FACT SHEET

Abstraction of *Initial ECG Interpretation*

Effective April 1, 2008 Through September 30, 2009 Discharges

1. The "Methodology" section:
   - The "Methodology" is a suggested step-by-step approach for efficient abstraction of this data element.
   - The abstractor may begin with the signed ECG tracing but this is not a requirement. If a signed ECG tracing is not available, start with any other source of initial ECG interpretation.
   - Only terms specifically identified or referred to by the physician/APN/PA as **ECG findings** AND where documentation is clear it is from the ECG performed closest to arrival should be considered in abstraction. A notation such as "STEMI" listed only as a physician diagnosis or impression, for example, should not be used in abstraction. Do not use findings from ECGs performed subsequent to the initial ECG.
   - **Stop abstraction if an Exclusion** is found in any documented interpretation and answer "No" to *Initial ECG Interpretation*. If an Exclusion is not found in an interpretation, continue through the rest of the interpretations to ensure no Exclusions exist elsewhere.
   - This approach should not result in a different answer to *Initial ECG Interpretation* than what would have been identified with pre-April 2008 abstraction guidelines.

2. Evaluate findings on ECG reports **line by line**.

   Example:

   Signed ECG report lists:

   Inferior Infarct
   ST abnormality
   *******Acute MI********

   Do not put two lines together to create the Inclusion "acute inferior infarct." In this interpretation, there is neither an Inclusion nor Exclusion, so the abstractor should continue review of the record for other interpretations of the initial ECG. If these were the only initial ECG findings documented, answer "No" to *Initial ECG Interpretation*.

3. **Do not cross-reference** findings between interpretations unless otherwise specified in abstraction guidelines.

   Example: "ST-elevation" on signed ECG report, ED MD report states initial ECG shows "Probable LVH with ST-T abnormalities." Do **not** put the two interpretations together to construct the Exclusion "ST-elevation with mention of LVH." If these were the only initial ECG findings documented, answer "Yes" to *Initial ECG Interpretation*.

4. "Contradictory documentation" is defined as an Inclusion plus a term which **directly** contradicts that term (e.g., "ST-elevation" and "No ST-elevation," "STEMI" and "not STEMI"). Answer "No" to *Initial ECG Interpretation* in cases of contradictory documentation.

   Examples which should **NOT** be classified as "contradictory documentation":

   - "ST-elevation" and "ST-depression"
   - "Acute lateral MI" and "no STEMI"

5. If at least one physician/APN/PA interpretation describes an **LBBB as old, chronic, or previously seen**, this negates any other LBBB findings in any other interpretations, including those LBBBs clearly described as new. If this documentation is found, ALL LBBB findings are disregarded in abstraction and not counted as Inclusions or Exclusions.

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6. Descriptors:

a. If an **Inclusion** term is described using one of the negative qualifiers/modifiers below, classify that term as an Exclusion and answer "No" to *Initial ECG Interpretation.*

Initial ECG Interpretation	
Negative qualifiers	**Negative modifiers**
o Cannot exclude	o Borderline
o Cannot rule out	o Insignificant
o Could be	o Scant
o Could have been	o Slight
o May have	o Sub-clinical
o May have had	o Subtle
o May indicate	o Trace
o Questionable (?)	o Trivial
o Risk of	
o Ruled out (r'd/o, r/o'd)	
o Suggestive of	
o Suspect	
o Suspicious	

b. **"Possible" is NOT a negative qualifier for *Initial ECG Interpretation.*** If an Inclusion term is described using the qualifier "possible," disregard that finding. It should not be classified as either an Inclusion or Exclusion. For example, if the signed ECG report states "1 mm ST-elevation in leads II, III, possible acute anterior MI" – Answer "Yes" to *Initial ECG Interpretation* due to the Inclusion "1 mm ST-elevation in leads II, III."

c. **An Exclusion described with a negative qualifier/modifier or "possible"** (e.g. "questionable IVCD") **is still an Exclusion** and *Initial ECG Interpretation* should be answered "No."

Common errors identified by validation

- To use an ECG report in abstraction, the report must be signed or initialed by a reviewing physician/APN/PA.
- To count an MI that is not labeled a STEMI as an Inclusion, there must be documentation of location (or "Q wave MI" or "transmural MI") AND **a descriptor of "acute" or "evolving."**
- LBBB described as "incomplete" and an intraventricular conduction delay (IVCD) or block are Exclusions.
- If ECG findings are not specifically labeled as coming from the ECG done closest to arrival (e.g., "initial," "first"), do not make assumptions. However, the abstractor may infer that the documented findings are from the ECG performed closest to arrival based on timing (e.g., H&P states "EKG shows STEMI" and only one EKG was done by that point in time).

Change in abstraction for 10/1/08+ discharges

Rather than essentially disregarding ECG findings where **"vs.," "or," "+/-," or "and/or"** is used in considering two findings, these descriptors have been added to the negative qualifier list (table 2.6, appendix H).

- If "vs.," "or," "+/-," or "and/or" is used in comparing two ECG findings, where **one of these findings is an Inclusion and the other is NOT an Inclusion** (e.g., "ST abnormalities consistent with ischemia and/or injury"), answer "No" to *Initial ECG Interpretation*.
- If "vs.," "or," "+/-," or "and/or" is used in comparing two ECG findings that are **both Inclusions**, consider the expression an Inclusion. For example, if "ST segment elevation and/or STEMI" is documented, answer "Yes" to *Initial ECG Interpretation*.

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