

#### REVSTAT

REVIEW STATUS (not abstracted)

0. Abstraction has not begun
1. Abstraction in progress
2. Abstraction completed w/o errors
3. TVG failure (exclusion)
4. Record contains missing required answers (error record)
5. Administrative exclusion from all measures

#### LEFTDATE (Validation)

Discharge date (received on pull list and may not be modified)

#### ADMDT (Validation)

Date of admission to acute inpatient care

#### AGE

Calculated field: ADMDT - BIRTHDT

#### CXRCTABN (Validation)

**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**?

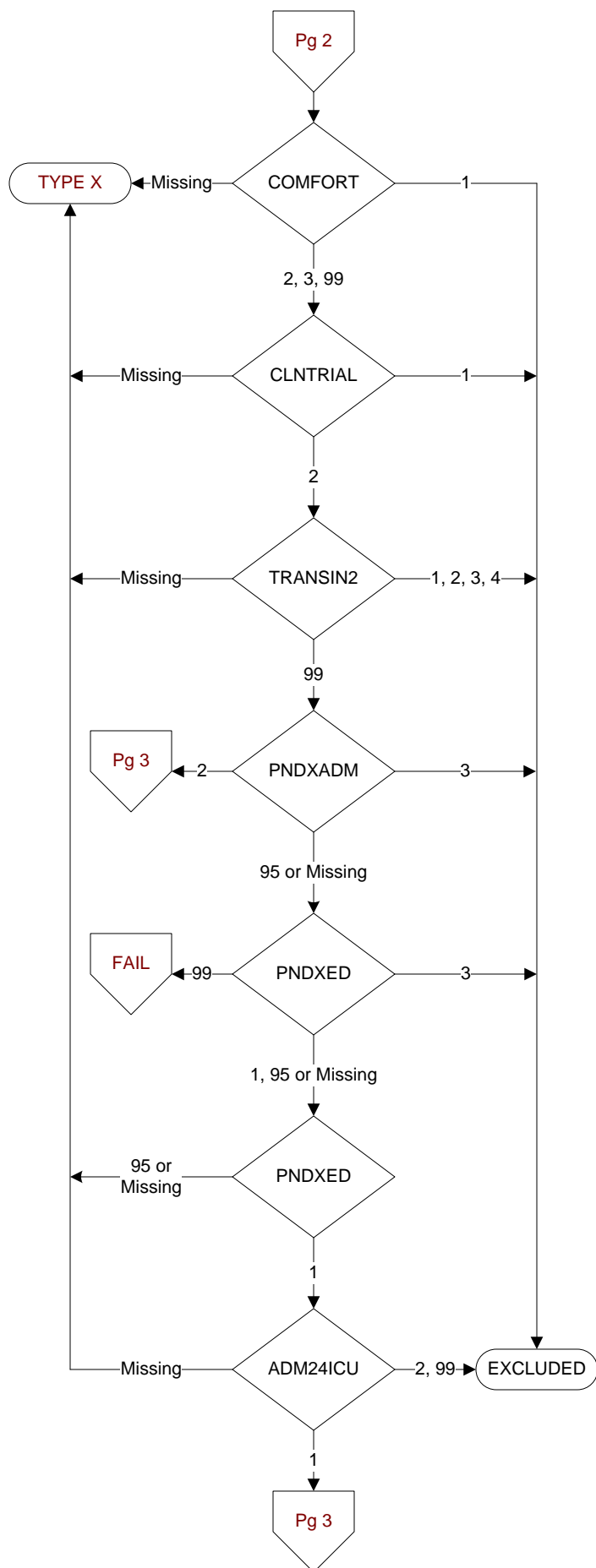
(SEE INCLUSION LIST)

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

#### CXRDONE (Validation)

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

**COMFORT** (Validation)

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

**CLNTRIAL** (Validation)

During this hospital stay, was the patient enrolled in a clinical trial in which patients with pneumonia were being studied?

1. yes
2. no

**TRANSIN2** (Validation)

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

**PNDXADM** (Validation)

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**

2. There is documentation that pneumonia is listed as an initial diagnosis/impression upon direct admit.
3. There is **NO** documentation of pneumonia as an initial diagnosis/impression upon direct admit.
95. Not applicable

**PNDXED** (Validation)

Was there documentation of the diagnosis of pneumonia as an **Emergency Department** final diagnosis/impression?

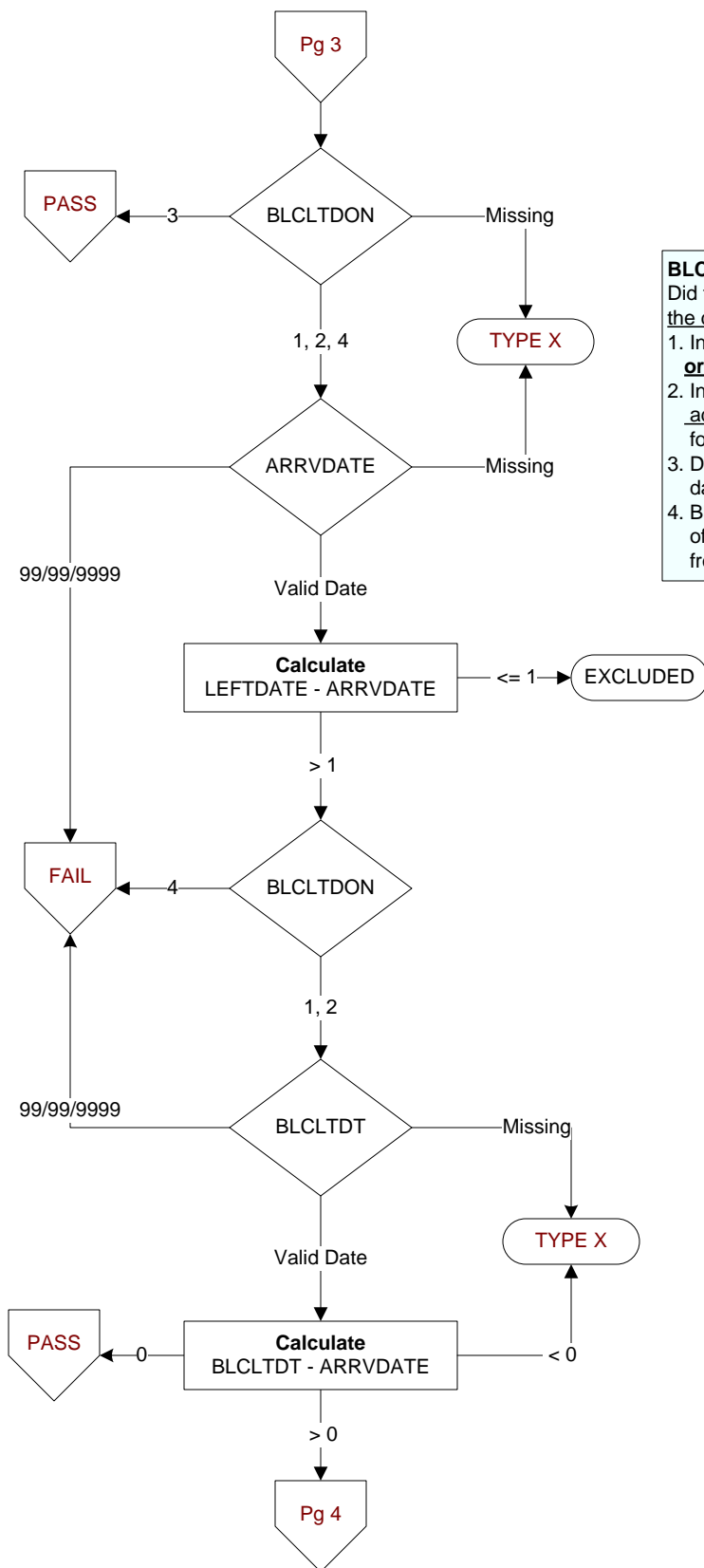
**Physician, Advanced Practice Nurse, or Physician Assistant documentation only**

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)

**ADM24ICU** (Validation)

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
99. Unable to determine

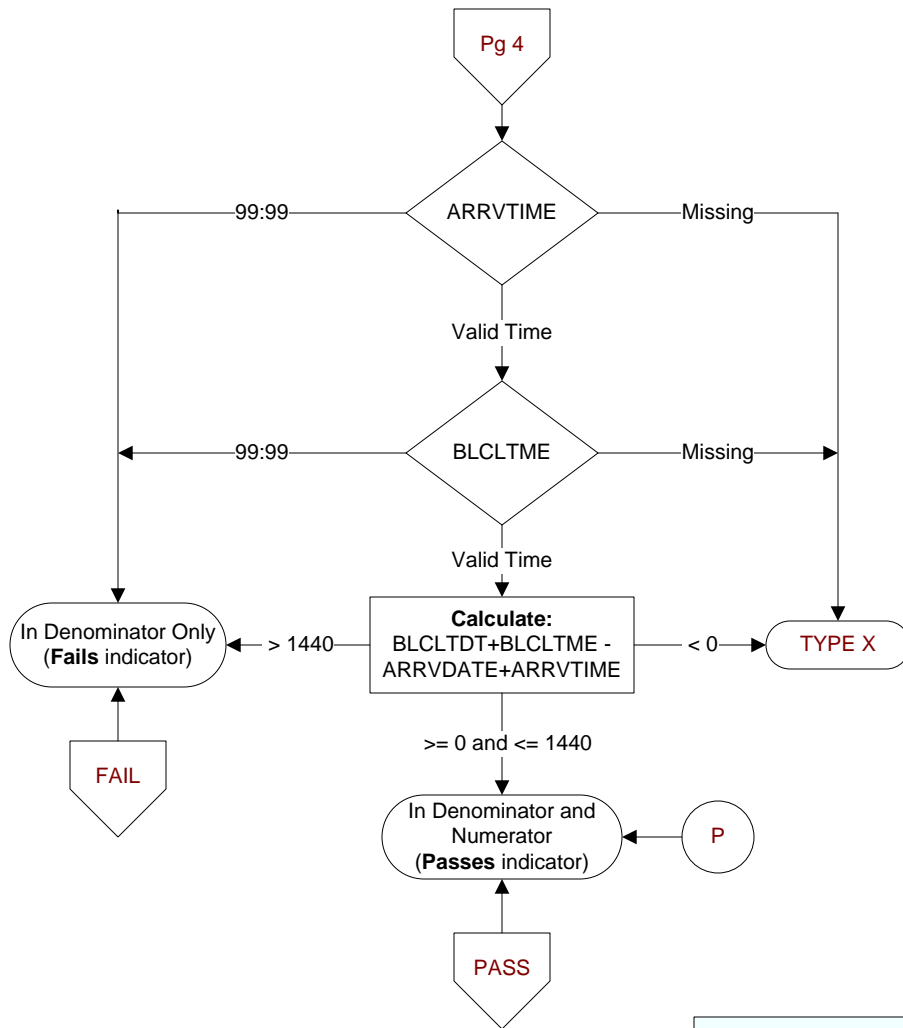


**BLCLTDON** (Acute Care)  
Did the patient have blood cultures collected the day prior to arrival, the day of arrival, or within 24 hours after hospital arrival?

1. Initial blood culture collected in the ED prior to admission order
2. Initial blood culture collected during this hospitalization but after admission order for ED patients (OR within 24 hours after arrival for Direct Admit patients)
3. Documentation that the patient had a blood culture collected the day prior to arrival up until the time of presentation to the hospital
4. Blood culture was not collected the day prior to arrival, the day of arrival, or within 24 hours after arrival or unable to determine from medical record documentation

**ARRVDATE** (Validation)  
Enter the earliest documented date the patient arrived at acute care at this VAMC.

**BLCLTDT** (Acute Care)  
Enter the date of the initial blood culture collected the day prior to arrival, the day of arrival, or within 24 hours after hospital arrival.



**ARRVTIME** (Validation)  
Enter the earliest documented time the patient arrived at acute care at this VAMC.

**BLCLTME** (Acute Care)  
Enter the time of the initial blood culture collected the day prior to arrival, the day of arrival, or within 24 hours after hospital arrival.