

VHA EXTERNAL PEER REVIEW PROGRAM  
PNEUMONIA INSTRUMENT  
VALIDATION MODULE  
Third Quarter FY2014

#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		<b>Organizational Identifiers</b>		
	VAMC CONTROL QIC BEGDTE REVDTE	Facility ID Control Number Abstractor ID Abstraction Begin Date Abstraction End Date	Auto-fill Auto-fill Auto-fill Auto-fill Auto-fill	
		<b>Patient Identifiers</b>		
	SSN PTNAMEF PTNAMEL BIRTHDT SEX MARISTAT RACE	Patient SSN First Name Last Name Birth Date Sex Marital Status Race	Auto-fill: no change Auto-fill: no change Auto-fill: no change Auto-fill: no change Auto-fill: can change Auto-fill: no change Auto-fill: no change	
1	arrvdate	Enter the <b>earliest</b> documented date the patient arrived at acute care at this VAMC.	mm/dd/yyyy  Abstractor may enter 99/99/9999 if arrival date is unable to be determined  <div style="border: 1px solid black; padding: 2px; width: fit-content;"> &lt; = 6 mos prior to or = admdt and &lt; = leftdate </div> <div style="border: 1px solid black; padding: 2px; width: fit-content; margin-top: 5px;"> Warning if &gt; 3 days prior to admdt </div>	<p><b>Arrival date is the earliest recorded date on which the patient arrived in the hospital's acute care setting where care for pneumonia could be most appropriately provided.</b> Arrival date may differ from admission date.</p> <p><b>ONLY ACCEPTABLE SOURCES:</b> Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); Nursing admission assessment/admitting note; Observation record; Procedure notes (such as cardiac cath, endoscopies, surgical procedures); Vital signs graphic record</p> <ul style="list-style-type: none"> <li>Review the <b>ONLY ACCEPTABLE SOURCES</b> to determine the earliest date the patient arrived at the ED, nursing floor, observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab for a direct admit.</li> <li>If the patient was transferred from your hospital's satellite/free-standing ED</li> </ul>

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				<p>or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival date at the first facility.</p> <ul style="list-style-type: none"> <li>Arrival date should NOT be abstracted simply as the earliest date in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE SOURCES, if the earliest date documented appears to be an obvious error, this date should not be abstracted. EXAMPLE: ED MAR has a med documented as 1430 on 11-03-20xx. All other dates in ED record are 12-03-20xx. The 11-03-20xx would not be used because it appears to be an obvious error.</li> <li>For Observation Status: <ul style="list-style-type: none"> <li>If the patient was admitted to observation from the ED of the hospital, use the date the patient arrived at the ED.</li> <li>If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient arrived at the ED or on the floor for observation care.</li> </ul> </li> <li>If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the date the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival date.</li> <li>For Direct Admits: <ul style="list-style-type: none"> <li>If the patient is a "Direct Admit" to the cath lab, use the earliest date the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival date.</li> <li>For "Direct Admits" to acute inpatient or observation, use the earliest date the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival date.</li> </ul> </li> </ul> <p>Timing of antibiotic administration begins with arrival date and time at acute care, not at Urgent Care unless Urgent Care is the ED or an integral part of the acute care VAMC.</p> <p>If unable to determine the date of arrival, enter default 99/99/9999. If the</p>

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				arrival date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999.
2	arrvtime	Enter the <b>earliest</b> documented time the patient arrived at acute care at this VAMC.	<div style="text-align: center;">_____ UMT</div> <p>If unable to find the time of arrival, the abstractor can enter <b>99:99</b></p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">           &lt; = 6 mos prior to or = admdt/pneadmtm and &lt; leftdate/leftime         </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;">           Warning if &gt;72 hours prior to admdt/pneadmtm         </div>	<p><b>Arrival time is the earliest recorded time the patient arrived in this hospital's acute care setting where care for pneumonia could be most appropriately provided. Arrival time may differ from admission time. ONLY ACCEPTABLE SOURCES:</b> Emergency Department record (includes ED Face Sheet, Consent/Authorization for treatment forms, Registration/sign-in forms, vital sign record, triage record, physician orders, ECG reports, telemetry/rhythm strips, laboratory reports, x-ray reports); Nursing admission assessment/admitting note; Observation record; Procedure notes (such as cardiac cath, endoscopies, surgical procedures); Vital signs graphic record</p> <ul style="list-style-type: none"> <li>• Review the <b>ONLY ACCEPTABLE SOURCES</b> to determine the earliest time the patient arrived at the ED, nursing floor, observation, or as a direct admit to the cath lab. The intent is to utilize any documentation which reflects processes that occurred after arrival at the ED or after arrival to the nursing floor/observation/cath lab as a direct admit.</li> <li>• If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient), and there is one medical record for the care provided at both facilities, use the arrival time at the first facility.</li> <li>• Arrival time should NOT be abstracted simply as the earliest time in one of the ONLY ACCEPTABLE SOURCES, without regard to other substantiating documentation. When looking at the ONLY ACCEPTABLE SOURCES, if the earliest time documented appears to be an obvious error, this time should not be abstracted. EXAMPLE: ED face sheet lists arrival time 1320, ED registration 1325, ED triage 1330. ED consent to treat form has 1:17 with "AM" circled. ED record documentation suggests the 1:17 AM is an obvious error. Enter 1320 for Arrival Time.</li> <li>• For Observation Status:</li> </ul>

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				<ul style="list-style-type: none"> <li>◦ If the patient was admitted to observation from the ED of the hospital, use the time the patient arrived at the ED.</li> <li>◦ If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient arrived at the ED or on the floor for observation care.</li> <li>• If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) or a SNF unit of the hospital, and is subsequently admitted to acute inpatient, use the time the patient presents to the ED or arrives on the floor for acute inpatient care as the arrival time. <ul style="list-style-type: none"> <li>◦ If the time the patient arrived on the floor is not documented by the nurse, enter the admission time recorded in EADT.</li> </ul> </li> <li>• For Direct Admits: <ul style="list-style-type: none"> <li>◦ If the patient is a "Direct Admit" to the cath lab, use the earliest time the patient arrived at the cath lab (or cath lab staging/holding area) as the arrival time.</li> <li>◦ For "Direct Admits" to acute inpatient or observation, use the earliest time the patient arrived at the nursing floor or in observation (as documented in the ONLY ACCEPTABLE SOURCES) as the arrival time.</li> </ul> </li> </ul> <p>Timing of antibiotic administration begins with arrival date and time at acute care, not at Urgent Care unless Urgent Care is the ED or an integral part of the acute care VAMC.</p> <p><b>If unable to determine the time of arrival, enter default time 99:99.</b> If the arrival time documented in the record is obviously in error (e.g. 33:00) and no other documentation is found that provides this information, enter 99:99.</p>

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3	admdt	Date of admission to acute inpatient care:	mm/dd/yyyy <b>Auto-filled: can be modified</b> <div>&gt; = arrvdate and &lt; = leftdate</div>	<b>Auto-filled; can be modified if abstractor determines that the date is incorrect.</b> <ul style="list-style-type: none"> <li>Admission date is the date the patient was actually admitted to acute inpatient care.</li> <li>For patients who are admitted to Observation status and subsequently admitted to acute inpatient care, abstract the date that the determination was made to admit to acute inpatient care and the order was written. Do not abstract the date that the patient was admitted to Observation.</li> <li>If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted.</li> <li>The admission date should not be abstracted from the earliest admission order without regards to substantiating documentation. If documentation suggests that the earliest admission order does not reflect the date the patient was admitted to inpatient care, this date should not be used.</li> </ul> <b>Exclusion:</b> Admit to observation, Arrival date <b>ONLY ALLOWABLE SOURCES:</b> Physician orders (priority data source), Face Sheet
4	pneadmtn	Time of admission to acute inpatient care:	____ UMT <b>Auto-filled: can be modified</b> <div>&gt; = arrvdate/arrvtime and &lt; leftdate/leftime</div>	<b>Auto-filled; can be modified</b> Abstractor to verify admission time is correct. <b>Admission time = time when the patient was formally admitted to inpatient status.</b> <b>Exclusion:</b> Admit to observation time, Arrival time If correction is necessary, enter time in Universal Military Time.
5	leftdate	Discharge date:	mm/dd/yyyy <b>Auto-filled: cannot be modified</b> > = admdt	Auto-filled; cannot be modified The computer auto-fills the discharge date from the OABI pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed.

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6	leftime	Time of discharge:	<div> <div>_____</div> <div>UMT</div> <div>&gt; admtdt/pneadmtm</div> </div>	<p><b>Does not auto-fill. Discharge time must be entered.</b></p> <p><b>Includes the time the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.</b></p> <p>If the patient expired, use the time of death as the discharge time.</p> <p><b>Suggested sources for patient who expire:</b></p> <p>Death record, resuscitation record, physician progress notes, physician orders, nurses notes</p> <p><b>For other patients:</b></p> <p>If the time of discharge is NOT documented in the nurses notes, discharge/transfer form, or progress notes, enter the discharge time documented in EADT under the "Reports Tab."</p> <p>Enter time in Universal Military Time: a 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.</p> <p>Converting time to military time:</p> <p>If time is in the a.m., no conversion is required.</p> <p>If time is the p.m., add 12 to the clock hour time.</p>

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7	entrprin	Enter the ICD-9-CM principal diagnosis code:	<p>__ __ __. __ __ (3 digits/decimal point/two digits)</p> <div> <p><b>Cannot enter 000.00, 123.45, or 999.99</b></p> </div> <p><b>*If code is not listed in JC Appendix A, Table 3.1, Table 3.2, or Table 3.3, the record is excluded.</b></p>	<p><b>Will auto-fill from PTF with ability to change. Do NOT change the principal diagnosis code <u>unless</u> the principal diagnosis code documented in the record is not the code displayed in the software.</b></p> <ul style="list-style-type: none"> <li>Principal diagnosis code must be one of the codes listed in Joint Commission Appendix A: Table 3.1 Pneumonia Codes, Table 3.2 Septicemia Codes, or Table 3.3 Respiratory Failure Codes.</li> <li>If the pneumonia, septicemia, or respiratory failure diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," coding conventions dictate that this terminology be coded as if the diagnosis existed or was established.</li> <li>Unacceptable pneumonia diagnosis qualifiers: Could be, could have been, risk of, subtle.</li> </ul> <p><b><u>Exclusion Statement:</u></b> Although coding designated the case for inclusion in the Joint Commission Pneumonia National Hospital Inpatient Quality Measures population, documentation in the record does not confirm an ICD-9-CM principal diagnosis code of pneumonia, septicemia, or respiratory failure.</p>

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8	pneothdx1 pneothdx2 pneothdx3 pneothdx4 pneothdx5 pneothdx12 pneothdx7 pneothdx8 pneothdx9 pneothdx10 pneothdx11 pneothdx6	Enter the ICD-9-CM other diagnosis codes:	_____.____ (3 digits/decimal point/two digits) <b>Can enter 12 codes</b> <div style="border: 1px solid black; padding: 5px; text-align: center;"> <b>Cannot enter 000.00, 123.45, or 999.99</b> </div> <div style="border: 1px solid black; padding: 5px; text-align: center;"> <b>Abstractor can enter xxx.xx in code field if no other dx found</b> </div> <b>If entrprin is a code from JC Table 3.2 or Table 3.3, a code from Table 3.1 must be entered in pneothdx or the record is excluded.</b> <b>If pneothdx is a code from JC Table 3.4, the record is excluded.</b>	<p><b>Can enter 12 ICD-9-CM other diagnosis codes. Will auto-fill from the PTF with ability to change. If the "other diagnoses" codes are incorrect, enter the codes as documented in the medical record.</b></p> <p>If entered manually, use the codes listed in discharge diagnosis (DD) under the reports tab.</p> <ul style="list-style-type: none"> <li>Any order in which pneumonia is noted in the listing of discharge diagnoses is acceptable.</li> <li>If the principal diagnosis is a code from Joint Commission Table 3.2 (Septicemia) or Table 3.3 (Respiratory Failure), then a code from Table 3.1 (Pneumonia) must be a secondary diagnosis entered in pneothdx; otherwise, the record will be excluded from review.</li> <li>If the pneumonia diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," coding conventions dictate that this terminology be coded as pneumonia and is an acceptable diagnosis of pneumonia (code the pneumonia as if it existed or was established).</li> <li>Unacceptable pneumonia diagnosis qualifiers: Could be, could have been, risk of, subtle.</li> </ul> <p>Enter xxx.xx in code field if no other diagnoses codes exist for this record.</p> <p><b><u>Exclusion Statement:</u></b></p> <p><b>Although coding designated the case for inclusion in the Joint Commission Pneumonia National Hospital Inpatient Quality Measures population, documentation in the record does not confirm pneumonia as the ICD-9-CM principal diagnosis code or other diagnosis code secondary to septicemia or respiratory failure.</b></p> <p><b><u>Exclusion Statement:</u> If an ICD-9-CM code from Joint Commission Table 3.4 (Appendix A) is entered in pneothdx, the case is excluded.</b></p>



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9	pnepxdt pnepxcd	<p>Enter the ICD-9-CM principal procedure code and date.</p> <p style="text-align: center;">Code Date</p> <div style="display: flex; justify-content: center; align-items: center;"> <div style="border: 1px solid black; padding: 2px 10px; margin-right: 5px;">           _____.____         </div> <div style="border: 1px solid black; padding: 2px 10px;">           ____/____/____         </div> </div>	<p style="text-align: center;">____. ____</p> <p><b>If there is no principal procedure, the abstractor can enter xx.xx in code field and 99/99/9999 in date field</b></p> <div style="border: 1px solid black; padding: 2px; text-align: center;"> <b>Cannot enter 00.00</b> </div> <p style="text-align: center;">mm/dd/yyyy</p> <p><b>Abstractor can enter 99/99/9999</b></p> <p><b>If there is no principal procedure, auto-fill othrpdx and otherpxdt with xx.xx and 99/99/9999</b></p> <div style="border: 1px solid black; padding: 2px; text-align: center;"> <b>&gt; = admtdt and &lt; = leftdate</b> </div>	<p><b>Principal procedure= that procedure performed for definitive treatment, rather than for diagnostic or exploratory reasons, or was necessary to treat a complication. The principal procedure is related to the principal diagnosis and needs to be accurately identified.</b></p> <ul style="list-style-type: none"> <li>VA records do not identify the principal procedure; use the above definition of principal procedure to determine the correct code to enter if there are multiple procedures during the episode of care. Ask for assistance from your RM or WVMI if you are uncertain.</li> </ul> <p><b>If no procedure was performed during the episode of care, fill ICD-9-CM code field with default code xx.xx. Do not enter 99.99 or 00.00 to indicate no procedure was performed.</b></p> <p><b>Date of the principal procedure is to be filled with 99/99/9999 if no procedure was performed.</b></p> <p>If the principal procedure date is unable to be determined from the medical record documentation, or the date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999.</p>

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10	othrpx1 othrpx2 othrpx3 othrpx4 othrpxdts5 othrpxdts1 othrpxdts2 othrpxdts3 othrpxdts4 othrpx5	Enter the ICD-9-CM other procedure codes and dates.  Code Date  <div> <div> <div> <div></div> <div></div> <div></div> </div> <div> <div></div> <div></div> <div></div> </div> </div> <div> <div></div> <div></div> <div></div> </div> </div>	<div> <div> <div> <div></div> <div></div> <div></div> </div> <div> <div></div> <div></div> <div></div> </div> </div> <div> <div> <div> <div></div> <div></div> <div></div> </div> <div> <div></div> <div></div> <div></div> </div> </div> <div> <div> <div> <div></div> <div></div> <div></div> </div> <div> <div></div> <div></div> <div></div> </div> </div> <div> <div> <div> <div></div> <div></div> <div></div> </div> <div> <div></div> <div></div> <div></div> </div> </div> <div> <div> <div> <div></div> <div></div> <div></div> </div> <div> <div></div> <div></div> <div></div> </div> </div> </div> </div> </div></div></div>	<p><b>Can enter 5 procedure codes, other than the principal procedure code.</b> Enter the ICD-9-CM codes and dates corresponding to each of the procedures performed, beginning with the procedure performed most immediately following the admission.</p> <ul style="list-style-type: none"> <li>• If no other procedures were performed, enter default code xx.xx in the code field and default date 99/99/9999 in the date field.</li> <li>• If no other procedure was performed, it is only necessary to complete the xx.xx and 99/99/9999 default entries for the first code and date. It is not necessary to complete the default entry five times.</li> <li>• If the date of a procedure is unable to be determined from the medical record documentation, or if the procedure date documented in the record is obviously in error (e.g. 02/42/20XX) and no other documentation is found that provides this information, enter 99/99/9999.</li> </ul>
11	adm24icu	Was the patient admitted or transferred to the intensive care unit at this VAMC within the first 24 hours following arrival at this hospital? 1. Yes 2. No 99. Unable to determine	1, 2, 99	<p>The definition of an ICU for the purpose of this review is that used by the CDC in the NHSN Patient Safety Project. An intensive care unit can be defined as a nursing care area that provides intensive observation, diagnosis, and therapeutic procedures for adults and/or children who are critically ill. An ICU excludes nursing areas that provide step-down, intermediate care or telemetry only and specialty care areas.</p> <p><b>ONLY ACCEPTABLE DATA Source: Physician orders. Other data sources may be used to support admission or transfer to ICU only.</b></p> <ul style="list-style-type: none"> <li>• In order to select "1" for this data element there must be a physician order for admission or transfer to an ICU <b>AND</b> documentation that the patient was transferred or admitted to the ICU care within 24 hours following hospital arrival.</li> <li>• The 24-hour timeframe relates to the time from hospital arrival to arrival in the ICU unit, not the time of the physician order to admit or transfer to the ICU.</li> </ul>

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				<ul style="list-style-type: none"> <li>• If documentation reflects ICU graphic sheets or ICU nursing notes and there is no physician order for ICU, select "2".</li> <li>• <b>If other pneumonia related reasons for transfer or admission to ICU, such as septic shock, respiratory distress or failure, hypotension, tachypnea, hypoxemia, or the need for a ventilator are documented, select "1."</b></li> <li>• <b>Any time spent in the ICU within the first 24 hours after arrival is included.</b></li> <li>• If there is no other documented reason why the patient was transferred/admitted to the ICU assume it was for complications due to pneumonia and select "1."</li> <li>• If there is an order for ICU, but the patient was not moved to an ICU because the patient's condition changed and did not require an ICU level of care, select "2". However, if the patient is not moved to an ICU unit due to lack of a bed, select "1."</li> <li>• <b>If the patient was admitted or transferred to the ICU within the first 24 hours after arrival for reasons other than complications due to pneumonia, answer "2" to the question.</b> <b>For example, a patient presents to the ED with pneumonia and shortly after arrival has a GI bleed or a cardiac arrhythmia or the ICU is the only place with monitored beds (e.g. tele-boarder), enter "2."</b></li> </ul> <p>Do not use abstractor judgment based on the type of care administered to the patient. The level of intensive care <b>MUST</b> be documented. Direct admits, admissions via the ED, or transfers from lower level of inpatient care are included. Do <b>not</b> include PCU unless identified as a Pulmonary Care Unit.</p> <p><b>Exclude:</b></p> <ul style="list-style-type: none"> <li>• ED, OR, or procedure units as inpatient units</li> <li>• <b>Intermediate care unit (IMCU)</b> Step down unit: <ul style="list-style-type: none"> <li>◦ A post critical care unit for patients that are hemodynamically stable who can benefit from close supervision and monitoring such as frequent pulmonary toilet, vital signs, and/or neurological and neurovascular checks.</li> </ul> </li> </ul>

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				<ul style="list-style-type: none"> <li>◦ Inpatient units with telemetry monitoring that are not intensive care units</li> <li>◦ Post coronary care unit (PCCU)</li> <li>◦ Specialty Care Units (e.g. bone marrow transplant, inpatient solid organ transplant, acute inpatient dialysis, hematology/oncology, long term acute care.</li> </ul>
12	dcdispo	<p>What was the patient's discharge disposition on the day of discharge?</p> <p>1. Home</p> <ul style="list-style-type: none"> <li>◦ Assisted Living Facilities (ALFs) - includes assisted living care at nursing home/facility</li> <li>◦ Court/Law Enforcement - includes detention facilities, jails, and prison</li> <li>◦ Home - includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, and homeless shelters</li> <li>◦ Home with Home Health Services</li> <li>◦ Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization</li> </ul> <p>2. Hospice - Home (or other home setting as listed in #1 above)</p> <p>3. Hospice - Health Care Facility</p> <ul style="list-style-type: none"> <li>◦ General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities</li> </ul> <p>4. Acute Care Facility</p> <ul style="list-style-type: none"> <li>◦ Acute Short Term General and Critical Access Hospitals</li> <li>◦ Cancer and Children's Hospitals</li> <li>◦ Department of Defense and Veteran's</li> </ul>	1, 2, 3, 4, 5, 6, 7, 99	<p><b>Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.</b></p> <ul style="list-style-type: none"> <li>• <b>Only use documentation written on the day prior to discharge or the day of discharge when abstracting this data element.</b> For example: Discharge planning notes on 04-01-20xx document the patient will be discharged back home. On 04-06-20xx, the nursing discharge notes on the day of discharge indicate the patient was being transferred to skilled care. Enter "5".</li> <li>• <b>Discharge disposition documentation in the discharge summary, post-discharge addendum, or a late entry, may be considered if written within 30 days after discharge date and prior to pull list date.</b></li> <li>• <b>If there is documentation that further clarifies the level of care, that documentation should be used to determine the correct value to abstract. If documentation is contradictory, use the latest documentation.</b> For example: Discharge planner note from day before discharge states "XYZ Nursing Home". Nursing discharge note on day of discharge states "Discharged: Home." Select "1".</li> <li>• If documentation is contradictory, and you are unable to determine the latest documentation, select the disposition ranked highest (top to bottom) in the following list. <ul style="list-style-type: none"> <li>◦ Acute Care Facility</li> <li>◦ Hospice - Health Care Facility</li> <li>◦ Hospice - Home</li> <li>◦ Other Health Care Facility</li> <li>◦ Home</li> </ul> </li> <li>• Values "2" and "3" hospice includes discharges with hospice referrals and</li> </ul>

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		<p>Administration Hospitals</p> <p>5. Other Health Care Facility</p> <ul style="list-style-type: none"> <li>◦ Extended or Immediate Care Facility (ECF/ICF)</li> <li>◦ Long Term Acute Care Hospital (LTACH)</li> <li>◦ Nursing Home or Facility including Veteran's Administration Nursing Facility</li> <li>◦ Psychiatric Hospital or Psychiatric Unit of a Hospital</li> <li>◦ Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital</li> <li>◦ Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed</li> <li>◦ Transitional Care Unit (TCU)</li> <li>◦ Veteran's Home</li> </ul> <p>6. Expired</p> <p>7. Left Against Medical Advice/AMA</p> <p>99. Not documented or unable to determine</p>		<p>evaluations</p> <ul style="list-style-type: none"> <li>• If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select "4".</li> <li>• If the medical record identifies the facility the patient is being discharged to by name only (e.g., Park Meadows) and does not reflect the type of facility of level of care, select "5".</li> <li>• If the medical record states only that the patient is being discharged and does not address the place or setting to which the patient was discharged, select "1".</li> <li>• Selection of option "7" (left AMA): <ul style="list-style-type: none"> <li>◦ Explicit "left against medical advice" documentation is not required (e.g., "Patient is refusing to stay for continued care"- select "7"). <b>For the purposes of this data element, a signed AMA form is not required.</b></li> <li>◦ If any source states the patient left against medical advice, select value "7", regardless of whether the AMA documentation was written last.</li> <li>◦ Documentation suggesting that the patient left before discharge instructions could be given without "left AMA" documentation does not count.</li> </ul> </li> </ul> <p><b>Excluded Data Sources:</b> Any documentation prior to the last two days of hospitalization, coding documents</p> <p><b>Suggested Data Sources:</b> Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record</p>

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13	cxrdone	<p>Did the patient have a chest x-ray or CT scan on the day of or the day prior to hospital arrival OR anytime during this hospital stay?</p> <p>1. Yes 2. No</p>	<p>1, *2</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p><b>If 2, Warning:</b> Are you certain the patient did not have a chest x-ray/CT scan within the timeframe?</p> </div> <p>*If 2, the record is excluded from the JC PN Hospital Inpatient Quality Measures population</p> <p>(Partial abstraction only)</p> <p>If cxrdone =2, go to end</p>	<p><b>If there is documentation the patient had a chest x-ray or CT scan <u>on the day of or day prior to hospital arrival OR anytime during this hospital stay</u>, select "1."</b></p> <p>CT scan = chest CT or abdominal CT that includes lung field findings</p> <p><b><u>Exclusion Statement:</u></b></p> <p><b>Lack of a chest x-ray or CT scan on the day of or day prior to arrival or during hospitalization excludes the case from the Joint Commission PN Hospital Inpatient Quality Measures.</b></p>
14	cxretabn	<p><b><u>Using the inclusion list</u></b>, was any chest x-ray or CT scan obtained the day of or day prior to hospital arrival OR anytime during this hospital stay <b><u>abnormal</u></b>?</p> <p><b>(SEE INCLUSION LIST)</b></p> <p>1. Yes, <b>a chest x-ray or CT scan done within the designated timeframe was abnormal</b> (included ANY inclusion terms).</p> <p>2. No, a chest x-ray/CT scan done within the designated timeframe <b>was not abnormal</b> (did not include ANY inclusion terms).</p> <p>99. Unable to determine from medical record documentation if the chest x-ray or CT scan done during the designated timeframe was abnormal</p>	<p>1, *2, *99</p> <p>*If 2 or 99, the record is excluded from the JC PN Hospital Inpatient Quality Measures population</p> <p>(Partial abstraction only)</p> <p>If cxretabn = 2 or 99 go to end</p>	<p><b>Read ALL options carefully.</b></p> <ul style="list-style-type: none"> <li>• Use the priority order for the Suggested Data Sources to review the medical record for documentation of acceptable terms from the Inclusion list.</li> <li>• If an Inclusion term is found in the x-ray/CT scan <u>interpretation</u> performed on the day of or the day prior to arrival or anytime during the hospital stay, select "1." Do not use the history or indication portion of the chest x-ray or CT scan.</li> <li>• If an inclusion term is not found after reviewing the prioritized suggested sources, continue to review the medical record for physician/APN/PA documentation of Inclusion terms.</li> <li>• If the only findings in the x-ray/CT scan report or physician/APN/PA documentation are chronic or normal, select "2." If the ONLY</li> </ul>

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES																												
				<p>documentation of an inclusion is prefaced with wording such as "no significant" or "no definite", select "2."</p> <p><b>Inclusion List (ONLY accepted terms)</b></p> <table><tr><td>Airspace disease</td><td>Interstitial process</td></tr><tr><td>Airspace process</td><td>Interstitial pneumonia</td></tr><tr><td>Air Bronchogram</td><td>Interstitial prominence</td></tr><tr><td>Bronchopneumonia</td><td>Haziness, hazy</td></tr><tr><td>Consolidation, consolidative process</td><td>Lung Process</td></tr><tr><td>Density, dense</td><td>Markings</td></tr><tr><td>Infection, infectious process</td><td>Opacity, opacification</td></tr><tr><td>Infiltrate, infiltration</td><td>Patchiness, patchy</td></tr><tr><td>Infiltrative process</td><td>Pneumonia</td></tr><tr><td>Inflammation, inflammatory process</td><td>Pneumonic process</td></tr><tr><td>Interstitial changes</td><td>Pneumonitis</td></tr><tr><td>Interstitial disease</td><td>Positive infiltrate</td></tr><tr><td>Interstitial edema</td><td>Pulmonary process</td></tr><tr><td>Interstitial fibrosis</td><td>Reticulonodular pattern</td></tr></table> <p><b>RECOMMENDED ORDER FOR SUGGESTED DATA SOURCES (Physician/APN/PA documentation only):</b></p>	Airspace disease	Interstitial process	Airspace process	Interstitial pneumonia	Air Bronchogram	Interstitial prominence	Bronchopneumonia	Haziness, hazy	Consolidation, consolidative process	Lung Process	Density, dense	Markings	Infection, infectious process	Opacity, opacification	Infiltrate, infiltration	Patchiness, patchy	Infiltrative process	Pneumonia	Inflammation, inflammatory process	Pneumonic process	Interstitial changes	Pneumonitis	Interstitial disease	Positive infiltrate	Interstitial edema	Pulmonary process	Interstitial fibrosis	Reticulonodular pattern
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				<div>1. Chest x-ray report (Regular and portable chest x-ray results are acceptable.)</div> <div>2. Chest CT scan report</div> <div>3. Other x-ray or CT scan with lung field findings (e.g., "infiltrate" listed as a finding in an abdominal CT scan report is acceptable).</div> <div>4. Physician's notes</div> <div>5. History and Physical</div> <div>6. Remainder of current hospital record</div> <div>Exclusion Statement:</div> <div>Lack of abnormal chest x-ray or CT scan within 24 hours prior to arrival or during hospitalization excludes the case from the Joint Commission PN Inpatient Hospital Quality Measures.</div>												
15	comfort	<div>When is the earliest physician, APN, or PA documentation of comfort measures only?</div> <div>1. Day of arrival (day 0) or day after arrival (day 1)</div> <div>2. Two or more days after arrival (day 2 or greater)</div> <div>3. Comfort measures only documented during hospital stay, but timing unclear</div> <div>99. Comfort measures only was not documented by the physician/APN/PA or unable to determine</div>	<div>*1, 2, 3, 99</div> <div>*If 1, the case is excluded from the JC PN Hospital Inpatient Quality Measures; Fall Assessment is applicable</div> <div>Warning if comfort = 2</div>	<div>Comfort Measures Only: refers to medical treatment of a dying person where the natural dying process is permitted to occur while assuring maximum comfort. It includes attention to the psychological and spiritual needs of the patient and support for both the dying patient and the patient's family. Comfort Measures Only is commonly referred to as "comfort care" by the general public. It is not equivalent to a physician order to withhold emergency resuscitative measures such as Do Not Resuscitate (DNR).</div> <div>Only accept terms identified in the list of inclusions. No other terminology will be accepted. Day of arrival is day 0.</div> <div>Inclusion (Only acceptable terms)</div> <table><tr><td>Brain death/dead</td><td>End of life care</td></tr><tr><td>Comfort care</td><td>Hospice</td></tr><tr><td>Comfort measures</td><td>Hospice care</td></tr><tr><td>Comfort measures only (CMO)</td><td>Organ harvest</td></tr><tr><td>Comfort only</td><td>Terminal care</td></tr><tr><td>DNR-CC</td><td></td></tr></table>	Brain death/dead	End of life care	Comfort care	Hospice	Comfort measures	Hospice care	Comfort measures only (CMO)	Organ harvest	Comfort only	Terminal care	DNR-CC	
Brain death/dead	End of life care															
Comfort care	Hospice															
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				<ul style="list-style-type: none"> <li>• <b>Determine the <u>earliest</u> day the physician/APN/PA DOCUMENTED comfort measures only in the ONLY ACCEPTABLE SOURCES.</b> Do not factor in when comfort measures only was actually instituted. Example: "Discussed comfort care with family on arrival" noted in day 2 progress note - Select "2."</li> <li>• <b>Consider comfort measures only documentation in the discharge summary as documentation on the last day of the hospitalization, regardless of when the summary is dictated.</b></li> <li>• <b>Physician/APN/PA documentation of comfort measures only mentioned in the following context is acceptable:</b> <ul style="list-style-type: none"> <li>◦ Comfort measures only recommendation</li> <li>◦ Order for consultation/evaluation by hospice care</li> <li>◦ Patient/family request for comfort measures only</li> <li>◦ Plan for comfort measures only</li> <li>◦ Referral to hospice care service</li> </ul> </li> <li>• <b>If any of the inclusions are documented in the ONLY ACCEPTABLE SOURCES, select option "1," "2," or "3" accordingly, unless otherwise specified.</b></li> <li>• <b>Documentation of "CMO should be disregarded if documentation makes clear it is not being used as an acronym for Comfort Measures Only (e.g., "hx dilated CMO" - Cardiomyopathy context).</b></li> <li>• <b>Disregard documentation of an Inclusion term in the following situations:</b> <ul style="list-style-type: none"> <li>◦ Inclusion term clearly described as negative (Examples: "No comfort care," "Not appropriate for hospice care," "Declines hospice care").</li> <li>◦ <b>NOTE:</b> If an Inclusion term is clearly described as negative in one source and NOT described as negative in another source, the second source would count for comfort measures only. (e.g., On Day 0, the physician documents, "The patient is not a hospice candidate." On Day 3, the physician orders a hospice consult. Select "2.")</li> <li>◦ Comfort measures made conditional upon whether or not the patient arrests. (<b>Examples:</b> "DNRCCA" (Do Not Resuscitate-Comfort Care Arrest; "Comfort Care Protocol will be implemented in the</li> </ul> </li> </ul>

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				<p>event of a cardiac or respiratory arrest"; "Family requests comfort measures only should the patient arrest.")</p> <ul style="list-style-type: none"> <li>Documentation that is dated prior to arrival or documentation which refers to the pre-arrival time period (e.g., comfort measures only order in previous hospitalization record, "Pt. on hospice at home" in physician ED note).</li> </ul> <p><b>EXCEPTION:</b> State-authorized portable orders (SAPOs). SAPOs are specialized forms, Out-of-Hospital DNR (OOH DNR) or Do Not Attempt Resuscitation (DNAR) orders, or identifiers authorized by state law, that translate a patient's preferences about specific-end-of-life treatment decisions into portable medical orders</p> <p><b>Examples:</b> DNR-Comfort Care form, MOLST (Medical Orders for Life- Sustaining Treatment), POLST (Physician Orders for Life-Sustaining Treatment)</p> <ul style="list-style-type: none"> <li>Pre-printed order forms signed by physician/APN/PA: Disregard an Inclusion term in a statement that is not part of the order or that is not clearly selected (on a form that offers options to select from).</li> </ul> <p><b>Examples:</b></p> <ul style="list-style-type: none"> <li>Inclusion term used only in the title of the form (e.g., DNR-Comfort Care order form - option "Comfort Care" is not checked.</li> <li>Inclusion term used only in the pre-printed instruction for completing the form (e.g., "Copy of form to hospice", "Instructions" section of the form further defines the option "Comfort care")</li> </ul> <p><b>ONLY ACCEPTABLE SOURCES:</b> Discharge summary, DNR/MOLST/POLST forms, Emergency Department record, physician orders, progress notes</p> <p><b>Excluded data source:</b> Restraint order sheet</p> <p><b>Exclusion Statement:</b> Clinician documentation of "comfort measures only" excludes the case from Joint Commission designated PN Hospital Inpatient Quality measures. Abstraction of required data elements for</p>

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				<b>VHA measures remains applicable.</b>
16	clntrial	During this hospital stay, was the patient enrolled in a clinical trial in which patients with pneumonia were being studied?	<p>*1, 2</p> <p><b>*If 1, the record is excluded from the JC PN Hospital Inpatient Quality Measures review; go to end. (Partial Abstraction only)</b></p> <p><b>If 2, go to transin3</b></p>	<p><b>In order to answer "Yes", BOTH of the following must be documented:</b></p> <p>1. <b>There must be a signed consent form for the clinical trial.</b> For the purposes of abstraction, a clinical trial is defined as an <b>experimental study</b> in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received; <b>AND</b></p> <p>2. <b>There must be documentation on the signed consent form that during this hospital stay the patient was enrolled in a clinical trial in which patients with pneumonia were being studied.</b> Patients may be newly enrolled in a clinical trial during the hospital stay or enrolled in a clinical trial prior to arrival and continued active participation in that clinical trial during this hospital stay.</p> <p><b>In the following situations, select "No":</b></p> <p>1. <b>There is a signed patient consent form for an observational study only.</b> Observational studies are non-experimental and involve no intervention (e.g., registries).</p> <p>2. <b>It is not clear whether the study described in the signed patient consent form is experimental or observational.</b></p> <p>3. <b>It is not clear which study population the clinical trial is enrolling.</b> Assumptions should not be made if the study population is not specified.</p> <p><b>ONLY ACCEPTABLE SOURCE:</b> Signed consent form for clinical trial</p> <p><b>Exclusion Statement: Enrollment of the patient in a clinical trial relevant to pneumonia during this hospital stay excludes the case from the Joint Commission PN Hospital Inpatient Quality Measures review.</b></p>
17	transin3	<p>Was the patient received as a transfer from an inpatient, outpatient or emergency/observation department of an <u>outside</u> hospital or from an ambulatory surgery center?</p> <p>1. Yes</p> <p>2. No</p>	1, 2	<p>If a patient is transferred in from any emergency department (ED) or observation unit <b>OUTSIDE</b> of your hospital, select "1". This applies even if the emergency department or observation unit is part of your hospital's system (e.g., your hospital's free-standing or satellite emergency department), has a shared medical record or provider number, or is in close proximity.</p> <p>If the patient is transferred to your hospital from an outside hospital where he was an inpatient or outpatient, select "1". This applies even if the two hospitals are close in proximity, part of the same hospital system, have the same provider number, and/or there is one medical record.</p>

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				<p><b>Select "Yes" in the following types of transfers:</b></p> <ul style="list-style-type: none"> <li>• <b>Long term acute care (LTAC):</b> Any LTAC hospital or unit (outside or inside your hospital)</li> <li>• <b>Acute rehabilitation:</b> Rehab unit in outside hospital, free-standing rehab hospital/facility/pavilion outside your hospital, OR rehab <b>hospital</b> inside your hospital</li> <li>• <b>Psychiatric:</b> Psych unit in outside hospital, free-standing psych hospital/facility/pavilion outside your hospital, OR psych <b>hospital</b> inside your hospital</li> <li>• <b>Cath lab, same day surgery, or other outpatient department of an outside hospital</b></li> <li>• <b>Disaster Medical Assistance Team (DMAT):</b> Provides emergency medical assistance following catastrophic disaster or other major emergency</li> </ul> <p><b>Select "No" in the following types of transfers:</b></p> <ul style="list-style-type: none"> <li>• Urgent care center</li> <li>• Psych or rehab unit inside your hospital</li> <li>• Dialysis center (unless documented as an outpatient department of an outside hospital)</li> <li>• Same Day Surgery or other outpatient department inside your hospital</li> <li>• Clinic (outside or inside your hospital)</li> <li>• Hospice facility (outside or inside your hospital)</li> <li>• Skilled nursing facility (SNF) care: Any facility or unit (outside or inside your hospital) providing SNF level of care to patient</li> </ul> <p>If there is conflicting documentation in the record, and you are unable to determine whether or not the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, select "No" UNLESS there is supporting documentation for one setting over the other. Examples: One source reports patient was transferred from an outside hospital's ED, another source reports patient was transferred in from an urgent care center. No additional documentation. Select "No".</p>

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				One source states patient came from physician office, another source reports patient was transferred from an outside hospital's ED, and transfer records from the outside hospital's ED are included in the record. Select "Yes". If, in cases other than conflicting documentation, you are unable to determine whether or not the patient was received as a transfer from an inpatient, outpatient, or emergency/observation department of an outside hospital or from an ambulatory surgery center, select "No". (E.g., "Transferred from Park Meadows" documented - Documentation is not clear whether Park Meadows is a hospital or not.) Suggested data sources: Ambulance record, emergency department record, history and physical, nursing admission assessment, progress notes, transfer sheet		
18	pnedpt	Did the patient receive care/services in the Emergency Department of this VAMC? 1. Yes 2. No	1, 2  If 2, auto-fill pndxed2 as 95, and go to pndxadm2	<b>For the purposes of this Pneumonia data element an Emergency Department (ED) patient is defined as any patient receiving care or services in the ED of this VAMC.</b>  <ul style="list-style-type: none"><li>• If the patient presents to the ED for outpatient services such as lab work and the patient receives the service in the ED, enter "1".</li><li>• A patient seen in an Urgent Care, ER Fast Track, etc. is NOT considered an ED patient <u>unless</u> the patient received services in the Emergency Department at this VAMC (e.g., patient treated at an urgent care and transferred to the main campus ED is considered an ED patient, but a patient seen at the urgent care and transferred to the hospital as a direct admit would not be considered an ED patient).</li><li>• For patients presenting to the ED who do NOT receive care or services in the ED, enter "2" (e.g., patient is sent to hospital from physician office and presents to ED triage and is instructed to proceed straight to floor).</li></ul> <b>Exclude: Urgent Care, fast track ED, terms synonymous with Urgent Care</b>		
19	pndxed2	Was there documentation of the diagnosis of pneumonia as an <b>Emergency Department</b> diagnosis/impression? <b>Physician, Advanced Practice Nurse, or Physician Assistant documentation only</b> <b>ONLY ACCEPTABLE INCLUSIONS:</b> <table><tr><td>Admission Pneumonia</td><td>NAP (nosocomial</td></tr></table>	Admission Pneumonia	NAP (nosocomial	1, 2, 95, 99 Will be auto-filled as 95 if pnedpt = 2 If 1 and transin3 = 1, go to blcltdon, else if 1, go to othrcond If 2 or 99, go to end	<b>ONLY ACCEPTABLE SOURCES: Emergency Department Record (ED admitting notes, ED form (1010M), ED history and physical, ED physician orders)</b> <b>Note: Accept inclusions used with adjectives/phrases such as possible, probable, questionable, rule/out, suspected. Do NOT accept inclusions used with negative modifiers (e.g. doubt pneumonia).</b> <b>Exclude: aspiration pneumonia, chronic infiltrate, chronic pneumonia,</b>
Admission Pneumonia	NAP (nosocomial					

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		<table><tr><td>Pathway</td><td>pneumonia)</td></tr><tr><td>BOOP (bronchiolitis obliterans organizing pneumonia)</td><td>PCP (pneumocystis carinii pneumonia)</td></tr><tr><td>CAP (community acquired pneumonia)</td><td>Persistent pneumonia</td></tr><tr><td>COP (cryptogenic organizing pneumonia)</td><td>PN, PNA, PNE, or Pneu</td></tr><tr><td>HAP or HCAP (healthcare acquired pneumonia)</td><td>Pneumonia</td></tr><tr><td>Infiltrate</td><td>Pneumonic Process</td></tr><tr><td>Lower respiratory infection/Lower respiratory tract infection</td><td>Pneumonitis</td></tr><tr><td>Lower lobe infection</td><td>Resolving Pneumonia</td></tr><tr><td>Lower lung infection</td><td>VAP (ventilator acquired pneumonia)</td></tr></table>	Pathway	pneumonia)	BOOP (bronchiolitis obliterans organizing pneumonia)	PCP (pneumocystis carinii pneumonia)	CAP (community acquired pneumonia)	Persistent pneumonia	COP (cryptogenic organizing pneumonia)	PN, PNA, PNE, or Pneu	HAP or HCAP (healthcare acquired pneumonia)	Pneumonia	Infiltrate	Pneumonic Process	Lower respiratory infection/Lower respiratory tract infection	Pneumonitis	Lower lobe infection	Resolving Pneumonia	Lower lung infection	VAP (ventilator acquired pneumonia)		<p>If 2, the record is excluded from JC designated PN Hospital Inpatient Quality Measures</p> <p>If 99, the record is included in the denominator for JC designated PN Hospital Inpatient Quality measures (partial abstraction only)</p> <div><p>Warning: If 99, was the ED final diagnosis/impression left blank in ALL ED sources</p></div>	<p><b>history of any of the Inclusion terms with no current context, pneumonia caused by chemical agents or aerosolized medications, post-obstructive pneumonia, recurrent pneumonia, recent pneumonia, S/P (status post) pneumonia</b></p> <p><b><u>Pneumonia diagnosis in the Emergency Department:</u></b></p> <ol style="list-style-type: none"><li><b>For the purposes of this data element:</b><ul style="list-style-type: none"><li>An ED admit is any patient who receives treatment, care, or evaluation in the ED.</li><li>The ED form is the document within the ED record which contains the final diagnosis/impression. The ED form (or 1010M) may be found in CPRS or the paper record.</li></ul></li><li><b>If pneumonia is listed as a diagnosis/impression on the ED form by any physician/APN/PA, select "1"</b> (review of other acceptable sources is not necessary).</li><li>Pneumonia need not be the primary or only diagnosis.</li><li><b>Only accept documentation of a pneumonia diagnosis that is clearly described as a diagnosis, impression, or plan to treat.</b> Do not take anything that is labeled as a differential diagnosis. <b>Examples:</b> Under a heading of diagnosis/impression, physician documents, "COPD vs Pneumonia", select "1". In ED narrative, physician notes, "Ddx - pancreatitis vs. acute alcohol hepatitis vs. UTI/pyelo vs PNA", select "2".</li><li>A pneumonia diagnosis written within narrative documentation can be used, but it must be clearly documented as a diagnosis/impression or a plan to treat for pneumonia. Examples: Physician documents "Start patient on Levaquin to cover pneumonia", select value "1".</li><li>Diagnosis of pneumonia cannot be taken from the chest x-ray, discharge summary, coding or billing documents.</li><li>If there is any documentation of <u>aspiration pneumonia</u> on an ONLY ACCEPTABLE SOURCE, select "2." Example: ED final diagnosis "Pneumonia versus aspiration pneumonia", select "2."</li></ol>
Pathway	pneumonia)																						
BOOP (bronchiolitis obliterans organizing pneumonia)	PCP (pneumocystis carinii pneumonia)																						
CAP (community acquired pneumonia)	Persistent pneumonia																						
COP (cryptogenic organizing pneumonia)	PN, PNA, PNE, or Pneu																						
HAP or HCAP (healthcare acquired pneumonia)	Pneumonia																						
Infiltrate	Pneumonic Process																						
Lower respiratory infection/Lower respiratory tract infection	Pneumonitis																						
Lower lobe infection	Resolving Pneumonia																						
Lower lung infection	VAP (ventilator acquired pneumonia)																						

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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES		
		<div>1. There is documentation that pneumonia was a diagnosis/impression in the ED</div> <div>2. There is NO documentation that pneumonia was a diagnosis/impression in the ED</div> <div>95. Not applicable</div> <div>99. Unable to determine from ED medical record documentation (only use if the ED diagnosis/impression is left blank in <b>ALL</b> Emergency Department sources)</div>		<div>8. For patients admitted to observation from the ED, who later result in inpatient status, a diagnosis/impression of pneumonia must be documented while in the ED.</div> <div>9. <b>If the <u>same</u> emergency room physician/APN/PA who completed the ED form</b> completes an admit note or order with an admission diagnosis of pneumonia or a pneumonia pathway that was initiated upon admission, select "1."</div> <div>10. If the ED physician does not document a diagnosis/impression of pneumonia and a hospitalist, attending physician or consultant <b>admits</b> the patient for pneumonia, select value "2".</div> <div>11. Those cases where the patient is seen in the emergency department but the medical record does not contain an ED form, which is different than just leaving the form blank (e.g., the physician treating the patient in the ED documented everything on an admit note) are limited to the following <b>ONLY ACCEPTABLE SOURCES</b>: Admitting notes, Admitting physician orders, Admit H&amp;P written or dictated within 24 hours of arrival.</div> <div><b>Exclusion Statement:</b> <b>No working diagnosis of pneumonia at the time of admission partially excludes the case from the Joint Commission PN Hospital Inpatient Quality Measures.</b></div>		
20	pndxadm2	<div>Was there documentation of the diagnosis of pneumonia as an admission diagnosis/impression for the <b>direct admit</b> patient?</div> <div><b>Physician, Advanced Practice Nurse, or Physician Assistant documentation only</b></div> <div><b>ONLY ACCEPTABLE INCLUSIONS:</b></div> <table><tr><td>Admission Pneumonia Pathway</td><td>NAP (nosocomial pneumonia)</td></tr></table>	Admission Pneumonia Pathway	NAP (nosocomial pneumonia)	<div>1, 2, 99</div> <div>If 1 and transin3 = 2, go to othrcond; else if 1, go to blcltdon</div> <div>If 2 or 99, go to end</div> <div>If 2, the record is excluded from JC</div>	<div><b>ONLY ACCEPTABLE SOURCES:</b> Admit History and Physical written or dictated within 24 hours of hospital arrival, Admitting notes, admitting physician orders, physician admission note</div> <div><b>Note: Accept inclusions used with adjectives/phrases such as possible, probable, questionable, rule/out, suspected. Do not accept inclusions used with negative modifiers (e.g. doubt pneumonia).</b></div> <div><b>Exclude: aspiration pneumonia, chronic infiltrate, chronic pneumonia, history of any of the Inclusion terms with no current context, pneumonia</b></div>
Admission Pneumonia Pathway	NAP (nosocomial pneumonia)					



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#	Name	QUESTION		Field Format	DEFINITION/DECISION RULES																
		<table><tr><td>BOOP (bronchiolitis obliterans organizing pneumonia)</td><td>PCP (pneumocystis carinii pneumonia)</td></tr><tr><td>CAP (community acquired pneumonia)</td><td>Persistent pneumonia</td></tr><tr><td>COP (cryptogenic organizing pneumonia)</td><td>PN, PNA, PNE, or Pneu</td></tr><tr><td>HAP or HCAP (healthcare acquired pneumonia)</td><td>Pneumonia</td></tr><tr><td>Infiltrate</td><td>Pneumonic Process</td></tr><tr><td>Lower respiratory infection/Lower respiratory tract infection</td><td>Pneumonitis</td></tr><tr><td>Lower lobe infection</td><td>Resolving Pneumonia</td></tr><tr><td>Lower lung infection</td><td>VAP (ventilator acquired pneumonia)</td></tr></table>	BOOP (bronchiolitis obliterans organizing pneumonia)	PCP (pneumocystis carinii pneumonia)	CAP (community acquired pneumonia)	Persistent pneumonia	COP (cryptogenic organizing pneumonia)	PN, PNA, PNE, or Pneu	HAP or HCAP (healthcare acquired pneumonia)	Pneumonia	Infiltrate	Pneumonic Process	Lower respiratory infection/Lower respiratory tract infection	Pneumonitis	Lower lobe infection	Resolving Pneumonia	Lower lung infection	VAP (ventilator acquired pneumonia)		<div>designated PN Hospital Inpatient Quality Measures If 99, the record is included in the denominator for JC designated PN Hospital Inpatient Quality measures (partial abstraction only)</div> <div>Warning: If 99, was diagnosis/impression left blank in ALL ACCEPTABLE SOURCES</div>	<div>caused by chemical agents or aerosolized medications, post-obstructive pneumonia, recurrent pneumonia, recent pneumonia, S/P (status post) pneumonia</div> <div><u>Pneumonia diagnosis on Admission-Direct Admit</u></div> <div><div>1. For the purposes of this data element, a direct admit is any patient who does NOT receive treatment, care or evaluation in the ED.</div><div>2. If pneumonia is documented as a diagnosis/impression (pneumonia does not need to be the primary or only diagnosis/impression) on any of the ONLY ACCEPTABLE SOURCES, select "1."</div><div>3. For patients who are a direct admit to observation, who later result in inpatient status, a diagnosis/impression of pneumonia must be documented upon admission to observation.</div><div>4. Diagnosis of pneumonia cannot be taken from the chest x-ray, discharge summary, coding or billing documents.</div><div>5. If there is documentation of <u>aspiration pneumonia</u> listed as an initial diagnosis for a direct admit patient in any of the allowable sources, select "2." Example: Direct Admit diagnosis "Pneumonia versus aspiration pneumonia", select "2."</div><div>6. Any of the ONLY ACCEPTABLE SOURCES can be used without a date or time except for an Admit H&amp;P.</div><div>7. An Admit History &amp; Physical (H&amp;P) is an H&amp;P labeled as such or contains documentation regarding admission.</div><div>8. History and Physical can be used ONLY if the physician/APN/PA documents on one of the ONLY acceptable sources to "see H&amp;P" or the H&amp;P is an admit H&amp;P written or dictated within 24 hours of arrival.</div><div>9. The initial progress note is not one of the ONLY ACCEPTABLE SOURCES for a Direct Admit and not considered an admission note unless it contains documentation regarding admission.</div><div>10. Only select "99" if there is no documentation of ANY diagnosis in any of the ONLY ACCEPTABLE SOURCES. If there is ANY diagnosis mentioned select value "1" or "2" as applicable.</div></div> <div><u>Exclusion Statement:</u> No working diagnosis of pneumonia at the time of admission partially</div>
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#	Name	QUESTION	Field Format	DEFINITION/DECISION RULES
		admission diagnosis/impression upon direct admit. 99. Unable to determine (only use if there is no documentation of ANY diagnosis in any of the ONLY ACCEPTABLE SOURCES)		<b>excludes the case from the Joint Commission PN Hospital Inpatient Quality Measures.</b>