

COAP 2004 & 2005 Variables and Definitions

Please note: Effective with PCIs performed on or after January 1, 2004, submit a form for ALL attempted and completed procedures, regardless of whether the procedure was completed. This is a change from earlier years.

Questions in **bold** are required fields for 2004 and 2005.

Question #	Elements	Definition
Demographics		
1.0	Last Name	Patient's last name
1.1	First Name	Patient's first name
1.2	Middle Name	Patient's middle name
1.3	Social security number	Patient's SSN or, if not known, any unique numeric identifier, e.g., hospital-assigned ID number.
1.4	Date of birth	Patient's date of birth: use mm/dd/yyyy format.
1.5	Gender	Patient's gender.
For Q 1.61- 1.66 (Race), select all that apply		
1.61	Race Caucasian	
1.62	Race African- American	
1.63	Race Asian	
1.64	Race Native American	
1.65	Race Hispanic	
1.66	Race Other	
1.7	Date of Admission	Date the patient was admitted to hospital where this procedure was performed.
1.8	Admission Status	Select from the following choices: Emergency Department (patient was admitted via the ED: walked in, medic transport, etc.); Transfer (patient was transferred from any other facility, e.g., SNF, free-standing cath lab, hospital); Other (e.g., direct admit to cath lab from physician's office).

Question #	Elements	Definition
1.9	Type of procedure	Select the procedure described on this form/this record. Select one only: CABG; PCI-based (completed procedure); or Attempted PCI (attempted, guidewire did not successfully cross the lesion). Do not complete form for combination procedure (e.g., CABG + AVR). If patient had multiple eligible procedures during same or different admissions, complete a separate form or record for each: for example, if patient had a PCI and CABG during the same admit, or two PCIs during same admit, complete one form/record for each procedure.
1.10	Date of procedure	Date this procedure was performed. Use mm/dd/yyyy format.
1.11	Time of procedure	Approximate time patient entered procedure room; use 24-hour clock.
1.12	Institution name	Name of hospital at which procedure was performed.
1.13	Site number	COAP-assigned hospital number (1-35)
1.14	Physician code	Unique identifier (Medicare provider number or any other unique identifier, e.g., hospital-assigned ID) of the physician performing the procedure.
1.15	Date of discharge	Date patient was discharged from the hospital where procedure was performed, regardless of disposition status.
Clinical Risk Factors and History		
For Q 2.0-2.3, provide either metric OR English.		
2.0	Height in inches	Patient's height in inches at time of admit.
2.1	Height in cm	Patient's height in centimeters at time of admit.
2.2	Weight in pounds	Patient's weight in pounds at time of admit.
2.3	Weight in kg	Patient's weight at time of admit, in kilo grams.
3.0	Pre-procedure creatinine	Enter the creatinine closest in time and prior to the procedure. If none is available, leave blank.
4.0	History of diabetes	Indicate if patient has a history of diabetes, regardless of type or control.
4.1	Type of diabetes control	If Yes to Q 4.0, indicate type of control (choose one only).

5.0	History of dialysis	Indicate if patient has ever had renal dialysis, regardless of duration, setting, or clinical course.
6.0	History of chronic obstructive lung disease	Indicate if patient has a history of COPD. Definition: COPD, asthma, or bronchitis, or has been treated or is being treated pharmacologically for COPD.
7.0	History of cerebrovascular disease	Indicate if patient has a history of CVD. Definition: CVA, RIND, TIA, unresponsive coma > 24 hours, or invasive or non-invasive carotid test with > 75% occlusion.
8.0	History of peripheral vascular disease	Indicate if patient has history of PVD. Definition: history of claudication, amputation for arterial insufficiency, peripheral vascular reconstruction (bypass or angioplasty), aortic aneurysm or positive non-invasive test.
9.0	History of hypertension	Indicate if patient has history of hypertension. Definition: diagnosed and treated with medication, diet, and/or exercise; systolic BP >140 or diastolic BP >90 on at least two occasions; or currently on antihypertensive pharmacologic therapy.
10.0	History of smoking tobacco cigarettes	Indicate if patient has ever smoked tobacco cigarettes.
10.1	Cigarette use	If Yes to Q10.0, indicate how recently cigarettes were smoked, relative to this admission.
Previous cardiac procedures		
11.0	Prior CABG surgery	Indicate if patient has ever had CABG prior to this procedure (including during this hospitalization), regardless of number of grafts.
12.0	Prior valve replacement or repair	Indicate if patient has ever had a surgical valve repair or replacement, excluding percutaneous valvuloplasty.
13.0	Previous PCI	Indicate if patient has ever had a percutaneous coronary intervention prior to this procedure (including during this hospitalization). Exclude diagnostic procedures.
Cardiac Risk Factors		
14.0	Angina type	Indicate patient's highest level of angina associated with this hospitalization and prior to the procedure: no angina, atypical chest pain, stable angina, acute coronary syndrome/unstable angina.
14.1	MI before procedure	Indicate if patient experienced acute MI (any type) before the procedure: if yes, indicate timing of MI: hospitalized with the MI, or MI developed after admission but before the procedure. (Intra- or post-procedure MI would be indicated in Q 35.0)
14.11	Type of MI	If Yes to Q14.1, indicate type of MI from these choices: non-ST, ST MI, or unknown. Select "unknown" if record documents MI but type cannot be determined.

14.12	Timing of MI	If Yes to Q14.1, indicate time from the onset of ACS or MI to the procedure.
15.0	Previous MI	Indicate if patient has history of MI (regardless of type) eight or more days before this admission (not this procedure).
16.0	CCSC Angina	For all patients, regardless of responses to Q 14.0-15.0, indicate highest level of angina associated with this hospitalization and prior to the procedure: no angina, Class I, II, III, or IV.
17.0	History of congestive heart failure	Indicate if patient has documented history of CHF. Definition: history of CHF in medical record; paroxysmal nocturnal dyspnea (PND); dyspnea on exertion (DOE) due to heart failure; chest x-ray showing pulmonary congestion.
18.0	Pre-procedure thrombolytic	Indicate if any thrombolytic was started before either the first attempted PCI guidewire crossing or before the CABG surgical incision.
18.1	Thrombolytic timing	If Yes to 18.0, indicate when the thrombolytic was started relative to either the first attempted PCI guidewire crossing (if form/record is for PCI) or to the CABG surgical incision (if form/record is for CABG).
19.0	Other pre- or intra-procedure medications	Indicate any/all medications initiated for the treatment of cardiac ischemia before or during the PCI or before or during the CABG. Select all that apply.
20.0	Pre-procedure LVEF	Indicate the LV ejection fraction measured closest in time and <u>prior</u> to the procedure. If no pre-procedure value is available, leave blank.
20.1	LVEF method	If 20.0 is answered, indicate the method of measurement: calculated LV gram, ECHO, or MUGA, or visual estimation based on LV gram, ECHO, or MUGA.
21.0-21.14	Stenosis	Indicate the highest degree of stenosis for each major vessel distribution prior to the procedure. If a precise value is available (e.g., 55%), enter that value and do not select a category range. If a precise value is not available select the best category. If there is no measurement of stenosis, indicate "Not Measured." Examples: (1) "Stenosis 40-50%", select category 2. (2) "Stenosis 40-60%" straddles two categories: select the category that includes the high end of the range, category 2, 51-70%. Definition of distribution: LM = LMCA, LMCA ostium Proximal LAD = proximal LAD Other LAD = Mid LAD, Distal LAD, 1 st /2 nd diagonal, 1 st septal. Circumflex = proximal CFX, mid CFX, 1 st /2 nd /3 rd marginals, distal CFX, left PDA, ramus. RCA = proximal RCA, RCA ostium, mid RCA, distal RCA, right PDA, right LV-BR.
22.0	Aortic stenosis	Indicate presence of aortic stenosis, defined as AS valve area <1.0cm ² .
22.1	Aortic insufficiency	Indicate presence of aortic insufficiency, defined as AI moderate to severe regurgitation by angiogram or echo.
22.2	Mitral stenosis	Indicate presence of mitral stenosis, defined as MS valve area <1.0 cm ² .
22.3	Mitral regurg	Indicate presence of moderate to severe MR by angiogram or echo.

23.0	Cardiogenic shock pre - procedure	Indicate if patient experienced cardiogenic shock before the procedure. Shock defined as IV inotropes and/or IABP need to maintain Systolic BM >80 mm and/or cardiac index < 1.8 liters/minute/M ² .
24.0	Pre-op IABP	Indicate if patient had an intra-aortic balloon pump inserted before the initiation of the procedure.
25.0	Priority	Indicate the priority of the procedure: elective, urgent, emergent, or Salvage. When considering the selecting of elective/urgent/emergent, emphasize the clinical picture (stable? Unstable? Worsening?) rather than the exact scheduling of the procedure. For example, a patient may fit the Unstable category clinically but procedure is done at 30 hours rather than 24.
CABG Procedure Variables: Answer 26.0-28.4 for CABG ONLY.		
26.0	Cardiopulmonary bypass	Indicate if CP bypass was employed.
27.0	Distal venous anastomoses	Indicate number of distal venous anastomoses, 0-8.
28.0-28.4	Distal arterial anastomoses	Indicate number of distal arterial anastomoses, by type (LIMA, RIMA, GEPA, Radial Artery, or other). Enter 0 in each field if none performed.
PCI Procedure Variables: Answer 29.0-32.0 for PCI ONLY (attempted and completed).		
29.0	Lesion Data	Complete this table for each lesion attempted, regardless of whether procedure was completed. For each lesion in sequence, answer all questions. For devices, select all that apply, and indicate the device considered the primary intervention to enlarge the lumen; if more than one device, the primary device is the one used to enlarge the lumen. If the guidewire crossing was unsuccessful, answer the following questions if possible: % stenosis pre-procedure; lesion treated before; lesion treated before with drug-eluting stent; lesion treated before with brachytherapy; if lesion in graft, type of graft. Do not answer other questions.
30.0	Procedure to treat AMI?	Answer this question for PCI only, whether completed or attempted. Answer Yes if the procedure is being performed for the treatment of any type of AMI. If No, go to 31.0.
30.1	Arrival at ER	Provide the arrival date and time at this hospital's ER only if answer to Q 30.0 is Yes, AND patient presented to ER with acute STEMI. If any of these conditions are not met, do not answer 30.1
30.2	Initial balloon or attempt	If 30.1 is completed, provide the date (use mm/dd/yyyy format) and time (use 24-hour clock) of the initial balloon inflation OR of other attempt to dilate lesion, even if procedure was not completed.
31.0	Diagnostic catheterization	Indicate if diagnostic cath performed during same cath lab visit.
32.0	Groin-sealing device	Indicate if any groin-sealing device was used.
Intra- or Post-Procedure Variables: Answer Q 33.0-40.0 for ALL patients.		
33.0	Intra- or post-	Indicate if an EKG was performed during or after the procedure for any reason.

	procedure EKG	
34.0	Intra- or post-procedure enzymes	Indicate the cardiac enzymes ordered during or after the procedure for any reason. Select all that apply.
35.0	Intra- or post-procedure MI	Answer 35.0 for both PCI and CABG patients, but note and use the different definitions. Answer 35.0 for PCI ONLY IF Q30.0 is No (that is, procedure is not being performed for treatment of AMI).
36.0	Intra- or post-procedure arrhythmia	Answer 36.0 for both PCI and CABG patients, but note and use the different definitions.
37.0	Creatinine	Indicate the highest Cr level measured from the beginning of the procedure to the time of discharge. If there is no Cr in this timeframe, select "Not Recorded".
38.0	New post-procedure dialysis	Indicate if patient without prior (pre-procedure) dialysis required dialysis post-procedure, regardless of setting or duration.
39.0	Intra- or post-procedure CVA	Indicate if patient experienced intra- or post-procedure CVA, defined as loss of neuro function caused by ischemic event, with residual symptoms lasting >72 hours after onset.
40.0	Intra- or post-procedure cardiac tamponade	Indicate if patient experienced tamponade, defined as fluid in the pericardial space resulting in systemic hypotension requiring intervention, documented by echo and/or other methods.
PCI Patients ONLY		
41.0	New intra- or post-procedure cardiogenic shock	Indicate if patient experience NEW onset cardiogenic shock during or after procedure.
CABG patients ONLY		
42.0	Post-procedure extubation	Enter total number of hours (rounded to nearest hour) patient was intubated from end of procedure to final extubation. If extubated on table, enter 0. If expired on table, enter 0. If extubated and reintubated during this hospitalization, provide best estimate of total hours intubated.

All Patients		
43.0	Return to OR	Indicate if during this hospitalization the patient was taken to the OR following the procedure in this record <u>for any reason</u> , regardless of apparent relationship or lack of relationship to the CABG or PCI. If no, proceed to 44.0. If yes, answer 43.1-3 (for PCI patient) or 43.4-43.5 (for CABG patient). Choose all that apply. Leave blank if none applies.
For PCI		
43.1	Unplanned CABG	Did PCI patient go to OR for an unplanned CABG?
43.2	Vascular complication	Did PCI patient go to OR for treatment of a vascular complication?
43.3	Other PCI complication	Did PCI patient go to OR for treatment of other situation that appeared to related to the PCI, e.g., wound infection?
For CABG		
43.4	Reop for bleeding or tamponade	Did CABG patient return to OR for reoperation for bleeding or tamponade?
43.5	Other complication of CABG	Did CABG patient return to OR for other complication of the CABG? This <u>includes</u> patients leaving original CABG with open chest, with planned return for late closure.
For all patients		
44.0	To cath lab	Indicate if during this hospitalization the PCI or CABG patient went to the cardiac cath lab after the initial procedure for any reason? If no, proceed to 45.0. If yes, select all that apply from 44.1-44.3.
45.0-45.4	Blood products	Indicate total units of each type of product used from the time of the procedure in this record to the time of discharge. Note: if patient had more than one eligible procedure during the same admission (e.g., PCI followed by CABG), complete one form for each procedure and answer the blood products questions for each.
46.0	Death	Indicate if patient died during this hospitalization, regardless of cause.
47.0	Discharge disposition	If patient was discharged alive, indicate discharge disposition.
47.1	Other disposition	May include situations such as discharge to motel/hotel/vehicle/homeless/shelter, or other circumstances.
48.0	Discharge medications	Indicate all medications prescribed at discharge, regardless of allergies or other contraindications; select all that apply. Anti-platelet agents do not include heparin.
49.0	Person completing	Indicate name or initials of person completing this form.