NCDR® Data Collection Form Premier 2.4.2 ACTION 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** Ambulance **or** Air, **Non-EMS 1st Med. Contact Date/Time**[3111, 3112]: _____ ☐ Time Estimated[3113]

→ **If** Ambulance **or** Air, **EMS Dispatch Date/Time**[3152, 3153]: _____ *(STEMI or STEMI Equiv.)*

→ **If** Ambulance **or** Air, **EMS Leaving Scene Date/Time**[3154, 3155]: _____ *(STEMI or STEMI Equiv.)*

→ **If** Ambulance **or** Air, **EMS Agency Number**[3156]: _____ *(STEMI or STEMI Equiv.)*

→ **If** Ambulance **or** Air, **EMS Run Number**[3157]: _____ *(STEMI or STEMI Equiv.)*

Cath Lab Activation Date/Time[3158, 3159]: _____ *(STEMI 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

Height[5000]: (cm)	**Weight**[5010]: (kg)	**Prior Heart Failure** (previous Hx)[5090]:	O No O Yes
Current/Recent Smoker (< 1 year)[5020]:	O No O Yes	**Prior PCI**[5100]:	O No O Yes
Hypertension[5030]:	O No O Yes	→ **If** Yes, **Most Recent PCI Date**[5101]:	_____
Dyslipidemia[5040]:	O No O Yes	**Prior CABG**[5110]:	O No O Yes
Currently on Dialysis[5050]:	O No O Yes	→ **If** Yes, **Most Recent CABG Date**[5111]:	_____
Cancer[5065]:	O No O Yes	**Atrial Fibrillation or Flutter**[5120]:	O No O Yes
→ **If** Yes, **Cancer Type**[5066]:	O Solid Organ O Hematologic	**Cerebrovascular Disease**[5130]:	O No O Yes
Diabetes Mellitus[5070]:	O No O Yes	→ **If** Yes, **Prior Stroke**[5131]:	O No O Yes
→ **If** Yes, **Diabetes Therapy**[5071]:	O None O Diet O Oral O Insulin O Other	→ **If** Yes, **Prior TIA**[5132]:	O No O Yes
		Peripheral Arterial Disease[5140]:	O No O Yes
Prior MI[5080]:	O No O Yes		

Home Functioning

Walking[5200]:	O Unassisted	O Assisted	O Wheelchair/Non-ambulatory	O Unknown
Cognition[5205]:	O Normal	O Mildly impaired	O Mod/Severely impaired	O Unknown
Basic ADLs[5210]: *(includes bathing, eating, dressing and toileting)*	O Independent of all ADLs O Full assist >1 ADL	O Partial assist =1 ADL O Unknown		

E. Medications

Oral Medications

Medication	Home Meds	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[6000-6022]	O No O Yes	O No O Yes O Contraindicated	O No O Yes O Contraindicated → **If** Yes, **Dose**: O 75-100mg O >100mg
Clopidogrel[6050- 6071]	O No O Yes	O No O Yes O Contraindicated → **If** Yes, **Start Date/Time:** _____ → **If** Yes, **Dose:** _____mg	O No O Yes O Contraindicated → **If** Yes, **Dose:**_____mg
Ticlopidine[6100-6121]	O No O Yes		O No O Yes O Contraindicated → **If** Yes, **Dose:**_____mg
Prasugrel[6150-6171]	O No O Yes	O No O Yes O Contraindicated → **If** Yes, **Start Date/Time:** _____	O No O Yes O Contraindicated → **If** Yes, **Dose:**_____mg
Ticagrelor[6180-6190]	O No O Yes	O No O Yes O Contraindicated → **If** Yes, **Start Date/Time:** _____	O No O Yes O Contraindicated
Warfarin[6200-6220]	O No O Yes		O No O Yes O Contraindicated
Dabigatran[6225-6226]	O No O Yes		O No O Yes O Contraindicated
Rivaroxaban[6230-6231]	O No O Yes		O No O Yes O Contraindicated
Apixaban[6240-6241]	O No O Yes		O No O Yes O Contraindicated
Beta Blocker[6250-6270]	O No O Yes	O No O Yes O Contraindicated	O No O Yes O Contraindicated
ACE Inhibitor[6300-6320]	O No O Yes	O No O Yes O Contraindicated	O No O Yes O Contraindicated
Angiotensin Receptor Blocker[6350-6370]	O No O Yes	O No O Yes O Contraindicated	O No O Yes O Contraindicated
Aldosterone Blocking Agent[6400-6420]	O No O Yes		O No O Yes O Contraindicated
Statin[6450-6471]	O No O Yes	O No O Yes O Contraindicated	O No O Yes O Contraindicated → **If** Yes, **Dose:** O Intensive statin therapy O Less than intensive statin therapy
Non-Statin Lipid-Lowering Agent[6500- 6520]	O No O Yes		O No O Yes O Contraindicated

E. MEDICATIONS (CONT)

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]: _____ → **If** Eptifibatide **or** Tirofiban, **Dose**[6806]: O Full O Reduced O Other
Anticoagulant[6850]	O No O Yes O Contraindicated → **If** Yes, **Medication Type(s):** ☐ IV Unfractionated Heparin[6851] **Initial Bolus**[6854]: O No O Yes → **If** Yes, **Initial Bolus Dose**[6855]: _____units → **If** Yes, **Start Date/Time**[6858,6859]: _____ **Initial Infusion**[6856]: O No O Yes → **If** Yes, **Initial Infusion Dose**[6857]: _____units/hr → **If** Yes, **Start Date/Time**[6866,6867]: _____ ☐ Enoxaparin (LMWH)[6860] **Start Date/Time**[6861, 6862]: _____ **Initial SubQ Dose**[6863]: _____mg **Initial IV Bolus**[6864]: O No O Yes **Injection Freq.**[6865]: O q12hr O q24hr O None ☐ Bivalirudin[6875] **Start Date/Time**[6876, 6877]: _____ ☐ Other parenteral anticoagulants given[6895]

F. PROCEDURES AND TESTS

Non-invasive Stress Testing[7000]: O No O Yes → **If** Yes, **Date**[7001]: _____

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]: _____

→ **If** Yes, **Angiography Date/Time**[7021, 7022]: _____

→ **If** Yes, **Number of Diseased Vessels**[7060]: O None O 1 O 2 O 3

→ **If** Yes, **Left Main Stenosis >=50%**[7065]: O No O Yes

→ **If** Yes and Prior CABG is 'Yes', **Graft is Present**[7070]: O No O Yes - graft patent O Yes - graft not patent

→ **If** Yes, **Proximal LAD >=70%**[7075]: O No O Yes

→ **If** Yes and Prior CABG is 'Yes', **Graft is Present**[7080]: O No O Yes - graft patent O Yes - graft not patent

→ **If** No, **Diagnostic Cath Contraindication**[7035]: O No O Yes

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 → **If** Yes, **CABG Date/Time**[7201, 7202]: _____

Patient treated with an in-hospital hypothermia protocol[7205]: O No O Yes

→ **If** Yes, **Where initiated**[7206]: O Pre-Hospital O ER O Cath Lab O ICU/CCU

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, **Strength of Dose**[8021]: O Full dose O Reduced dose

→ **If** Yes, **Type of Thrombolytics**[8022]: O Tenecteplase O Reteplase O Other

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

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

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

→ **If** Reperfusion Candidate 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 Candidate 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
→ **If** Yes, **Date**[9001]: _____

Cardiogenic Shock[9010]: O No O Yes
→ **If** Yes, **Date**[9011]: _____

Heart Failure[9020]: O No O Yes
→ **If** Yes, **Date**[9021]: _____

CVA/Stroke[9030]: O No O Yes
→ **If** Yes, **Date**[9031]: _____
→ **If** Yes, **Hemorrhagic**[9032]: O No O Yes

Atrial Fibrillation[9060]: O No O Yes
→ **If** Yes, **Date**[9065]: _____

VTach/VFib[9070]: O No O Yes
→ **If** Yes, **Date**[9075]: _____

Cardiac Arrest[9035]: O No O Yes → **If** Yes, **Date**[9037]: _____

Suspected Bleeding Event[9040]: O No O Yes
→ **If** Yes, **Suspected Bleeding Event Date**[9041]: _____
→ **If** Yes, **Bleeding Event Location:** (check all that apply)
☐ Access Site[9042] ☐ Retroperitoneal[9043] ☐ GI[9044] ☐ GU[9045] ☐ Other[9046]
→ **If** Yes, **Surgical Procedure or Intervention Required**[9047]: O No O Yes

RBC/Whole Blood Transfusion[9050]: O No O Yes
→ **If** Yes, **First Transfusion Date**[9051]: _____
→ **If** Yes, **CABG-Related Transfusion**[9052]: O No O Yes

New Requirement For Dialysis[9080]: O No O Yes
→ **If** Yes, **Date**[9085]: _____

Mechanical Support[9090]: O No O Yes
→ **If** Yes, **Device**[9095]: O IABP O Impella O TandemHeart O ECMO O LVAD O Other

I. Laboratory Results

Cardiac Markers

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

	Troponin	CK-MB
Initial	**Collected**[10010]: O No O Yes – I O Yes – T → **If** Yes, **Value**[10013]: _____ (ng/mL) → **URL**[10014]: _____	**Collected**[10020]: O No O Yes → **If** Yes, **Value**[10023]: _____ O IU/L O % O (mg/mL)/IU O ng/mL → **ULN**[10025]: _____
Peak	**Collected**[10030]: O No O Yes – I O Yes – T → **If** Yes, **Value**[10033]: _____ (ng/mL) → **URL**[10034]: _____ ☐ Peak same as initial[10035]	**Collected**[10040]: O No O Yes → **If** Yes, **Value**[10043]: _____ O IU/L O % O (mg/mL)/IU O ng/mL → **ULN**[10045]: _____ ☐ Peak same as initial[10046]

Creatinine

Initial	**Collected**[10100]: O No O Yes → **If** Yes, **Date/Time**[10101, 10102]: _____ → **If** Yes, **Value**[10103]: _____ (mg/dL)	**Peak**	**Collected**[10110]: O No O Yes → **If** Yes, **Date/Time**[10111, 10112]: _____ → **If** Yes, **Value**[10113]: _____ (mg/dL) ☐ Peak same as initial[10114]

Hemoglobin

Initial	**Collected**[10150]: O No O Yes → **If** Yes, **Date/Time**[10151, 10152]: _____ → **If** Yes, **Value**[10153]: _____ (g/dL)	**Lowest**	**Collected**[10200]: O No O Yes → **If** Yes, **Date/Time**[10201, 10202]: _____ → **If** Yes, **Value**[10203]: _____ (g/dL) ☐ Lowest same as initial[10204]

Initial Hemoglobin A1c

Collected[10250] O No O Yes → **If** Yes, **Date/Time**[10251, 10252]: → **If** Yes, **Value**[10253]: %

Initial INR

Collected[10300]: O No O Yes → **If** Yes, **Date/Time**[10301, 10302]: → **If** Yes, **Value**[10303]:

Lipids (mg/dL)

Panel Performed[10350]: O No O Yes → **If** Yes, **Date/Time**[10351, 10352]: _____ ☐ Value Out of Range[10360]

→ **If** Yes, **TC**[10353]: _____ → **If** Yes, **HDL**[10354]: _____ → **If** Yes, **LDL**[10355]: _____ → **If** Yes, **Triglycerides**[10356]: _____

Initial BNP	Initial NT-proBNP
Collected[10400]: O No O Yes → **If** Yes, **Value**[10401]: (pg/mL)	**Collected**[10405]: O No O Yes → **If** Yes, **Value**[10406]: (pg/mL)

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** Other Acute Care Hospital, **Transfer for CABG**[11108]: O No O Yes

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

→ **If** Deceased, **Cause of Death**[11150]: O Cardiac O Non-cardiac

→ **If** Deceased, **Time of Death**[11151]: _____

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)