

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)

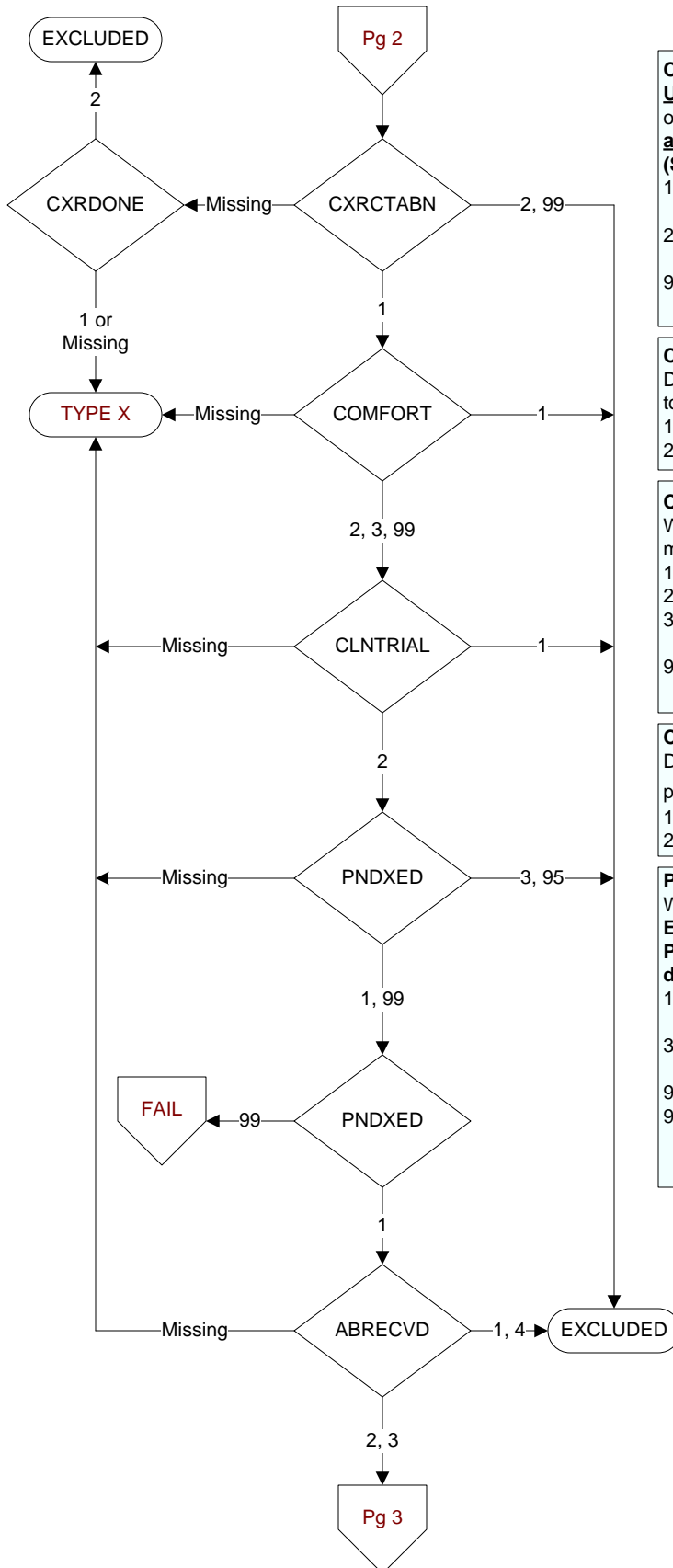
Date of admission to acute inpatient care

BIRTHDT

Patient date of birth (received on pull list)

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

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)

ABRECVD (Acute Care)

Did the patient receive antibiotics via an appropriate route (PO, NG, PEG, IM, or IV)?

1. Antibiotic received only within 24 hours prior to arrival or the day prior to arrival and not during hospital stay
2. Antibiotic received within 24 hours prior to arrival or the day prior to arrival and during hospital stay
3. Antibiotic received only during hospital stay (not prior to arrival)
4. Antibiotic not received or unable to determine from medical record documentation

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)

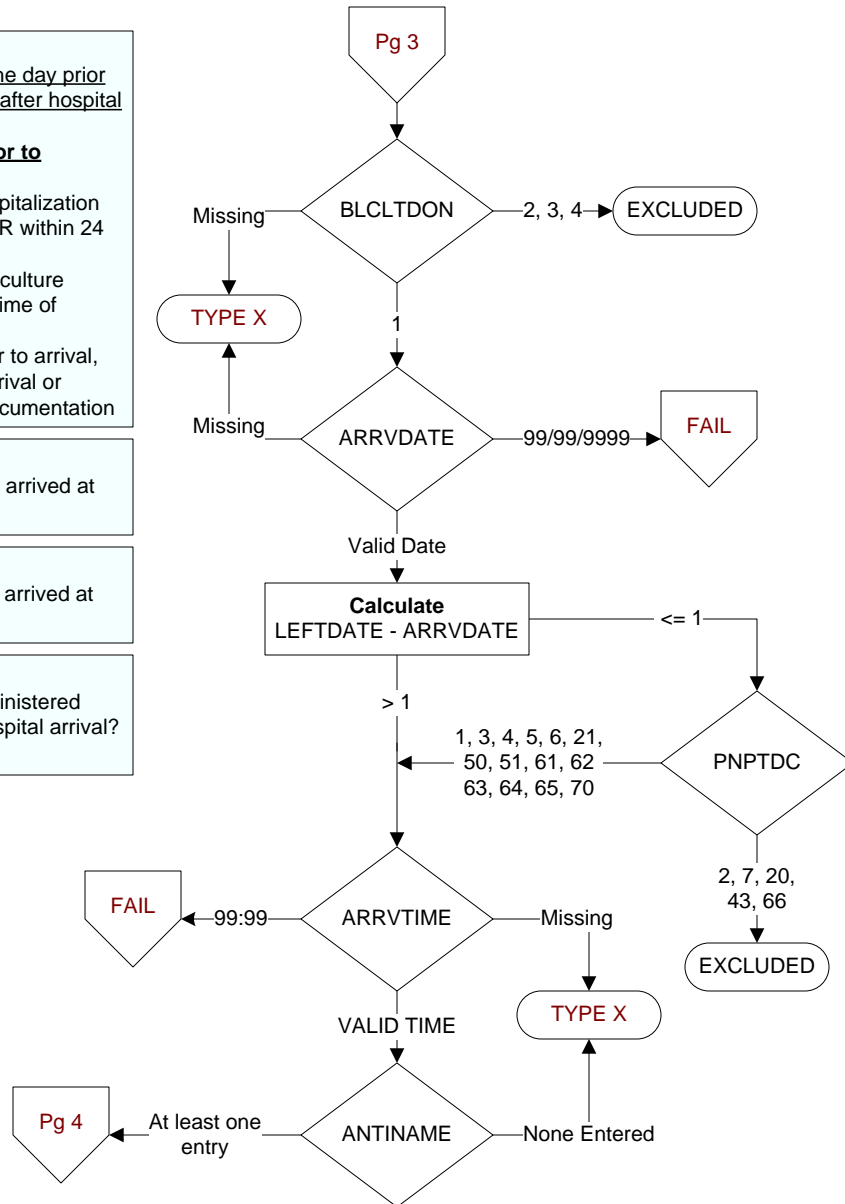
Enter the earliest documented date the patient arrived at acute care at this VAMC.

ARRVTIME (Validation)

Enter the earliest documented time the patient arrived at acute care at this VAMC.

ANTINAME (Acute Care)

What was the name of the antibiotic dose administered from hospital arrival through 24 hours after hospital arrival? (up to 75 entries)



PNPTDC (Validation)

Enter the patient's discharge disposition:

1. Discharged to home care or self care (routine discharge)
2. Discharged/transferred to a short term general hospital for inpatient care
3. Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification **in anticipation of skilled care**
4. Discharged/transferred to a facility that provides custodial or supportive care
5. Discharged/transferred to a Designated Cancer Center or Children's Hospital
6. Discharged/transferred to home **under care of organized home health service organization in anticipation of covered skilled care.**
7. Left against medical advice or discontinued care
20. Expired
21. Discharged/transferred to court/law enforcement (includes transfers to incarceration facilities such as jail, prison, or other detention facilities)
43. Discharged/transferred to a federal health care facility
50. Hospice – home
51. Hospice – medical facility (certified) providing hospice level of care
61. Discharged/transferred to hospital-based Medicare approved swing bed
62. Discharged/transferred to inpatient rehabilitation facility (IRF) including rehabilitation distinct parts of a hospital
63. Discharged/transferred to a Medicare certified long-term care hospital
64. Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65. Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66. Discharged/transferred to a Critical Access Hospital (CAH)
70. Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List

