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|  |  | **Organizational Identifiers** |  |  |
|  | 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 |  |
|  |  | Patient Identifiers |  |  |
|  | 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 |  |
|  |  | **Administrative Data** |  |  |

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| 1 | arrvdate | Enter the **earliest** 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   |  | | --- | | < = admdt and < = leftdate | | **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**. The intent of the arrival data elements is to capture the earliest date and time the patient was in this VAMC. Arrival date may differ from admission date.   * Do not include documentation from external sources (e.g., ambulance records, clinic records, physician office record, or lab reports) obtained prior to arrival to determine arrival date. The intent is to utilize documentation that reflects processes that occurred in the ED or hospital. * For patients in observation status and subsequently admitted to hospital:   + If the patient was admitted to observation from the ED of the hospital, use the date the patient presented to ED.   + If the patient was admitted to observation from an outpatient setting of the hospital, use the date the patient presented to ED or arrived on the floor for observation care.   + If the patient was a direct admit to observation, use the earliest date the patient arrived at the hospital. * If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) 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. * For “Direct Admits” to acute inpatient, use the earliest date the patient arrived at the hospital.   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.  **Cont’d next page** |

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|  |  |  |  | **Arrival date cont’d**  **ONLY ACCEPTABLE SOURCES:** Any ED documentation (includes ED vital sign record, ED Outpatient Registration form, triage record, ECG, lab or x-ray reports, etc., if these services were rendered while the patient was an ED patient), nursing admission assessment /admitting note, observation record, procedure notes (such as bronchoscopy, endoscopy), vital signs graphic record  Only enter 99/99/9999 if the arrival date is unable to be determined from the medical record documentation. If the 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. |

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| 2 | arrvtime | Enter the **earliest** documented time the patient arrived at acute care at this VAMC. | \_\_\_\_\_  UMT **If unable to find the time of arrival, the abstractor can enter 99:99**   |  | | --- | | < =admdt/pneadmtm and < leftdate/leftime | | **Arrival time is the earliest recorded time the patient arrived in the hospital’s acute care setting where care for pneumonia could be most appropriately provided**. **Determine the earliest time the patient arrived at this VHA hospital, such as in the ED or observation unit**.   * Do not include documentation from external sources (e.g., ambulance records, clinic records, physician office record, or lab reports) obtained prior to arrival to determine arrival time. The intent is to utilize documentation that reflects processes that occurred in the ED or hospital. * For patients in observation status and subsequently admitted to hospital:   + If the patient was admitted to observation from the ED of the hospital, use the time the patient presented to ED.   + If the patient was admitted to observation from an outpatient setting of the hospital, use the time the patient presented to ED or arrived on the floor for observation care.   + If the patient was a direct admit to observation, use the earliest time the patient arrived at the hospital. * If the patient is in an outpatient setting of the hospital (e.g., undergoing dialysis, chemotherapy) 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. If the time the patient arrived on the floor is not documented by the nurse, enter the admission time recorded in EADT. * For “Direct Admits” to acute inpatient, use the earliest time the patient arrived at the hospital.   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.  **Cont’d next page** |

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|  |  |  |  | **Arrival time cont’d**  **ONLY ACCEPTABLE SOURCES:** Any ED documentation (includes ED vital sign record, ED Outpatient Registration form, triage record, ECG, lab or x-ray reports, etc., if these services were rendered while the patient was an ED patient), nursing admission assessment /admitting note, observation record, procedure notes  (such as bronchoscopy, endoscopy), vital signs graphic record  **If unable to determine the time of arrival, enter default time 99:99.** 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. |
| 3 | admdt | Date of admission to acute inpatient care: | mm/dd/yyyy  **Auto-filled: can be modified**   |  | | --- | | > = arrvdate and < = leftdate | | **Auto-filled; can be modified if abstractor determines that the date is incorrect.**  **Exclusion:** admit to observation, arrival date  Admission date is the date the patient was actually admitted to acute inpatient care.  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.  If there are multiple inpatient orders, use the order that most accurately reflects the date that the patient was admitted. 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.  **ONLY ALLOWABLE SOURCES:** Physician orders, face sheet |

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| 4 | pneadmtm | Time of admission to acute inpatient care: | | \_\_\_\_\_ UMT **Auto-filled: can be modified**   |  | | --- | | > = arrvdate/arrvtime and < leftdate/leftime | | | **Auto-filled; can be modified**  Abstractor to verify admission time is correct. DO NOT use ED discharge time or patient transfer time. | |
| 5 | leftdate | Discharge date: | mm/dd/yyyy  **Auto-filled. Cannot be modified**  > = admdt | | The computer will auto-fill the discharge date from the OQP pull list. This date cannot be modified in order to ensure the selected episode of care is reviewed. | |
| 6 | leftime | Time of discharge: | \_\_\_\_\_\_ UMT   |  | | --- | | > admdt/pneadmtm | | | **Does not auto-fill. Discharge time must be entered.**  **Includes the time the patient was discharged from acute care, left against medical advice (AMA), or expired during this stay.**  If the patient expired, use the time of death as the discharge time.  **Suggested sources for patient who expire:**  Death record, resuscitation record, physician progress notes, physician orders, nurses notes  **For other patients:**  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.”  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.  Converting time to military time:  If time is in the a.m., no conversion is required.  If time is the p.m., add 12 to the clock hour time. | |

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| 7 | entrprin | Enter the ICD-9-CM principal diagnosis code: | \_\_ \_\_ \_\_. \_\_ \_\_  (3 digits/decimal point/two digits)   |  | | --- | | **Cannot enter 000.00, 123.45, or 999.99** |   \***If code is not listed in JC Appendix A, Table 3.1, Table 3.2, or Table 3.3, the record is excluded**. | **Will auto-fill from PTF with ability to change. If the principal diagnosis code is incorrect, enter the principal diagnosis code as documented in the medical record.**  **Principal diagnosis code must be one of the codes listed in Joint Commission Table 3.1, Table 3.2, or Table 3.3 (Appendix A).**  Table 3.1: Pneumonia Codes; Table 3.2: Septicemia Codes;  Table 3.3: Respiratory Failure Codes  Do not change the principal diagnosis code unless a different principal diagnosis code is documented in the medical record.  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.  Unacceptable pneumonia diagnosis qualifiers: Could be, could have been, risk of, subtle.  **Exclusion Statement:**  **Although coding designated the case for inclusion in the Joint Commission Pneumonia National Hospital Quality Measures population, documentation in the record does not confirm an ICD-9-CM principal diagnosis code of pneumonia, septicemia, or respiratory failure.** |

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| 8 | pneothdx1  pneothdx2  pneothdx3  pneothdx4  pneothdx5  pneothdx6  pneothdx7  pneothdx8  pneothdx9  pneothdx10  pneothdx11  pneothdx12 | Enter the ICD-9-CM other diagnosis codes: | \_\_ \_\_ \_\_. \_\_ \_\_  (3 digits/decimal point/two digits)  Can enter 12 codes   |  | | --- | | **Cannot enter 000.00, 123.45, or 999.99** | | **Abstractor can enter xxx.xx in code field if no other dx found** |   **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.**  **If pneothdx is a code from JC Table 3.4, the record is excluded.** | **Can enter 12 ICD-9-CM other diagnosis codes.** **Will auto-fill from PTF with ability to change. If the “other diagnoses” codes are incorrect, enter the codes as documented in the medical record.** If entered manually, use the codes listed in the discharge summary for this inpatient episode of care.  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.  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).  Unacceptable pneumonia diagnosis qualifiers: Could be, could have been, risk of, subtle.  **Any order in which pneumonia is noted in the listing of discharge diagnoses is acceptable**.  **Exclusion Statement**:  **Although coding designated the case for inclusion in the Joint Commission Pneumonia National Hospital 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.**  **Exclusion Statement: If an ICD-9-CM code from Joint Commission Table 3.4 (Appendix A) is entered in pneothdx, the case is excluded.** |

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| 9 | pnepxcd  (code)  pnepxdt  (date) | Enter the ICD-9-CM principal procedure code and date.  Code Date   |  |  | | --- | --- | | \_\_ \_\_. \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | \_\_ \_\_. \_\_ \_\_  **If there is no principal procedure, the abstractor can enter xx.xx in code field and**  **99/99/9999 in date field**   |  | | --- | | **Cannot enter 00.00** |   mm/dd/yyyy  **Abstractor can enter 99/99/9999**  **If there is no principal procedure, auto-fill othrpx and otherpxdt with xx.xx and 99/99/9999**   |  | | --- | | > = admdt and < = leftdate | | Principal procedure= that procedure performed for definitive treatment, rather than for diagnostic or exploratory reasons, or was necessary to treat a complication. Related to the principal diagnosis.  Enter the ICD-9-CM code principal procedure code assigned by the VAMC, even if it does not meet the strict definition noted above.  **If there is no principal procedure, enter default code xx.xx in code field and default date 99/99/9999 in date field.**  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. |

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| 10 | othrpx1  othrpx2  othrpx3  othrpx4  othrpx5  (codes)  othpxdts1  othpxdts2  othpxdts3  othpxdts4  othpxdts5  (dates) | Enter the ICD-9-CM other procedure codes and dates.  Code Date   |  |  | | --- | --- | | \_\_ \_\_. \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | \_\_ \_\_. \_\_ \_\_ | \_\_/\_\_/\_\_\_\_ | | \_\_ \_\_. \_\_ \_\_ **If no other procedure was performed, the abstractor can enter xx.xx in code field and 99/99/9999 in date field**   |  | | --- | | **Cannot enter 00.00** |   mm/dd/yyyy  **Abstractor can enter 99/99/9999**   |  | | --- | | > = admdt and < = leftdate |   **Can enter 5 codes and dates** | **Can enter 5 procedure codes, other than the principal procedure code.** 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.  **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.**  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.  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. |

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| 12 | pnedpt | Did the patient receive care/services in the Emergency Department of this VAMC?  1. Yes  2. No | 1,2  If 1, auto-fill pndxadm as 95  If 2, auto-fill pnuobsv as 95, pnadecdt as 99/99/9999, pnadectm as 99:99, pnedcdt as 99/99/9999, pnedctm as 99:99, pndxed  as 95, uncertdx as 95, and go to adm24icu | **For the purposes of this data element an Emergency Department (ED) patient is defined as any patient receiving care or services in the ED of this VAMC.**  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”.  A patient seen in an Urgent Care, ER Fast Track, etc. is NOT considered an ED patient unless 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).  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).  **Exclude:** Urgent Care, fast track ED, terms synonymous with Urgent Care |
| 13 | pnuobsv | Was there documentation the patient was placed in observation services in the Emergency Department of this VAMC?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if pnedpt = 2 | **The intent is to capture emergency department patients placed into observation services in this Emergency Department prior to admission to the facility as an inpatient.**  If there is documentation the patient was placed into observation services and received care in observation provided by the Emergency Department or in an observation unit of the ED, select “1.”  If there is documentation the patient is being admitted for observation outside the Emergency Department, select “2.”  If there is no documentation the patient received observation services in the ED of this VAMC, select “2.”  **ONLY ALLOWABLE SOURCE: ED record** |

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| 14 | pnadecdt | Enter the earliest documented date of the decision to admit the patient. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  pnedpt = 2  Abstractor can enter 99/99/9999  **If arrvdate = admdt, computer will auto-fill = arrvdate**   |  | | --- | | > =arrvdate and < = admdt | | **For purposes of this data element, Decision to Admit Date is the date on which the physician/APN/PA makes the decision to admit the patient from the Emergency Department to the hospital as an inpatient.** This will not necessarily coincide with the date the patient is officially admitted to inpatient status.  **ONLY ACCEPTABLE SOURCE: ED record. Do not include any documentation from external sources (e.g., ambulance record, clinic note) obtained prior to arrival.**   * If there are multiple dates documented for the decision to admit abstract the earliest date. * If it can be determined that the patient arrived on the same date and departed on the same date, the arrival date can be used as the decision to admit date. * If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the date the physician/APN/PA made the decision to admit. * If the decision to admit date is dated prior to the date of patient arrival or after the date of departure, enter 99/99/9999. * If the date of the decision to admit is unable to be determined from medical record documentation, enter 99/99/9999.   If the admission date is the same date as arrival, Decision to Admit date will be auto-filled by the computer software.  The medical record must be abstracted as documented (i.e., face value). When the date documented is obviously in error (e.g. 11/42/20XX) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.  **Excludes, but is not limited to:** Bed assignment date, Admit Orders date, Admit to Observation date |

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| 15 | pnadectm | Enter the **earliest** documented time of the decision to admit the patient. | \_\_\_\_  UMT  Will be auto-filled as 99:99 if  pnedpt = 2  Abstractor can enter 99:99   |  | | --- | | > =arrvdate/arrvtime and < = admdt/pneadmtm | | **For purposes of this data element “decision to admit time” is the time the physician/APN/PA communicates the decision to admit the patient from the Emergency Department to the hospital as an inpatient.** The decision to admit time will not necessarily coincide with the time the patient is officially admitted to inpatient status.  **ONLY ACCEPTABLE SOURCE: ED record. Do not include any documentation from external sources (e.g., ambulance record, clinic note) obtained prior to arrival.**   * If there are multiple times documented for the decision to admit abstract the earliest time. * If the decision to admit the patient is made, but the actual request for a bed is delayed until an inpatient bed is available, record the time the physician/APN/PA communicated the decision to admit. * Do not use admit order time for the Decision to Admit Time unless documentation clearly indicates this is the time the provider communicated the decision. If the documentation does not clearly indicate this was the time of the decision, enter 99:99. * If documentation of the decision to admit time is prior to arrival or after departure from the ED, enter 99:99. * If the time of the decision to admit is unable to be determined from medical record documentation, enter 99:99.   The medical record must be abstracted as documented (i.e., at face value). When the time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99.  **Excludes, but is not limited to:** Bed assignment time, Admit Orders time, Report Called Time, Admit to Observation time |

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| 16 | pnedcdt | Enter the date the patient departed from the emergency department. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  pnedpt = 2  Abstractor can enter 99/99/9999   |  | | --- | | > =arrvdate or = admdt and <= 3 days after admdt | | **ONLY ACCEPTABLE SOURCE: ED record**   * If the date of departure from the ED is not documented, but the date of departure can be determined from other documentation, (e.g., you are able to identify from documentation the patient arrived and was transferred to medical unit on the same day), enter this date. * For patients who are placed into observation under the services of the Emergency Department, abstract the date of departure from the observation services (e.g., patient is seen in the ED and admitted to an observation unit of the ED on 05/01/20XX then is discharged from the observation unit on 5/02/20XX abstract 5/02/20XX as the departure date. * For patients who are placed into observation outside the services of the Emergency Department, abstract the date of departure from the ED. * If there is documentation the patient left against medical advice and it cannot be determined what date the patient left against medical advice, enter 99/99/9999. * If the date the patient departed from the ED is unable to be determined from medical record documentation, enter 99/99/9999.   The medical record must be abstracted as documented (i.e., face value). When the date documented is obviously in error (e.g. 11/42/20XX) or outside the parameters of care (e.g., after discharge date) and no other documentation is found that provides this information, enter 99/99/9999.  **Includes, but is not limited to:** ED departure date, ED discharge date, ED leave date |

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| 17 | pnedctm | Enter the time the patient departed from the emergency department. | \_\_\_\_  UMT  Will be auto-filled as 99:99 if  pnedpt = 2  Abstractor can enter 99:99   |  | | --- | | > =arrvdate/arrvtime and < = 72 hours after admdt/pneadmtm | | **ED Departure Time is the time the patient physically left the Emergency Department.** **The intention is to capture the latest time at which the patient was receiving care in the ED, under the care of Emergency Department services, or awaiting transport to another service/unit.**   * When more than one acceptable ED departure/discharge time is documented, abstract the **latest time**.   For example: Two departure times are found in the ED nurse’s notes: 12:03 via wheelchair and 12:20 via wheelchair. Enter the later time of 12:20 as ED departure time.   * If patient expired in the ED, use the time of death as the departure time. * For patients who are placed into observation under the services of the emergency department, abstract the time of departure from the ED observation services. For example, the patient is seen in the ED and admitted to an observation unit of the ED, then discharged from the observation unit. Enter the time the patient departed from the ED observation unit. * For patients who are placed into observation outside the services of the emergency department, abstract the time of departure from the emergency department. * Do not use the time the discharge order was written because it may not represent the actual time of departure. * If the time the patient departed from the ED is unable to be determined from medical record documentation, enter 99:99.   The medical record must be abstracted as documented (i.e., at face value). When the time documented is obviously in error (e.g. 33:00), and no other documentation is found that provides this information, enter 99:99.  **Includes, but is not limited to:** ED Leave time, ED Discharge time, ED Departure time, ED Check Out time  **Excludes, but is not limited to**: Report Called time  **ONLY ACCEPTABLE SOURCE:** ED record |

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| 18 | adm24icu | Was the patient admitted or transferred to the intensive care unit at this VAMC within the first 24 hours following arrival at the hospital?   1. Yes 2. No 3. Unable to determine | 1,2,99   |  | | --- | | If 1, auto-fill drpnursk as 1 | | **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.”**  **Any time spent in the ICU within the first 24 hours after arrival is included.**  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.”  If there is an order for ICU and the patient has not been moved due to lack of a bed, select “1.”  **Note: 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. 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.”**  Do not use abstractor judgment based on the type of care administered to the patient. The level of intensive care MUST be documented.Direct admits, admissions via theED, or transfers from lower level of inpatient care are included.  Do **not** include PCU unless identified as a Pulmonary Care Unit.  **Exclude:**   * ED, OR, or procedure units as inpatient units * **Intermediate care unit (IMCU)** Step down unit: * 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. * Inpatient units with telemetry monitoring that are not intensive care units * Post coronary care unit (PCCU) |

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| 19 | dcdispo | What was the patient’s discharge disposition on the day of discharge?  1. Home   * Assisted Living Facilities * Court/Law Enforcement – includes detention facilities, jails, and prison * Board and care, domiciliary, foster or residential care, group or personal care homes, and homeless shelters * Home with Home Health Services * Outpatient Services including outpatient procedures at another hospital, outpatient Chemical Dependency Programs and Partial Hospitalization   2. Hospice – Home  3. Hospice – Health Care Facility   * General Inpatient and Respite, Residential and Skilled Facilities, and Other Health Care Facilities   4. Acute Care Facility   * Acute Short Term General and Critical Access Hospitals * Cancer and Children’s Hospitals * Department of Defense and Veteran’s Administration Hospitals   5. Other Health Care Facility   * Extended or Immediate Care Facility (ECF/ICF) * Long Term Acute Care Hospital (LTACH) * Nursing Home or Facility including Veteran’s Administration Nursing Facility * Psychiatric Hospital or Psychiatric Unit of a Hospital * Rehabilitation Facility including Inpatient Rehabilitation Facility/Hospital or Rehabilitation Unit of a Hospital * Skilled Nursing Facility (SNF), Sub-Acute Care or Swing Bed * Transitional Care Unit (TCU)   6. Expired  7. Left Against Medical Advice/AMA  99. Not documented or unable to determine | | | 1,2,3,4,5,6,7,99 | **Discharge disposition: The final place or setting to which the patient was discharged on the day of discharge.**  **Notes for Abstraction:**   * **Only use documentation from the day of or the day before discharge when abstracting this data element.** 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 back to skilled care. Enter “5”. * **Consider discharge disposition documentation in the discharge summary or a post-discharge addendum as day of discharge documentation, regardless of when it was dictated/written.** * **If documentation is contradictory, use the latest documentation. If there is documentation that further clarifies the level of care that documentation should be used to determine the correct value to abstract.** For example: Nursing discharge note documents that the patient is being discharged to “XYZ” Hospital. The Social Service notes from the day before discharge further clarify that the patient will be transferred to the rehab unit of “XYZ” Hospital, select option “5”. * **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”.** * **To select option “7” there must be explicit documentation that the patient left against medical advice.** Examples:   Progress notes state that patient requests to be discharged but that discharge was medically contraindicated at this time. Nursing notes reflect that patient left against medical advice and AMA papers were signed, select value “7”.  Physician order written to discharge to home. Nursing notes reflect that patient left before discharge instructions could be given, select value “1”.  Cont’d next page |
|  |  |  | | |  | **Discharge disposition cont’d**  **Suggested Data Sources:** Discharge instruction sheet, discharge planning notes, discharge summary, nursing discharge notes, physician orders, progress notes, social service notes, transfer record  **Excluded Data Sources:** Any documentation prior to the day of or day before discharge |
| 20 | cxrdone | | 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?  1. Yes  2. No | 1,\*2   |  | | --- | | **If 2, Warning:** Are you certain the patient did not have a chest x-ray/CT scan within the timeframe? |   \*If 2, the record is excluded from the JC PN Hospital Quality Measures population  (Partial abstraction only)  If cxrdone =2, go to smokcigs | | **If there is documentation the patient had a chest x-ray or CT scan on the day of or day prior to hospital arrival OR anytime during this hospital stay, select “1.”**  CT scan = chest CT or abdominal CT that includes lung field findings  **Exclusion Statement:**  **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 Quality Measures. Smoking counseling, pneumococcal vaccination, and influenza vaccination were abstracted for VHA data.** |

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| 21 | cxrctabn | **Using the inclusion list,** was any chest x-ray or CT scan obtained the day of or day prior to hospital arrival OR anytime during this hospital stay **abnormal**?  **(SEE INCLUSION LIST)**  1. Yes, **a chest x-ray or CT scan done within the designated timeframe was abnormal** (included **ANY** inclusion terms).  2. No, a chest x-ray/CT scan done within the designated timeframe **was not abnormal** (did not include **ANY** inclusion terms).  99. Unable to determine from medical record documentation if the chest x-ray or CT scan done during the designated timeframe was abnormal | 1,\*2, \*99  \*If 2 or 99, the record is excluded from the JC PN Hospital Quality Measures population  (Partial abstraction only)  If cxrctabn =2or 99 go to smokcigs | **Read ALL options carefully.**   * **Use the priority order for the Suggested Data Sources to review the medical record for documentation of acceptable terms from the Inclusion list.** * **If an Inclusion term is found in the x-ray/CT scan interpretation 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.** * **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.** * **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 documentation of an inclusion is prefaced with wording such as “no significant” or “no definite”, select “2.”  |  |  | | --- | --- | | **Inclusion List (ONLY accepted terms)** | | | Airspace disease | Interstitial process | | Airspace process | Interstitial pneumonia | | 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 |   **Cont’d next page** |
|  |  |  |  | **Abnormal CXR/CT cont’d**  **RECOMMENDED ORDER FOR SUGGESTED DATA SOURCES (Physician/APN/PA documentation only):**  1. Chest x-ray report (Regular and portable chest x-ray results are acceptable.)  2. Chest CT scan report  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).  4. Physician’s notes  5. History and Physical  6. Remainder of current hospital record  **Exclusion Statement:**  **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 Hospital Quality Measures. Smoking counseling, pneumococcal vaccination, and influenza vaccination were abstracted for VHA data.** |

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| 22 | comfort | When is the earliest physician, APN, or PA documentation of comfort measures only?  1. Day of arrival (day 0) or day after arrival (day 1)  2. Two or more days after arrival (day 2 or greater)  3. Comfort measures only documented during hospital stay, but timing unclear  99. Comfort measures only was not documented by the physician/APN/PA or unable to determine | \*1,2,3,99  **\*If 1, the case is excluded from the JC PN Hospital Quality Measures; Fall Assessment is applicable**     |  | | --- | | Warning if comfort = 2 | | **Only accept terms identified in the list of inclusions. No other terminology will be accepted. Day of arrival is day 0.**   |  |  | | --- | --- | | **Inclusion (Only acceptable terms)** | | | Brain death/dead | Hospice | | Comfort care | Hospice care | | Comfort measures | Organ harvest | | Comfort measures only CMO) | Palliative care | | Comfort only | Palliative measures | | DNR-CC | Terminal care | | End of life care |  |  * **Determine the earliest day the physician/APN/PA DOCUMENTED comfort measures only in the ONLY ACCEPTABLE SOURCES.** Do not factor in when comfort measures only was actually instituted**.** E.g., “Discussed comfort care with family on arrival” noted in day 2 progress note – Select “2.” * **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.** * **Physician/APN/PA documentation of comfort measures only mentioned in the following context is acceptable:** comfort measures only recommendation, order for consultation/evaluation by hospice/palliative care, patient/family request for comfort measures only, referral to hospice/palliative care service. * If any of the inclusions are documented **in the ONLY ACCEPTABLE SOURCES**, select option “1,” “2,” or “3” accordingly, unless otherwise specified.   **Disregard documentation of an Inclusion term in the following situations:**   * Inclusion term clearly described as negative (e.g. “No comfort care,” “Not appropriate for hospice care,” “Declines palliative care”).   **Cont’d next page** |
|  |  |  |  | **Comfort Measures Only cont’d**  **NOTE:** 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.”)   * Do not use 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 discharge summary).  **EXCEPTION:** 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  **Examples:** DNR-Comfort Care form, MOLST (Medical Orders for Life- Sustaining Treatment), POLST (Physician Orders for Life-Sustaining Treatment)   * Inclusion terms not clearly selected on a pre-printed order form, even if orders are signed by physician/APN/PA.   **Examples:** Home Health/Hospice order form - “Hospice” not circled or selected; DNR-Comfort Care order form - option “Comfort Care” not checked or selected.   |  |  | | --- | --- | | **Exclusion (Only acceptable exclusion terms)\*:** | | | DNR-CCA | DNRCC-Arrest | | DNR-Comfort Care Arrest | DNRCCA | | DNRCC-A |  |   **ONLY ACCEPTABLE SOURCES:** Discharge summary, DNR/MOLST/POLST forms, physician orders, progress notes  **Excluded data source:** Restraint order sheet  **Exclusion Statement: Clinician documentation of “comfort measures only” excludes the case from Joint Commission designated PN Hospital Quality measures. Abstraction of required data elements for VHA measures remains applicable.** |
| 23 | clntrial | During this hospital stay, was the patient enrolled in a clinical trial in which patients with pneumonia were being studied? | \*1,2  **\*If 1, the record is excluded from the JC PN Hospital Quality Measures review; go to end.**  **(Partial Abstraction only)**  **If 2, go to transin2** | **In order to answer “Yes”, BOTH of the following must be documented:**  1. **There must be a signed consent form for the clinical trial.** For the purposes of abstraction, a clinical trial is defined as an **experimental study** in which research subjects are recruited and assigned a treatment/intervention and their outcomes are measured based on the intervention received; **AND**  2**. 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.** 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.  **In the following situations, select "No":**  1. **There is a signed patient consent form for an observational study only**. Observational studies are non-experimental and involve no intervention (e.g., registries).  2. **It is not clear whether the study described in the signed patient consent form is experimental or observational**.  3. **It is not clear which study population the clinical trial is enrolling**. Assumptions should not be made if the study population is not specified.  **ONLY ACCEPTABLE SOURCE**: Signed consent form for clinical trial  **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 Quality Measures review.** |
| 24 | transin2 | Was the patient received as a transfer from an inpatient, outpatient, or emergency/observation department of another hospital OR from an ambulatory surgery center?   1. Patient received as a transfer from an inpatient department of another hospital 2. Patient received as a transfer from an outpatient department of another hospital (excludes emergency/observation departments) 3. Patient received as a transfer from the emergency/observation department of another hospital   4. Patient received as a transfer from an ambulatory surgery center  99. None of the above or unable to determine from medical record documentation | 1,2,3,4,99  If pnedpt = 1, go to pndxed  If pnedpt = 2, go to pndxadm | **If a patient is transferred in from the emergency department or observation unit of ANY outside hospital, select value “3”, regardless of whether the two hospitals are close in proximity, part of the same hospital system, have a shared medical record or provider number, etc.**   * If a patient is transferred in from a Disaster Medical Assistance Team (DMAT), which provides emergency medical assistance following a catastrophic disaster or other major emergency, select value “3.” * The emergency department includes free-standing and satellite emergency departments/rooms. * If the medical record reflects only that the patient was received as a transfer from another hospital and the abstractor is unable to determine if the patient was in an inpatient or an outpatient department, select value “1.” |
| 25 | pndxed | Was there documentation of the diagnosis of pneumonia as an **Emergency Department** final diagnosis/impression?  **Physician, Advanced Practice Nurse, or Physician Assistant documentation only**   1. There is documentation that pneumonia was a final diagnosis/impression on the ED form.   3. There is NO documentation of pneumonia as a final diagnosis/impression on the ED form  95. Not applicable  99. Unable to determine from ED medical record documentation (only use if the final ED diagnosis/impression is left blank in **ALL** Emergency Department sources) | 1,3,95,99  Will be auto-filled as 95 if pnedpt = 2  If 1, go to uncertdx  If 3 or 99, go to smokcigs  If 3, the record is excluded from JC designated PN Hospital Quality Measures  If 99, the record is included in the denominator for JC designated PN Hospital Quality measures  (partial abstraction only)   |  | | --- | | Warning: If 99, was the ED final diagnosis/impression left blank in ALL ED sources | | **ONLY Acceptable Inclusions: infiltrate, lower respiratory infection, lower lobe infection, admission Pneumonia Pathway (or equivalent), pneumonitis, PN, PNA, PNE, Pneu, Pneumonia**  **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).**  **Exclude: aspiration pneumonia, chronic infiltrate, pneumonia caused by chemical agents or aerosolized medications**  **Pneumonia diagnosis in the Emergency Department:**   1. **For the purposes of this data element, an ED admit is any patient who receives treatment, care, or evaluation in the ED.** 2. For the purposes of this data element, the ED form is the document within the ED record which contains the final diagnosis/impression. The ED form may be named the 1010M and found in CPRS or the paper record. 3. Pneumonia need not be the primary or only diagnosis. 4. 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. 5. **If pneumonia is listed as the final diagnosis/impression on the ED form by any physician/APN/PA, select “1”** (review of other acceptable sources is not necessary). 6. If there is documentation of aspiration pneumonia as an ED final diagnosis/impression, select “3.” Example: ED final diagnosis “Pneumonia versus aspiration pneumonia”, select “3.” 7. Diagnosis of pneumonia cannot be taken from the chest x-ray, discharge summary, coding or billing documents. 8. Do not use medical student, intern, resident, attending physician/APN/PA, etc. documentation of a differential diagnosis. |
|  |  |  |  | **Pneumonia ED Diagnosis/impression cont’d**  **If pneumonia was not listed as the final diagnosis/impression on**  **the ED form, go to A; otherwise if there is not an ED form, go to section B.**  **A. Pneumonia is NOT listed as the final diagnosis/impression**  **on the ED form:**  **1. If the same physician/APN/PA (ED OR hospitalist, attending, or consultant) who completed the ED form** completes an admit note or order with an admission diagnosis of pneumonia or a pneumonia pathway that was initiated upon admission, select “1.”  2.If the admit note or admit orders completed by the same physician/APN/PA does not include a diagnosis of pneumonia, select “3.”  **B. Medical Records that do not contain an ED form:**  1. If pneumonia is documented as a diagnosis/impression (pneumonia does not have to be the primary or only diagnosis/impression) on ANY of the ONLY ACCEPTABLE SOURCES, select “1.”  2. If the admit orders refer to a Pneumonia pathway, select “1.”  3. History & physical can be used ONLY if the physician/APN/PA documents on one of the ONLY acceptable sources to “see H&P.”  4. Do not use a H&P labeled Admit H&P or a H&P that contains an admit note or order within the body of text  5. If the patient is seen in the ED but the record does not contain an ED form, the ONLY acceptable sources are limited to admitting physician orders and admit notes.  **ONLY ACCEPTABLE SOURCES:** ED admitting notes, ED H&P, ED physician orders, ED record  **Exclusion Statement:**  **No working diagnosis of pneumonia at the time of admission partially excludes the case from the Joint Commission PN Hospital Quality Measures. Smoking counseling, pneumococcal vaccination, and influenza vaccination remain applicable measures.** |
| 26 | pndxadm | Was there documentation of the diagnosis of pneumonia as an admission diagnosis/impression for the **direct admit** patient?  **Physician, Advanced Practice Nurse, or Physician Assistant documentation only**   1. There is documentation that pneumonia is listed as an initial diagnosis/impression upon direct admit. 2. There is NO documentation of pneumonia as an initial diagnosis/impression upon direct admit.   95. Not applicable | 2,3,95  Will be auto-filled as 95 if pnedpt = 1  If 2 and transin2 = 99, go to heltrisk; else if 2 go to smokcigs  If 3, go to smokcigs  If 2 and transin2 <> 99 OR if 3, the record is excluded from JC designated PN Hospital Quality Measures  (partial abstraction only) | **ONLY Acceptable Inclusions: infiltrate, lower respiratory infection, lower lobe infection, admission Pneumonia Pathway (or equivalent), pneumonitis, PN, PNA, PNE, Pneu, Pneumonia**  **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).**  **Exclude: aspiration pneumonia, chronic infiltrate, pneumonia caused by chemical agents or aerosolized medications**  **ONLY ACCEPTABLE SOURCES:** Admitting notes, admitting physician orders, physician admission note  **Pneumonia diagnosis on Admission—Direct Admit**   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.** 2. 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. 3. 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 “2.” 4. If the admit orders refer to a Pneumonia pathway, select “2.” 5. If there is documentation of aspiration pneumonia listed as an initial diagnosis for a direct admit patient in any of the allowable sources, select “3.” Example: Direct Admit diagnosis “Pneumonia versus aspiration pneumonia”, select “3.” 6. Any of the ONLY ACCEPTABLE SOURCES can be used without a date or time. 7. History and Physical can be used ONLY if the physician/APN/PA documents on one of the ONLY acceptable sources to “see H&P.”   8. Do not use a H&P labeled Admit H&P or a H&P that contains an admit note or order within the body of text  **Cont’d next page** |
|  |  |  |  | **Pneumonia Diagnosis Direct Admit cont’d**  9. Diagnosis of pneumonia cannot be taken from the chest x-ray, discharge summary, coding or billing documents.  **Exclusion Statement:**  **No working diagnosis of pneumonia at the time of admission partially excludes the case from the Joint Commission PN Hospital Quality Measures. Smoking counseling, pneumococcal vaccination, and influenza vaccination remain applicable measures.** |
| 27 | uncertdx | Despite being seen by the physician/APN/PA, is there documentation of a reason (s) the patient’s initial clinical picture was unclear or not suggestive of pneumonia which resulted in a delay in the diagnosis of pneumonia at the time of admission?  **(Physician/APN/PA documentation only)**  1.Yes  2. No or unable to determine  95. Not applicable | 1,2,95  Will be auto-filled as 95 if pnedpt = 2  If transin2 = 1,2,3, or 4, go to blcltdon, else if transin2 = 99, go to heltrisk | **Please read D/D rules carefully. The primary intent of this question is to determine if the physician/APN/PA identified clinical circumstances that would delay the diagnosis of pneumonia. Documentation of the delay can refer to the pneumonia diagnosis or to antibiotic administration.**  **For the purposes of this data element, the initial clinical picture is defined as the clinical picture from arrival to admission for ED patients and as the clinical picture on admission for direct admits.**  **Physician/APN/PA must specifically document both of the following required elements to select “yes”:**  1) The initial clinical picture was questionable, unclear or not suggestive of pneumonia, etc. **AND**  2) This resulted in a delay in the diagnosis of pneumonia at the time of admission. (There must be documentation of a delay. Do not infer there was a delay in the diagnosis of pneumonia.)  If the timeframe from arrival in the hospital until the time the patient is seen by the physician/APN/PA is greater than 6 hours, do not consider this appropriate documentation of diagnostic uncertainty. For example, “Patient triaged earlier but unable to see patient until now” and arrival time was 10:00 and first clinician documentation occurred at 17:00, select “2.”  **ONLY ACCEPTABLE SOURCES:** ED department record (ED admits), Physician admitting note (Direct admits)  **Exclude:** systems reasons for delays in the administration of antibiotics (e.g., antibiotic not available in ED, patient had to sit in waiting room for 6 hours, chest x-ray delayed), radiology reports or consultation |