Disclosures

• Dr. Fonarow, MD, FACC, FAHA
  – Boston Scientific, Takeda, Amgen, Johnson&Johnson, Medtronic, Gambro, NIH/NIAID, Novartis, NHLBI

• Kim Hustler RN
  No Disclosures

• Susan Rogers RN, MSN, NE-BC
  No Disclosures

Objectives

- Discuss the registry updates for ACTION Registry-GWTG
- Verbalize ACTION Registry-GWTG recognition criteria
ARS Question # 1
How Long Have YOU Been Participating In THE ACTION Registry-GWTG Data Collection Process?

1. Less than 1 year
2. 1-3 Years
3. 4-7 years
4. Not applicable

Registry Updates

Recognition Levels

<table>
<thead>
<tr>
<th>Award Levels</th>
<th>Must meet compliance on composite measures</th>
<th>Participate In</th>
</tr>
</thead>
</table>
| Platinum     | 90% compliance  
> = 8 consecutive quarters entering data | Premier |
| Gold         | 90% compliance  
> = 8 consecutive quarters entering data | Premier or Limited |
| Silver       | 90% compliance  
> = 4 consecutive quarters entering data | Premier or Limited |
Recognition

2012
• 164 hospitals met the Platinum level
• 20 hospitals met the Gold level
• 73 hospitals met the Silver level

2011
• 171 hospitals met Gold level
• 88 hospitals met Silver level
Mission: Lifeline® Reports and Data

Mission: Lifeline® Program

• Mission: Lifeline
  – Implementation of national recommendations and guidelines on a community level
  – Addresses care of the STEMI patients across the patient care continuum
  – Recognizes there is no “one size fits all” solution to barriers
  – Preserves a role for local STEMI Referral Center
  – Takes process improvement outside the doors of the hospitals and into the community (EMS)

Mission: Lifeline® Program Report Goals

• Mission: Lifeline Reports
  – Provides data feedback to identify process improvement success as STEMI care is approached from a systems perspective
  – EMS involvement is critical to meeting the FMC to PCI ≤ 90 minutes
  – Serves as a tool to actively involve all STEMI care partners including Referral Centers, EMS and other Receiving Centers
Mission: Lifeline and ACTION Registry-GWTG Relationship

- AHA
  - Quality Improvement Specialists
  - Mission: Lifeline Implementation
  - Process M:L Reports using AR-G data

- ACC
  - Keeper of AR-G Data
  - Operational Support for data upload
  - Executes Data Release Consent Forms
  - Analyze the AR-G data using logic specific to ACTION reports
  - Posts AR-G and M:L Reports

- DCRI
  - Analyze the AR-G data using logic specific to M:L
  - M:L Reports

Where are the Mission: Lifeline® Receiving Report Companion Guides located?

- MISSION: LIFELINE
  - Receiving Center Report Glossary
  - MISSION: LIFELINE
  - Receiving Center Interpretation Manual

AHA Mission: Lifeline Report Resources

WWW.HEART.ORG/MISSIONLIFELINE

COLLECT AND REPORT SUDDENLY
SARIN RECOGNITION: GET ACCIDENTED
Collect and Report Your Data

There are times where the denominator in the Mission: Lifeline reports differs from the denominators in the ACTION Registry-GWTG Outcome reports. How does this happen?

Mission: Lifeline Receiving Report Interpretation Manual

MISSING VALUES

In general, missing data is assumed to be "no" in the feedback report calculations. However, missing data will be included in the denominator for performance rates, so a large amount of missing data may have an adverse effect on your site’s performance metrics. For example:

• 10 STEMI Patients are entered for Q2 2012
• All 10 are eligible to receive acute ASA (Seq 6000-6021)
  – All 10 patients were actually given ASA within first 24 hours of admission
    • Per data entry, 7 of these 10 = Acute ASA = "YES"
    • 3 of these patients have NO value entered – was left blank

“Records with Null values, including in reporting performance measure elements, are included in the denominator in the Mission: Lifeline reports.”

Performance Score Reflected for Acute ASA: 70%
7 Documented as Administered / 10 Eligible

70% - Not Eligible for Mission: Lifeline Recognition
Our hospital is “missing” some data in the Mission: Lifeline report. Why is this?

Highlighted Area = Elements NOT available in the Limited Form

<table>
<thead>
<tr>
<th>Limited Users</th>
<th>Premier Users</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mission: Lifeline Receiving Hospital report Glossary

- Entire STEMI population not evaluated in ED, excluding patients with STEMI diagnosed on subsequent ECG, non-ST-elevation MI, documented non-system reason for delay in PPCI, and arrival to PPCI > 12 hours.
- Patients may have missing or negative values for specific time intervals, which excludes them from ONLY the affected intervals. All other intervals with valid dateline data are included in the graph.
Explain the First Medical Contact to PCI ≤ 90 Minutes Measure?

Mission: Lifeline Measure:
Mission: Lifeline First Medical Contact to Primary PCI ≤ 90 Minutes Variable (%) – All STEMI admissions who receive a primary PCI within 90 minutes from first medical contact prior to arrival at the Receiving Center.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Distribution</th>
<th>Mean</th>
<th>Median</th>
<th>25th</th>
<th>75th</th>
</tr>
</thead>
<tbody>
<tr>
<td>FMC</td>
<td>50.1%</td>
<td>0.85</td>
<td>0.67</td>
<td>0.5</td>
<td>1.1</td>
</tr>
<tr>
<td>PCI</td>
<td>50.0%</td>
<td>0.85</td>
<td>0.67</td>
<td>0.5</td>
<td>1.1</td>
</tr>
<tr>
<td>STEMI</td>
<td>50.0%</td>
<td>0.85</td>
<td>0.67</td>
<td>0.5</td>
<td>1.1</td>
</tr>
</tbody>
</table>

First Medical Contact to PCI ≤ 90 Minutes Measure
What patients are included?

ACTION Registry-GWTG DATA Definition:
• FMC – What exactly is FMC?
  Pre-Arrival 1st Med Contact Date/Time = Eye to Eye contact between the STEMI patient and the 1st Medical provider to deliver (ACS) Acute Coronary Syndrome care –
  • 12 Lead ECG
  • Aspirin Administration
  • Nitroglycerine Administration
First Medical Contact to PCI ≤ 90 Minutes Measure
What patients are NOT included?

Mission: Lifeline FMC to PCI Scenario 1

0900 – Pt. arrives at Urgent Care
C/C Nausea, Indigestion
0955 – 12 Lead ECG Acquired
1005 – MD reads 12 Lead as “possible STEMI”
1015 – 911 EMS is Called
1025 – EMS arrives at patient
1032 – EMS Departs Scene, confirms STEMI
1035 – EMS notifies ED via radio of patient status and 12 Lead ECG findings
1037 – STEMI Alert is activated
1045 – EMS arrives and is directed through ED
1105 – 1st Device Activated

1) The time that should be entered for Seq 3106 (PreArrival FMC Time)?
a) 0930  b) 0955  c) 1015
2) What is the total FMC to PCI time?
a) 75 mins  b) 95 mins  c) 120 mins

Mission: Lifeline FMC to PCI Scenario 2

1500 – Betty White presents to The Dental Clinic of America – She happens to be Weak and Dizzy
1520 – EMS Called
1530 – EMS at Betty’s Side
1535 – EMS acquires a 12 Lead ECG
No STEMI noted
1540 – EMS enroute to ED
1555 – EMS arrives at PCI ED
1600 – ECG Acquired in ED- Shown Same as EMS’s ECG
1650 – Repeat ECG Acquired in ED
1652 – STEMI Alert Activated

1) The time that should be entered for Seq 3106 (PreArrival FMC Time)?
a) 1500  b) 1520  c) 1530
2) What is the total FMC to PCI time?
a) 75 mins  b) 95 mins  c) 120 mins
Mission: Lifeline FMC to PCI Scenario 3

0000 - EMS Arrives at Patient with a chief complaint of Chest Pain and SOB
0030 - Patient Arrives at ED - Basic EMT Crew – No Pre-hospital 12 Lead Acquired
0035 - 12 Lead ECG Acquired in ED
0045 - STEMI Noted on 12 Lead
0050 - STEMI Alert Called
0125 - Patient to Cath Lab
0140 - 1st Device Activated

Total FMC to PCI = a) 80 Minutes  b) 90 Minutes  c) 100 minutes
Door to Balloon = a) < 90 Minutes  b) > 90 Minutes

Mission: Lifeline FMC to PCI Measure - INCLUDED OR EXCLUDED
Mission: Lifeline Regional Reports

- Looks at the Mission: Lifeline data across a user-specified region
  - Physical Region
  - Functional Region
  - State as a Region
  - Corporate Region
- Provides state, national and regional benchmarks
- Option for Blinded versus Un-Blinded Data
- Requires Data Release Consent Forms specific to M:L Regional Reports
- Region organized through a Region Champion and local AHA Quality Improvement and/or Mission: Lifeline staff
- Cost – One time fee $475.00 per 20 hospitals (so long as the template does not change)

Examples of Regions Receiving M:L Regional Reports

Mission: Lifeline Regional Reports
For More Mission: Lifeline Information

• WWW.HEART.ORG/MISSIONLIFELINE
• Lori Hollowell, Quality and Systems Improvement Consultant,
  Mission: Lifeline and ACTION Registry-GWTG
  – Lori.Hollowell@heart.org
• Katherine Kuban, Mission: Lifeline Program Manager
  – Katherine.Kuban@heart.org
  – Chris Bjerke, National Director, Mission: Lifeline
  – Chris.Bjerke@heart.org
• MissionLifeline@heart.org
ACTION Registry-GWTG
Using the Dashboard Comparator

Susan Rogers RN, MSN, NE-BC

Objectives

➢ Discuss the basic dashboard functionality
➢ Describe the methods that may help to identify performance successes and gaps
➢ Discuss the results of using the comparator

Access Your Hospital's Reports
Create Your Hospital's compare Groups
On Demand Reports
Drill Down: Patient Level
Comparator

- Select Filter Criteria
- Run Analysis
- Export Results
- Six or more hospitals are required for comparison
Comparator Drill Down

Documentation:
Your hospital belongs to a system of hospitals.
The QI committee members at your hospital requested data comparing the other hospitals in your System on Metric 22.

Dashboad Comparator: How would you interpret these results?

ARS Question:

How would you interpret these results?

1. My hospital is able to perform an ECG on AMI patients within 10 minutes of arrival more often than the other hospitals in my System.
2. The other hospitals in my System have larger volumes of patients.
Your hospital belongs to a System of hospitals. The QI committee members at your hospital requested data comparing the other hospitals in your System on Metric 22.

How would you interpret these results?
1. My hospital is able to perform an ECG on AMI patients within 10 minutes of arrival more often than the other hospitals in my System.
2. The other hospitals in my System have larger volumes of patients.

**Dashboard Comparator: Error Message**

Documentation:
You log into the Comparator, pick your compare criteria and receive this message.

**Comparison Analysis Chart**
The filter criteria chosen is too restrictive, the comparison group has less than six hospitals. Refine the filter and try running the analysis again.
ARS Question
What do I do to receive the compare report?
1. Change the criteria selected
2. Expand the number of beds
3. Expand the number of hospitals
4. Include additional states in your region
5. All of the above

Documentation:
What steps do I take to receive the compare report?
1. Change the criteria selected
2. Expand the number of beds
3. Expand the number of hospitals
4. Include additional states in your region
5. All of the above

Thank You
NCDR. 13 Case Scenario Presentation
ACTION Registry-GWTG

Kim Hustler, RN
Clinical Quality Consultant

Case Scenarios

• Unique sessions for beginners to experts
• Real case scenarios
• Process for utilizing the dashboard
• ARS participation

Objectives for the ACTION Registry-GWTG
Case Scenario Presentation

Discuss the implication of data entry on dashboard and outcome reports

Discuss the utilization of the companion guide in determining reasons for dashboard fall outs

Demonstrate knowledge of data abstraction through participation with ARS
Dashboard drill down
ADP for medically treated Metric #29

Documentation:

• You are reviewing your Executive Summary in the eReports
• You identify a significant difference in the results for Metric #29 ADP for medically treated patients-78.8% compared to #28 ADP for revascularized patients-93%

<table>
<thead>
<tr>
<th>Discharge Quality Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. ADP prescribed patients discharged on ADP receptor inhibitors</td>
</tr>
<tr>
<td>29. ADP receptor inhibitors prescribed at discharge for medically treated ARD patients</td>
</tr>
<tr>
<td>29. Adherence bleeding agents at discharge for ARD patients</td>
</tr>
<tr>
<td>76.8</td>
</tr>
<tr>
<td>8.5</td>
</tr>
</tbody>
</table>

ADP for medically treated Metric #29

• You identify on the eReport page-Metric #29 is located in the grouping "Discharge Quality Metric"
• Click on the Discharge Quality Metric tab to open

• Identified-Q1 2011 is the quarter that had the lowest score
• Click on the bar for 2011 Q1
ADP for medically treated Metric #29

- The drill down provides the individual patient performance
- Look for “no’s” in the numerator column
- There are 3 “no’s”

Export to excel-to narrow down search- helpful with high volume of patients

Highlight the row you wish to be utilized for filtering (title row)

To filter- select “data”- click on filter (funnel shape)
ADP for medically treated Metric #29

• The filtering arrows appear - click on arrow

ADP for medically treated Metric #29

• You review the patient records to assess if data entry error or issue with care provided
• Findings - patient 1782677 presented with symptoms of ACS
• STEMI - to cath lab - left heart cath completed
• No PCI - anatomy not suitable to primary PCI
• Recommended for CABG - patient refused

Patient Level Detail Report:

<table>
<thead>
<tr>
<th>Year/Order</th>
<th>Patient ID</th>
<th>Incl. in Numerator</th>
<th>STEMI/STEMI</th>
<th>PCI</th>
<th>CABG</th>
<th>Discharge Status</th>
<th>Discharge Location</th>
<th>Clopidogrel Prescribed at Discharge</th>
<th>Ticlopidine Prescribed at Discharge</th>
<th>Prasugrel Prescribed at Discharge</th>
<th>Comfort Measures</th>
<th>Warfarin at Discharge</th>
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</thead>
<tbody>
<tr>
<td>2013-01</td>
<td>124270</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<td>No</td>
</tr>
<tr>
<td>2013-02</td>
<td>183751</td>
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<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Home</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Review drill down to see if data was entered correctly
ARS Question #1

Should this patient be included in the denominator since they did not have reperfusion (no PCI/no stent)?

1. No
2. Yes

ADP for medically treated Metric #29

Documentation:
- Findings: Patient 1782677 presented with symptoms of ACS
- STEMI: to cath lab - left heart cath completed
- No PCI: anatomy not suitable to primary PCI
- Recommended for CABG: patient refused

Should this patient be included in the denominator since they did not have reperfusion (no PCI/no stent)?

1. No
2. Yes

Overall AMI Performance Composite

Documentation:
- The Executive summary dashboard & Outcomes report has a score of 75%
- The Overall AMI Performance Composite has:
  - Denominator of 8
  - Numerator of 6
ARS Question # 2

Does this mean there were 8 patients in the registry for the rolling 4 quarters?

1. No
2. Yes

Overall AMI Performance Composite

Documentation:

- The Overall AMI Performance Composite (75%) has:
  - Denominator of 8
  - Numerator of 6

Does this mean there were 8 patients in the registry for the rolling 4 quarters?

1. No
2. Yes

Overall AMI Performance Composite

Documentation:

- Higher volume facility
- Overall performance composite score is 98.2%
ARS Question #3

How many patients were entered? How many eligible care opportunities were there? How many care measures were provided?

1. P- 93, E- 636, C- 625
2. P- 106, E- 698, C- 711
3. P- 106, E- 711, C- 698

<table>
<thead>
<tr>
<th>Line#</th>
<th>Description</th>
<th>Mean</th>
<th>Class</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000</td>
<td>Executive Summary Detail</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1001</td>
<td>Composition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1002</td>
<td>Overall AMI Performance Composite</td>
<td>698</td>
<td>711</td>
<td>98.2</td>
</tr>
<tr>
<td>1003</td>
<td>Overall Defect Free Care</td>
<td>93</td>
<td>711</td>
<td>87.7</td>
</tr>
<tr>
<td>1004</td>
<td>STEMI Performance Composite</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1005</td>
<td>NonSTEMI Performance Composite</td>
<td>73</td>
<td>73</td>
<td>97.3</td>
</tr>
<tr>
<td>1006</td>
<td>Acute AMI Performance Composite</td>
<td>253</td>
<td>259</td>
<td>98.1</td>
</tr>
<tr>
<td>1007</td>
<td>Discharge AMI Performance Composite</td>
<td>445</td>
<td>453</td>
<td>98.2</td>
</tr>
</tbody>
</table>

---

Overall AMI Performance Composite

Documentation:

- Higher volume facility
- Overall performance composite score is 98.2%

How many patients were entered? How many eligible care opportunities were there? How many care measures were provided?

1. P- 93, E- 636, C- 625
2. P- 106, E- 698, C- 711
3. P- 106, E- 711, C- 698

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<td>STEMI Performance Composite</td>
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<td>453</td>
<td>98.2</td>
</tr>
</tbody>
</table>

---

Overall AMI Performance Composite

Documentation:

- The score of 98.2% is great, but you want to find out what opportunities were missed
- There were 13 care opportunities that your patients were eligible for, but did not receive

<table>
<thead>
<tr>
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<th>Class</th>
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<td>Executive Summary Detail</td>
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<td>453</td>
<td>98.2</td>
</tr>
</tbody>
</table>
ARS Question #4

How would you identify which patients and which care measures were not provided to these patients?

1. Dashboard Overall Composite
2. Outcomes Report detail lines
3. Dashboard Overall Composite drill down

Overall AMI Performance Composite

Documentation:
- The score of 98.2% is great, but you want to find out what opportunities were missed.
- There were 13 care opportunities that your patients were eligible for, but did not receive.

How would you identify which patients and which care measures were not provided to this patient?

1. Dashboard Overall Composite
2. Outcomes Report detail lines
3. Dashboard Overall Composite drill down

Dashboard
Door to ECG Metric #22

Documentation:
- You have been working hard to reduce your door to ECG times.
- You review your Outcomes Report and note a negative value for Pre-Hospital to Balloon time, detail line 1268 ECG to arrival time.

<table>
<thead>
<tr>
<th>Pre-Hospital/ECG to admission</th>
<th>Door to ECG Metric #22</th>
<th>1268 ECG to Arrival</th>
<th>- 60</th>
</tr>
</thead>
</table>
ARS Question #5

What could cause the “ECG to arrival time” to be a negative value?

1. ECG was performed prior to arrival
2. ECG - Pre-Hospital, ECG #4021 - time prior to arrival
3. ECG - After 1st hosp. arrival, #4021 - time after arrival
4. Selection for #4010 & time for #4021 do not coincide

Door to ECG

Documentation:
- You review your Outcomes Report and note a negative value for Pre-Hospital to Balloon time, detail line 1268 ECG to arrival time

Dashboard

Submission near data deadline

Documentation:
- You are working through the quarter and want to verify the data entered is correct for the next Outcomes report
- You review the dashboard graphs and individual metric drill downs for the performance measures and quality metrics
- You find a few errors - make the corrections - data collection tool - then resubmit your data through the DQR on Sunday at 09:00
ARS Question #6

Will the corrections be included in the Sunday dashboard data aggregation?

1. No
2. Yes

Overall AMI Performance Composite

Documentation:
• You review the dashboard graphs and individual metric drill downs for the performance measures & quality metrics
• You find a few errors and make corrections- data collection tool- resubmit your data through the DQR on Sunday at 09:00

Will the corrections be included in the Sunday dashboard data aggregation?
1. No
2. Yes

Dashboard Published quarters

Documentation:
• Submitted Q2 data on time for Q2 deadline 8/31/2012
• After deadline- note errors in Q2 submission
• Made corrections in tool & resubmitted DQR 11/28/2012, Q3 deadline 11/30/2012
• Looked to dashboard for the Q2 changes
ARS Question #7

When will the Q2 changes be reflected in the dashboard?

1. With the next Sunday’s data aggregation
2. After the Q3 Outcomes Report is created
3. Upon request Q2 Outcomes Report will be re-aggregated
4. The changes will not be available in the dashboard

Published quarters

Documentation:
• Submitted Q2 data on time for Q2 deadline 8/31/2012
• After deadline-note errors in Q2 submission
• Made corrections in tool & resubmitted DQR 11/28/2012, Q3 deadline 11/30/2012
• Looked to dashboard for the Q2 changes

When will the Q2 changes be reflected in the dashboard?
1. With the next Sunday’s data aggregation
2. After the Q3 Outcomes Report is created
3. Upon request Q2 Outcomes Report will be re-aggregated
4. The changes will not be available in the dashboard

Dashboard

Overall Defect Free Care

Documentation:
• Reviewing Defect Free Composite
• Q1-79.7%, Q2-86.1%
• Defect free care is % of time providing perfect care
• Drill down to see what metric needs improvement
ARS Question #8

Why is ASA at Arrival blank for 4 patients listed?
1. Data fields was left blank (null values)
2. Patients not included in the denominator
3. ASA not given

Defect Free Care

Documentation:
• Reviewing Defect Free Composite
• Q1-79.7%, Q2-86.1%
• Defect free care is % of time providing perfect care
• Drill down to see what metric need improvement

Why is ASA at Arrival blank for 4 patients listed?
1. Data fields was left blank (null values)
2. Patients not included in the denominator
3. ASA not given