ACTION Registry® – GWTG™

NCDR® ACTION Registry®- GWTG™ v2.4 (Limited)

Acute Coronary Treatment and Intervention Outcomes Network Registry

A. DEMOGRAPHICS

Last Name[2000]: | **First Name**[2010]: | **Middle Name**[2020]:

SSN[2030]: ☐SSN N/A[2031] | **Patient ID**[2040]: | **Other ID**[2045]:

Birth Date[2050]: mm / dd / yyyy | **Sex**[2060]: O Male O Female | **Patient Zip Code**[3000]: ☐ Zip Code N/A[3001]

Race: (check all that apply) ☐ White[2070] ☐ Black/African American[2071] ☐ American Indian/Alaskan Native[2073]
☐ Asian[2072] → **If** Yes, ☐ Asian - Indian[2080] ☐ Chinese[2081] ☐ Filipino[2082] ☐ Japanese[2083] ☐ Korean[2084] ☐ Vietnamese[2085] ☐ Other[2086]
☐ Native Hawaiian/Pacific Islander[2074] → **If** Yes, ☐ Native Hawaiian[2090] ☐ Guamanian or Chamorro[2091] ☐ Samoan[2092] ☐ Other Island[2093]

Hispanic or Latino Ethnicity[2076]: O No O Yes → **If** Yes**, Ethnicity Type:** (check all that apply)
☐ Mexican, Mexican-American, Chicano[2100] ☐ Puerto Rican[2101] ☐ Cuban[2102] ☐ Other Hispanic, Latino or Spanish Origin[2103]

B. ADMISSION

Means of Transport to First Facility[3100]: O Self/Family O Ambulance O Air

→ **If** Ambulance **or** Air**, EMS 1st Med. Contact Date/Time**[3105, 3106]: _____ ☐ Time Estimated[3107] ☐ Non-System Reason for Delay[3108]

→ **If** Self/Family**,** Non-**EMS 1st Med. Contact Date/Time**[3111, 3112]: _____ ☐ Time Estimated[3113]

EMS Dispatch Date/Time[3152, 3153]: _____ *(STEM or STEMI Equiv.)* **EMS Leaving Scene Date/Time**[3154, 3155]: _____ *(STEM or STEMI Equiv.)*

EMS Agency Number[3156]: _____ *(STEM or STEMI Equiv.)* **EMS Run Number**[3157]: _____ *(STEM or STEMI Equiv.)*

Cath Lab Activation Date/Time[3158, 3159]: _____ *(STEM or STEMI Equiv.)*

Transferred from Outside Facility[3110]: O No O Yes → **If** Yes**, Means of Transfer**[3115]: O Ambulance O Air

→ **If** Yes**, Arrival at Outside Facility Date/Time**[3120, 3121]: _____ ☐ Time Estimated[3122]

→ **If** Yes**, Transfer from Outside Facility Date/Time**[3125, 3126]: _____ ☐ Time Estimated[3127]

→ **If** Yes**, Name of Transferring Facility/AHA Number**[3150, 3151]: _____

Your Facility

Arrival Date/Time[3200, 3201]: | **Location of First Evaluation**[3220]: O ED O Cath Lab O Other

Admission Date[3210]: | → **If** ED**, Transfer Out Date/Time**[3221, 3222]: _____

Insurance Payors: (check all that apply) ☐ Private Health Insurance[3300] ☐ Medicare[3301] ☐ Medicaid[3302] ☐ Military Health Care[3303]
☐ State-Specific Plan (non-Medicaid)[3304] ☐ Indian Health Service[3305] ☐ Non-US Insurance[3306] ☐ None[3307]

Provider Name[3310-3312]: | **Provider NPI**[3315]: | **HIC #**[3320]:

C. CARDIAC STATUS ON FIRST MEDICAL CONTACT

Symptom Onset Date/Time[4000, 4001]: ☐ Time Estimated[4002] ☐ Time Not Available[4003]

First ECG Obtained[4010]: O Pre-Hospital (e.g. ambulance) O After 1st hosp. arrival

First ECG Date/Time[4020, 4021]: ☐ Non-System Reason for Delay[4022]

STEMI or STEMI Equivalent[4030]: O No O Yes

→ **If** Yes, **ECG Findings**[4040]: O ST elevation O LBBB (new or presumed new) O Isolated posterior MI

→ **If** Yes, **STEMI or STEMI Equivalent First Noted**[4041]: O First ECG O Subsequent ECG

→ **If** Subsequent ECG**, Subsequent ECG with STEMI or STEMI Equivalent Date/Time**[4042, 4043]: _____

→ **If** No**, Other ECG Findings**[4044]: (demonstrated within first 24 hours of medical contact)
O New or presumed new ST depression O New or presumed new T-Wave inversion
O Transient ST elevation lasting < 20 minutes O Old LBBB O None O Other

Heart Failure[4100]: O No O Yes | **Heart Rate**[4120]: (bpm) | **Cardiac Arrest**[4135]: O No O Yes

Cardiogenic Shock[4110]: O No O Yes | **Systolic BP**[4130]: (mmHg) | → **If** Yes**, Pre-Hospital**[4140]: O No O Yes

→ **If** Yes**, Outside Facility**[4145]: O No O Yes

D. History and Risk Factors

Weight[5010]**:**	(kg)		**Diabetes Mellitus**[5070]**:**	O No	O Yes
Current/Recent Smoker (< 1 year)[5020]**:**	O No	O Yes	**Cerebrovascular Disease**[5130]**:**	O No	O Yes
Hypertension[5030]**:**	O No	O Yes	→ **If** Yes**, Prior Stroke**[5131]**:**	O No	O Yes
Currently on Dialysis[5050]**:**	O No	O Yes	→ **If** Yes**, Prior TIA**[5132]**:**	O No	O Yes
			Peripheral Arterial Disease[5140]**:**	O No	O Yes

J. Discharge

Discharge Date[11000]**:** **Provider Name**[11003-11005]**:** _____ **Provider NPI**[11006]**:** _____

Comfort Measures Only[11010]**:** O No O Yes

Enrolled in Clinical Trial During Hospitalization[11020]**:** O No O Yes

Discharge Status[11100]**:** O Alive O Deceased

→ **If** Alive**, Smoking Counseling**[11101]**:** O No O Yes

→ **If** Alive**, Cardiac Rehabilitation Referral**[11104]**:** O No-No Referral O No-Medical Reason O No-Pt Reason/Preference O No-Health Care System Reason O Yes

→ **If** Alive**, Discharge Location**[11105]**:** O Home O Extended care/transitional care unit/Rehab O Other acute care hospital O Skilled nursing facility O Other O Left against medical advice (AMA)

→ **If** Other Acute Care Hospital**, Transfer Time**[11106]**:** _____

→ **If** Other Acute Care Hospital**, Transfer for PCI**[11107]**:** O No O Yes

→ **If** Alive**, Hospice Care**[11110]**:** O No O Yes

E. Medications

Oral Medications

Medication	Medications Administered in First 24 Hours (Up to 24 hours after first medical contact*)	Medications Prescribed At Hospital Discharge (Discharge medications are not required for patients who expired or were discharged to 'Other acute care Hospital', 'AMA' or are receiving Hospice Care)
Aspirin[6010, 6020]	O No O Yes O Contraindicated	O No O Yes O Contraindicated
Clopidogrel[6060- 6070]	O No O Yes O Contraindicated → **If** Yes, **Start Date/Time:** _____ → **If** Yes, **Dose:** _____mg	O No O Yes O Contraindicated
Ticlopidine[6120]		O No O Yes O Contraindicated
Prasugrel[6160-6170]	O No O Yes O Contraindicated → **If** Yes, **Start Date/Time:** _____	O No O Yes O Contraindicated
Ticagrelor[6185-6190]	O No O Yes O Contraindicated → **If** Yes, **Start Date/Time:** _____	O No O Yes O Contraindicated
Warfarin[6220]		O No O Yes O Contraindicated
Dabigatran[6226]		O No O Yes O Contraindicated
Rivaroxaban[6231]		O No O Yes O Contraindicated
Apixiban[6241]		O No O Yes O Contraindicated
Beta Blocker[6260,6270]	O No O Yes O Contraindicated	O No O Yes O Contraindicated
ACE Inhibitor[6320]		O No O Yes O Contraindicated
Angiotensin Receptor Blocker[6370]		O No O Yes O Contraindicated
Aldosterone Blocking Agent[6420]		O No O Yes O Contraindicated
Statin[6470]		O No O Yes O Contraindicated

E. MEDICATIONS (CONTINUED)

Intravenous and Subcutaneous Medications

Category	Medications Administered
GP IIb/IIIa Inhibitor[6800] (any time during this hospitalization)	O No O Yes O Contraindicated → **If** Yes, **Medication Type**[6801]: O Eptifibatide O Tirofiban O Abciximab → **If** Yes, **Start Date/Time**[6802, 6803]: _____
Anticoagulant[6850]	O No O Yes O Contraindicated → **If** Yes, **Medication Type(s):** ☐ IV Unfractionated Heparin[6851] ☐ Enoxaparin (LMWH)[6860] ☐ Bivalirudin[6875] ☐ Other parenteral anticoagulants given[6895]

F. PROCEDURES AND TESTS

LVEF[7010]**:** % ☐ LVEF Not Assessed[7011] → **If** Not Assessed**, Planned for after discharge**[7012]**:** O No O Yes

Diagnostic Coronary Angiography[7020]**:** O No O Yes → **If** Yes**, Provider Name**[7040-7050]**:** _____ **Provider NPI**[7055]**:** _____

PCI[7100]**:** O No O Yes → **If** Yes**, Provider Name**[7113-7115]**:** _____ **Provider NPI**[7116]**:** _____

→ **If** Yes**, Cath Lab Arrival Date/Time**[7101, 7102]**:** _____

→ **If** Yes**, Arterial Access Site**[7112]**:** O Femoral O Brachial O Radial O Other

→ **If** Yes**, First Device Activation Date/Time**[7103, 7104]**:** _____

→ **If** Yes**, Stent(s) Placed**[7105]**:** O No O Yes → **If** Yes**, Stent Type(s):** ☐ Bare metal stent[7106] ☐ Drug eluting stent[7107] ☐ Other[7108]

→ **If** Yes**, PCI Indication**[7109]**:** O Primary PCI for STEMI O Rescue PCI for STEMI (after failed full-dose lytic) O PCI for NSTEMI
O PCI for STEMI (stable after successful full-dose lytic) O PCI for STEMI (unstable, >12 hr from sx onset)
O PCI for STEMI (stable, >12 hr from sx onset) O Other

→ **If** Primary PCI for STEMI**, Non-System Reason for Delay in PCI**[7110]**:**
O Difficult vascular access O Cardiac arrest and/or need for intubation before PCI
O Patient delays in providing consent for the procedure O Difficulty crossing the culprit lesion during the PCI procedure
O Other O None

CABG[7200]**:** O No O Yes

G. REPERFUSION STRATEGY (IMMEDIATE REPERFUSION) → IF STEMI OR STEMI EQUIVALENT[4030] = 'YES'

Was Patient a **Reperfusion Candidate**[8000]**:** O No O Yes

→ **If** No**, Primary Reason**[8011]**:** O No ST elevation/LBBB O MI diagnosis unclear O Chest pain resolved
O ST elevation resolved O MI symptoms onset >12 hours O No chest pain O Other

→ **If** Yes, **Primary PCI**[8015]**:** O No O Yes

→ **If** Yes**, Thrombolytics**[8020]**:** O No O Yes

→ **If** Yes**, Dose Start Date/Time**[8023, 8024]**:** _____

→ **If** Yes**, Non-System Reason for Delay**[8025]**:** O No O Yes

→ **If** Yes**, Lytic ineligible and requiring prolonged transfer time for primary PCI** [8026]**:** O No O Yes

→ **If** Reperfusion Candiate is 'Yes' and Primary PCI is 'No', **Reason Primary PCI Not Performed**[8030]

O Non-compressible vascular puncture(s) O Spontaneous reperfusion (documented by cath only) O Other
O Active bleeding on arrival or within 24 hours O Patient/family refusal O Not performed (not a PCI center)
O Quality of life decision O DNR at time of treatment decision O No reason documented
O Anatomy not suitable to primary PCI O Prior allergic reaction to IV contrast O Thrombolytic Administered

→ **If** Reperfusion Candiate is 'Yes' and Thrombolytics is 'No', **Reason Thrombolytics Not Administered**[8035]

O Known bleeding diathesis
O Recent bleeding within 4 weeks
O Recent surgery/trauma
O Intracranial neoplasm, AV malformation, or aneurysm
O Severe uncontrolled hypertension
O Suspected aortic dissection
O Significant close head or facial trauma within previous 3 months
O Active peptic ulcer
O Traumatic CPR that precludes thrombolytics
O Ischemic stroke w/in 3 months except acute ischemic stroke within 3 hours
O Any prior intracranial hemorrhage
O Pregnancy
O Prior allergic reaction to thrombolytics
O DNR at time of treatment decision
O Other
O Expected DTB < 90 minutes
O No reason documented

H. In-Hospital Clinical Events

Reinfarction[9000]**:**	O No	O Yes	**CVA/Stroke**[9030]**:**	O No	O Yes
Cardiogenic Shock[9010]**:**	O No	O Yes	→ **If** Yes**, Hemorrhagic**[9032]	O No	O Yes
Heart Failure[9020]**:**	O No	O Yes	**Suspected Bleeding Event**[9040]**:**	O No	O Yes
Cardiac Arrest[9035]**:**	O No	O Yes → **If** Yes**, Date**[9037]**:** _____	**RBC/Whole Blood Transfusion**[9050]**:**	O No	O Yes

I. Laboratory Results

Positive Cardiac Markers Within First 24 Hours[10000]**:** O No O Yes

Troponin		**Creatinine**	
Initial	**Collected**[10010]**:** O No O Yes – I O Yes – T → **If** Yes**, Value**[10013]**:** _____ (ng/mL) → **URL**[10014]**:** _____	**Initial**	**Collected**[10100]**:** O No O Yes → **If** Yes**, Value**[10103]**:** _____ (mg/dL)

Hemoglobin		**Lipids** (mg/dL)	
Initial	**Collected**[10150]**:** O No O Yes → **If** Yes**, Value**[10153]**:** _____ (g/dL)		**Panel Performed**[10350]**:** O No O Yes ☐ Value Out of Range[10360] → **If** Yes**, LDL**[10355]**:** _____

K. Optional Elements (For AMI Core Measure Reporting only)

Point of Origin[12000]**:**

- O Non-health care facility
- O Clinic
- O Transfer from a hospital (different facility)
- O Transfer from a skilled nursing facility (SNF) or intermediate care facility (ICF)
- O Transfer from another health care facility
- O Emergency room
- O Court/law enforcement
- O Information not available
- O D: Transfer from one distinct unit of the hospital to another distinct unit of the same hospital resulting in a separate claim to the Payor
- O E: Transfer from ambulatory surgery center
- O F: Transfer from hospice and is under a hospice plan of care or enrolled in a hospice program

Transfer from Another ED[12010]**:** O No O Yes

CMS Comfort Measures Timing[12020]**:** O Day 0 or 1 O Day 2 or after O Timing unclear O Not documented/UTD

Principal Diagnosis Code[12090]**:** **Principal Procedure Code**[12100]**:** **Date**[12101]**:**

Other Diagnosis Code(s)[12110-12]**:**

Other Procedure Code(s)[12120-21]**:** **Date(s)**[12122-23]**:**

Physician 1[12130]**:** **Physician 2**[12131]**:**

CMS Discharge Status[12140]**:**

- O D/C – Home or self care
- O D/C – Short term general hospital
- O D/C – To a skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
- O D/C – Intermediate care facility
- O D/C – Institution not defined elsewhere in this code list
- O D/C – Home under care of organized home health service organization in anticipation of covered skilled care
- O Left against medical advice or discontinued care
- O Expired
- O Expired in a medical facility (e.g. hospital, SNF, ICF, or freestanding hospice)
- O D/C – Federal health care facility
- O Hospice – Home
- O Hospice – Medical facility
- O D/C – Hospital-based Medicare-approved swing bed
- O D/C – Inpatient rehabilitation facility (IRF) including rehabilitation-distinct part units of a hospital
- O D/C – Medicare-certified long term care hospital (LTCH)
- O D/C – Nursing facility certified under Medicaid but not certified under Medicare
- O D/C – To a psychiatric hospital or a psychiatric-distinct part unit of a hospital
- O D/C – Critical access hospital (CAH)