “Not Applicable” when ROSC care was terminated or the patient expired and TH was not initiated.

27. TH Initiated Location:
- Enter “PH” when prehospital was the location TH was initiated.
- Enter “ED” when the emergency room was the location TH was initiated.
- Enter “Cath Lab” when the cath lab was the location TH was initiated.
- Enter “ICU” when the ICU was the location TH was initiated.
- Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
- Enter “Not Applicable” when ROSC care was terminated or the patient expired and TH was not initiated.

28. TH Modality (List all That Apply)
- Enter “Ice Packs” when the cooling method included ice packs.
- Enter “External Cooling Device” when the cooling method included external cooling such as a blanket or jacket
- Enter “Peripheral Vascular Cooling” when the cooling method included cooled intravenous saline infusions.
- Enter “Central Vascular Cooling” when the cooling method included cooling by means of a central line for intravascular cooling.
- Enter “Other” when there was another cooling method used.
- Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
- Enter “Not Applicable” when ROSC care was terminated or the patient expired and TH was not initiated.

29. Target Temperature
- Enter the “32 degrees Celsius” when the Target Temperature ordered by the physician was 32 degrees Celsius.
- Enter the “33 degrees Celsius” when the Target Temperature ordered by the physician was 33 degrees Celsius.
- Enter the “34 degrees Celsius” when the Target Temperature ordered by the physician was 34 degrees Celsius.
- Enter “Specific Range” when the physician has ordered a range from one temperature to another. Target temp 32-34 degrees Celsius would be an example.
- Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
- Enter “Not Applicable” when ROSC care was terminated or the patient expired and TH was not initiated.
30. Target Temperature Reached Date
   → Enter the “Date” the target temperature was reached.
   → Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when ROSC care was terminated or the patient expired and TH was not initiated.

31. Target Temperature Reached Time
   → Enter the “Time” the target temperature was reached.
   → Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when ROSC care was terminated or the patient expired and TH was not initiated.

32. Re-warming Initiated Date
   → Enter the “Date” re-warming of the patient began.
   → Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when ROSC care was terminated or the patient expired and TH was not initiated.

33. Re-warming Initiated Time
   → Enter the “Time” re-warming of the patient began.
   → Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when ROSC care was terminated or the patient expired and TH was not initiated.

34. Re-warming Ended Date
   → Enter the “Date” re-warming of the patient was completed.
   → Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when ROSC care was terminated or the patient expired and TH was not initiated.

35. Re-warming Ended Time
   → Enter the “Time” re-warming of the patient was completed.
   → Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
   → Enter “Not Applicable” when ROSC care was terminated or the patient expired and TH was not initiated.

36. Adverse Events (List All That Apply-as a result of the therapeutic hypothermia)
   → Enter “Aspiration” when this was an adverse event.
   → Enter “Bleeding” when this was an adverse event.
   Examples:
   • Flank Bruising
   • Hematuria
   • Blood in Gastric Tube Aspirate
   • Increased Abdominal Girth
   • Increased Bruising or Petechiae
   → Enter “Cardiac Arrhythmias with a Temperature > 32 Degrees Celsius” when this was an adverse event.
   → Enter “Coagulopathy” when this was an adverse event.
   → Enter “Decubitus” when this was an adverse event.
ROSC/ TH INFORMATION

- Enter “Deep Vein Thrombosis” when this was an adverse event.
- Enter “Hyperkalemia” when this was an adverse event.
- Enter “Hypokalemia” when this was an adverse event.
- Enter “Hypomagnesium” when this was an adverse event.
- Enter “Ileus” when this was an adverse event.
- Enter “Infection/Pneumonia” when this was an adverse event.
- Enter “Sepsis” when this was an adverse event.
- Enter “Shivering with a Temperature >32 Degrees Celsius” when this was an adverse event.
- Enter “Other” when there was an adverse event not listed in the options above.
- Enter “Not Documented” when it is unknown or there is no acceptable resource to obtain the information.
- Enter “Not Applicable” when the patient’s care was terminated after ROSC, did not meet criteria for TH, or the patient did not have any adverse events.

37. Total Glasgow Coma Scale on Discharge
   Enter the Glasgow Coma Scale documented in the medical record on discharge.
   - Enter “3” when this is the documented Glasgow Coma Scale on discharge or the patient expired.
   - Enter “4” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “5” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “6” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “7” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “8” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “9” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “10” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “11” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “12” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “13” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “14” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “15” when this is the documented Glasgow Coma Scale on discharge.
   - Enter “Not Documented” when the patient’s Glasgow Coma Scale is unknown or there is no acceptable resource to obtain the information.

38. Cerebral Performance Categories Scale (CPC) on Discharge
   Enter the patient’s CPC Scale on discharge.
   - Enter “1” when this was the CPC Scale on discharge.
   - Enter “2” when this was the CPC Scale on discharge.
   - Enter “3” when this was the CPC Scale on discharge.
   - Enter “4” when this was the CPC Scale on discharge or the patient expired.
   - Enter “5” when this was the CPC Scale on discharge.
   - Enter “Not Documented” when the patient’s CPC Scale is unknown or there is no acceptable resource to obtain the information.
Quarterly data is due the 30\textsuperscript{th} day after the third month for which it is due.

Enter the quarterly data by clicking the maroon “Quarterly Total’s” button on the left side of the data entry screen.

**Total Quarterly Number of MI Admissions:**

→ Enter the current **Quarter’s Total Number** of patients with a hospital discharge diagnosis of MI (ICD-9 code 410). This number includes all hospital patients; walk-ins into the ED, direct admits to a bed, and admitted patients who have an MI during their hospital stay, and the PH STEMI patients. This information may have to be obtained from medical records or the coding department in the hospital. Enter the number under the appropriate quarter.

**Total Quarterly Number of Percutaneous Coronary Procedures on 9-1-1/Field STEMI Patients:**

→ Enter the **Quarter’s Total Number** of those patients who had positive PH 12L ECG for STEMI and went on to receive an actual percutaneous coronary intervention. Enter this information by clicking the Quarterly Total’s button on the left side of the data entry screen. Enter the number under the appropriate quarter.

**Quarters:**

1\textsuperscript{st} Quarter: January-March  
2\textsuperscript{nd} Quarter: April-June  
3\textsuperscript{rd} Quarter: July-September  
4\textsuperscript{th} Quarter: October-December