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Welcome to the 2015 Mission: Lifeline® EMS Recognition web-based application.
Application closes February 28, 2015 at 23:59.59 CT.

NEW for 2015 – Please Carefully Review
There are three options for Ambulance services to choose from when completing and submitting the 2015 Mission: Lifeline EMS Application.
1) Individual Application (stand-alone)
2) Individual Application with Team Application option
3) Joint Application

2015 Mission: Lifeline EMS Application Flow Chart

When determining the most appropriate application to complete, please consider the following:

- *Each STEMI patient may only be included in 1 application submitted by the applicant. When STEMI patient A is used in the joint application volume, this STEMI patient may not also be included in an individual application.*
- *An Ambulance Service may submit a Joint Application and an Individual/Team Application so long as the volume requirements are met for each using unique STEMI patients to each application submitted.*
- *Patients treated between January 1, 2014 and December 31, 2014 should be used for the population included in the 2015 award application.*
- *To view achievement criteria and volume requirements -* 2015 Mission: Lifeline EMS Recognition Measures and Criteria

Individual Application

- Ambulance Service meets volume requirement, acquires 12 lead ECG AND transports the STEMI patient

Team Application

- Primary Service meets the individual application requirements
- Primary Service will be expected to enter contact information of all included partnering medical first responding agencies/departments in the team section

Joint Application

- Two ambulance agencies frequently collaborate on STEMI patient calls.
- The number of collaborative STEMI calls that are completed by the 2 agencies, meet the minimum volume requirement.
- One of the two collaborative agencies must meet the %ECG criteria on all patients, 35 years of age or over, with the complaint of non-traumatic chest pain.
- If an ambulance service meets the volume criteria with 2 or more collaborating agencies, one Joint Application may be submitted for each dual configuration, where each dual configuration meets the volume requirement.
- If an ambulance agency submits a Joint Application and has an additional volume of STEMI patients that will allow the agency to also meet the volume requirements for the Individual Application, the agency may also submit a separate Individual Application (stand-alone or team option)

Opportunities for Medical First Responders (MFR):
Medical First Responders (i.e., respond on emergency medical calls but do not transport) are vital in the system response to the possible STEMI patient. When the MFR agency/department is 12 Lead capable, acquires the 12 lead ECG and turns the patient over to a transporting agency, there is an opportunity for the MFR agency/department to apply for EMS Recognition via the JOINT application process, so long as the volume criteria is met. However, when the MFR agency/department is not 12 lead capable, the MFR agency/department should contact the primary ambulance agency(ies) that provides response to medical calls and then request to be included as a TEAM member via the INDIVIDUAL with TEAM option application submitted by the ambulance agency.

Interfacility Transport:
At this time, the EMS Recognition measures are inclusive of patients that are transported from the field directly to a STEMI Receiving Center and have primary PCI performed and those that are transported from the field, directly to a STEMI Referring Center and have Fibrinolytics administered. Measure to include the interfacility transport process are being considered for future EMS Recognition opportunities.

2015 Mission: Lifeline EMS Application Data Summary Entry Tips:

- Once the application is started, the application will remain open until the applicant selects the FINAL **NEXT** option at the end of the application OR it will remain open until the submission deadline (2/28/2015 – 23:59.59 CT)
- The same computer that was used to begin any open applicaiton must be used to return to the incompleted and open application.
- There are times in the application when there is not an opportunity to "Go Back" - this is a limitation of the survey itself. If an error in the data sumbitted is recognized, please contact MissionLifeline@heart.org at least **72 hours prior to the submission deadline**.
- Once the application is submitted, if an applicant needs to re-access the application, a request must be made to MissionLifeline@heart.org and must be made at least 48 hours prior to the submission deadline.
- Questions proceeded with an asterisk (*) REQUIRE a response.
- Data submitted is confidential.
- The % ECG measure plus one additional measure (either FMC to PCI or Arrival to Lytics measure) are REQUIRED for each application to be accepted and complete.
- When the denominator equals “0” – zero, enter "0".
- Review the inclusions and exclusions for each measure to assure appropriate patient population is accounted for in each of the three measures.
- Volume requirements are calculated prior to any applied exclusions.

- The SUBMIT button must be selected for the application to be formally submitted.
- Once submitted, a PDF copy of the submitted application is available for download and saving.

2015 Mission: Lifeline EMS Application Tools

- 2015 Guide to Mission: Lifeline EMS Recognition – comprehensive guide for EMS recognition with a glossary
- Helpful Preparation Worksheets - Tools to aid in coordinating follow up data with destination hospitals
- PDF Version of the Application– pdf version of the actual application that can be completed prior to starting the official online application
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If there are any questions prior to beginning this application, contact MissionLifeline@heart.org.

Are you ready to begin the 2015 Mission: Lifeline EMS Application?

- ○ YES (click the "Next" button in the lower right corner of your screen)
- ○ NOT YET (please close your browser window)

Select the Application that will be completed and submitted.

- ☑ Individual Application (Stand alone or Team option)
- ☑ Joint Application

INDIVIDUAL APPLICATION

* Please provide the contact and agency information of the individual who should receive the final Mission: Lifeline award notification.

First name	
Last name	
Title	
Agency/Department Name	
Street Address	
Street Address (Continued)	
City	
State (two-letter abbreviation)	
Zip code	
Primary Contact's Email address	
Secondary Email address	
Phone number	
Ambulance Agency State ID Number	
State (two-letter abbreviation) associated with above State ID #	

* Pre-hospital type: (select one)

- EMS Ground - Non-fire Department
- Air Ambulance
- Fire Department/EMS
- Medical First Responder (12 Lead Capable)

* The American Heart Association has permission to publish the award status of this agency. By providing this authorization, it will remain in effect until written notice is provided to the American Heart Association or until program participation has ended. Below are some examples of where the award status might be published:

· Recognition Events
· Advertisements
· Conference banners/signage
· AHA Websites, digital media, mobile apps

- AGREE (Please indicate (exactly how AHA should publish the agency's name):
- DO NOT AGREE

JOINT APPLICATION - Two ambulance agencies collaborate to complete the 12 lead acquisition and transport of the STEMI patient to the destination hospital.

* Please provide the contact and agency information of the individual who should receive the final Mission: Lifeline award notification and is associated with the FIRST of the two ambulance agencies submitting the Joint Application.

FIRST AGENCY

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First name	
Last name	
Title	
Agency/Department Name	
Street Address	
Street Address (Continued)	
City	
State (two-letter abbreviation)	
Zip code	
Primary Contact's Email address	
Secondary Email address	
Phone number	
Ambulance Agency State ID Number	
State (two-letter abbreviation) associated with above State ID #	

* Pre-hospital type for the FIRST of the two agencies submitting via the Joint Application: (select one)

- ○ EMS Ground - Non-fire Department
- ○ Air Ambulance
- ○ Fire Department/EMS
- ○ Medical First Responder (12 Lead Capable)

* The American Heart Association has permission to publish the award status of FIRST agency. By providing this authorization, it will remain in effect until written notice is provided to the American Heart Association or until program participation has ended. Below are some examples of where the award status might be published:

- Recognition Events
- Advertisements
- Conference banners/signage
- AHA Websites, digital media, mobile apps

- ○ AGREE (Please indicate (exactly how AHA should publish the FIRST agency's name):
- ○ DO NOT AGREE

* Please provide the contact and agency information of the individual who should receive the final Mission: Lifeline award notification and is associated with the **SECOND** of the two ambulance agencies submitting the Joint Application.

SECOND AGENCY

First name	
Last name	
Title	
Agency/Department Name	
Street Address	
Street Address (Continued)	
City	
State (two-letter abbreviation)	
Zip code	
Primary Contact's Email address	
Secondary Email address	
Phone number	
Ambulance Agency State ID Number	
State (two-letter abbreviation) associated with above State ID #	

* Pre-hospital type for the **SECOND** of the two agencies submitting via the Joint Application: (select one)

- ○ EMS Ground - Non-fire Department
- ○ Air Ambulance
- ○ Fire Department/EMS
- ○ Medical First Responder (12 Lead Capable)

* The American Heart Association has permission to publish the award status of SECOND agency. By providing this authorization, it will remain in effect until written notice is provided to the American Heart Association or until program participation has ended. Below are some examples of where the award status might be published:

- Recognition Events
- Advertisements
- Conference banners/signage
- AHA Websites, digital media, mobile apps

- ○ AGREE (Please indicate (exactly how AHA should publish the SECOND agency's name):
- ○ DO NOT AGREE

* Please select transport destination of the STEMI patients that will be reported for Mission:Lifeline Recognition: *(check all that apply)*

STEMI patients that are transported to a STEMI Referring Center when the STEMI patient is transferred for PCI <u>without</u> Fibrinolytic administration, are <u>NOT</u> to be included in either the FMC to PCI measure nor the Arrival to Lytics measure denominators.

- ☑ STEMI Receiving Center (PCI hospital)
- ☑ STEMI Referring Center (Non-PCI hospital)

Measure 1 – Percent 12 Lead ECG acquired
Inclusion Criteria: *Patients with non-traumatic chest pain, 35 years of age or over, and transported.*

** Questions with an asterisk (*) are mandatory.*
Enter a zero "0" when there is no data to report.

* DENOMINATOR - Report the total number of patients that meet the above inclusion criteria.

Number of Non-Traumatic Chest pain patients, 35 years of age and older, and transported to a hospital:

Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	0
Total	

* NUMERATOR - Report the number of patients, included above, that received a pre-hospital 12-Lead ECG.

Number of non-traumatic chest pain patients, 35 years and older and transported to a hospital that received a pre-hospital 12 lead ECG:

Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	0
Total	

NOTE : Check the numbers entered in for accuracy prior to clicking NEXT. The application does not allow the user to go back once the calculations are shown.

Patients with non-traumatic chest pain, 35 years and over, treated by EMS, who get a pre-hospital 12-lead ECG
The percentages are calculated below based on the numerators and denominators manually input on previous pages.

Quarter 1 Percentage: 0%

Quarter 2 Percentage: 0%

Quarter 3 Percentage: 0%

Quarter 4 Percentage: 0%

Annual Percentage: {Invalid Expression} / ${e://Field/Measure1AnnualTotalDenominator}) *100,1)}%

Measure 2 – Percent FMC (First Medical Contact) to Device Activation/Primary PCI in 90 minutes or less.

***Inclusion Criteria:* Patients 18 years of age or over, with a STEMI noted on pre-hospital ECG, AND transported to a STEMI Receiving Center AND Primary PCI was performed.**

**** Questions with an asterisk (*) are mandatory.***
Enter a zero "0" when there is no data to report.

* DENOMINATOR - Report the total number of patients that meet the above inclusion criteria.

Number of patients 18 years of age or older, with STEMI noted on pre-hospital ECG, who are transported directly to a STEMI Receiving Center AND who had Primary PCI performed:

Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	0
Total	

* NUMERATOR - Report the number of patients, included above, where the total time from FMC (first medical contact) to device activation/Primary PCI was achieved in *90 minutes or less*.

Number of patients where FMC to device activation/Primary PCI is 90 minutes or less:

Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	0
Total	

Outlier Volume – Report the number of patients, included in the denominator volumes above, where the total time from pre-hospital FMC to device activation/Primary PCI was **GREATER** than 90 minutes.

(Adding the Outlier volumes to the volumes reported in the Numerator will equal the volumes reported in the Denominator. Outlier Volume + Numerator Volume = Denominator Volume

Number of patients where FMC to device activation/Primary PCI is greater than 90 minutes:

Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	0
Total	

Exclusions – Of the patients reported in the Outlier volume, report the **number of patients** that experienced one or more of the following allowable exclusions.

- Delay caused by patient or family providing consent for treatment and/or transport
- Delay caused by patient experiencing cardiac arrest and/or the need for intubation
- Delay caused by difficulty in accessing femoral or radial artery (in the cath lab)
- Delay caused by difficulty in crossing the coronary lesion (in the cath lab)

· Only count the patient, not the number of allowable exclusions applied to the patient
Example- One patient with 4 applicable exclusions should be counted as "1".

· Exclusions must be documented in the patient record

· Exclusions may have occurred at any time between FMC and device activation

Number of outlier patients with at least one allowable exclusion:

Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	0
Total	

NOTE : Check the numbers entered in for accuracy prior to clicking NEXT. The application does not allow the user to go back once the calculations are shown.

STEMI patients transported directly to a STEMI receiving center, with pre-hospital first medical contact to device time in 90 minutes or more.

Quarter 1 Percentage: 0%

Quarter 2 Percentage: 0%

Quarter 3 Percentage: 0%

Quarter 4 Percentage: 0%

Annual Percentage: {Invalid Expression} / (${e://Field/Measure2AnnualTotalDenominator} - ${e://Field/Measure2AnnualTotalExclusions})) *100,1)}%

Measure 3 – Percent Arrival (to STEMI Referring Center) to Fibrinolytic Administration in 30 minutes or less.

Inclusion Criteria: *Patients that are 18 years of age or over, with a STEMI noted on Pre-Hospital ECG, transported to a STEMI Referring Center AND Fibrinolytic Therapy was administered.*

**** Questions with an asterisk (*) are mandatory.***
Enter a zero "0" when there is no data to report.

* DENOMINATOR - Report the number of patients that meet the above inclusion criteria.

Number of patients 18 years of age or older, with STEMI noted on pre-hospital ECG, who are transported directly to a STEMI Referring center AND had fibrinolytic therapy administered:

Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	0
Total	

* NUMERATOR - Report the number of patients, included above, where the total time from Arrival to the STEMI Referring center and the time of Fibrinolytic Therapy Administration was achieved in 30 minutes or less.

Number of patients with time of arrival to fibrinolytic therapy administration in 30 minutes or less:

Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	0
Total	

Outlier Volume – Report the number of patients, included in the denominator volumes above, where the total time from arrival at the Referring center to fibrinolytic administration was greater than 30 minutes.
(Adding the Outlier volumes to the volumes reported in the Numerator will equal the volumes reported in the Denominator. Outlier Volume + Numerator Volume = Denominator Volume

Number of patients where Arrival to Lytics is greater than 90 minutes:

Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	0
Total	

Exclusions – Of the patients reported in the Outlier volume, report the **number of patients** that experienced one or more of the following allowable exclusions.

- Delay caused by patient or family providing consent for treatment and/or transport
- Delay caused by patient experiencing cardiac arrest and/or the need for intubation

- Only count the patient, not the number of allowable exclusions applied to the patient
  Example- One patient with 2 applicable exclusions should be counted as "1".
- Exclusions must be documented in the patient record
- Exclusions may have occurred at any time between FMC and device activation

Number of outlier patients with at least one allowable exclusion:

Quarter 1	0
Quarter 2	0
Quarter 3	0
Quarter 4	0
Total	

NOTE : Check the numbers entered in for accuracy prior to clicking NEXT. The application does not allow the user to go back once the calculations are shown.

Fibrinolytic eligible STEMI patients treated and transported to a referring center for fibrinolytic therapy with a door to needle time in 30 minutes or less:

We've calculated the percentages below based on the numerators and denominators you input on previous pages.

Quarter 1 Percentage: 0%

Quarter 2 Percentage: 0%

Quarter 3 Percentage: 0%

Quarter 4 Percentage: 0%

Annual Percentage: {Invalid Expression} / (${e://Field/Measure3AnnualTotalDenominator} - ${e://Field/Measure3AnnualTotalExclusions})) *100,1)}%

At this time, the primary service applicant can list all partnering Medical First Responder Agencies/Departments that assist with calls that involve a possible STEMI patient, regardless of the assisting department's ability to acquire a 12 lead ECG, level of certification or their ability to transport.

Would you like to include the names and contact information of these Medical First Responding Agencies/Departments and enter the TEAM option of the EMS recognition application?

- (•) YES
- ( ) NO

Are there any additional Medical First Responder Agencies/Departments you would like to include in the TEAM option of the Individual Application?

- (•) Yes
- ( ) No

How many agencies are going to be included in the Team portion of the application?

10

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY 1

Medical First Responder Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY 2

Medical First Responder Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY 3

Medical First Responder Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY 4

Medical First Responder Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY 5

Medical First Responder Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY 6

Medical First Responder Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY 7

Medical First Responder Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY 8

Medical First Responder Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY 9

Medical First Responder Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY 10

Medical First Responder Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

How many additional agencies will be included in the Team portion of the application?

10

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY +1}

Medical First Response Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY +2}

Medical First Response Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY +3}

Medical First Response Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY +4}

Medical First Response Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY +5}

Medical First Response Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY +6}

Medical First Response Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY +7}

Medical First Response Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY +8}

Medical First Response Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY +9}

Medical First Response Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

TEAM APPLICATION

* Please provide the name of the Medical First Responder agencies/departments below.

MEDICAL FIRST RESPONDER AGENCY +10}

Medical First Response Agency/Department Name	
City	
State (two-letter abbreviation)	
Contact's First name	
Contact's Last name	
Contact's Title	
Email address	

Application Submission Authorization

The 2015 Mission: Lifeline EMS Recognition Application submission must be authorized by either the EMS Director, Chief or Training Officer from the Ambulance agency(ies)

I attest that the above information is true and complete to the best of my knowledge. As the submitter of this INDIVIDUAL application, I am authorized to release the above information to the American Heart Association on behalf of this Ambulance agency. I understand the American Heart Association will review the information I have submitted for correctness and will assign the proper award status based on the program criteria.

- Agree
- Disagree

Application Submission Authorization

The 2015 Mission: Lifeline EMS Recognition Application submission must be authorized by either the EMS Director, Chief or Training Officer from the Ambulance agency(ies)

I attest that the above information is true and complete to the best of my knowledge. As the submitter of this JOINT application, I am authorized to release the above information to the American Heart Association on behalf of both Ambulance agencies included in this application. I understand the American Heart Association will review the information I have submitted for correctness and will assign the proper award status based on the program criteria.

- Agree
- Disagree

* Please provide the name and contact information of the medical director of the agency submitting an Individual Application.

First name	
Last name	
Title	
Contact phone number	
Street address	
Street address (continued)	
City	
State (two-letter abbreviation)	
Zip code	
Email address	

* Please provide the name and contact information of the medical director of the FIRST of two agencies submitting a Joint Application.

First name	
Last name	
Title	
Contact phone number	
Street address	
Street address (continued)	
City	
State (two-letter abbreviation)	
Zip code	
Email address	

* Please provide the name and contact information of the medical director of the SECOND of two agencies submitting a Joint Application.

First name	
Last name	
Title	
Contact phone number	
Street address	
Street address (continued)	
City	
State (two-letter abbreviation)	
Zip code	
Email address	

* Please provide the name and contact information of the person completing and submitting this form.

First name	
Last name	
Title	
Contact phone number	
Email address	

* Please type your name below:

E Signature	

* Please provide the name of the person, representing the co-applicant agency, who authorized the completion and submission of this 2015 Mission: Lifeline Recognition Application by the person named above.

First name	
Last name	
Title	
Date (mm/dd/yyyy)	
Contact phone number	
Email address	