

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)

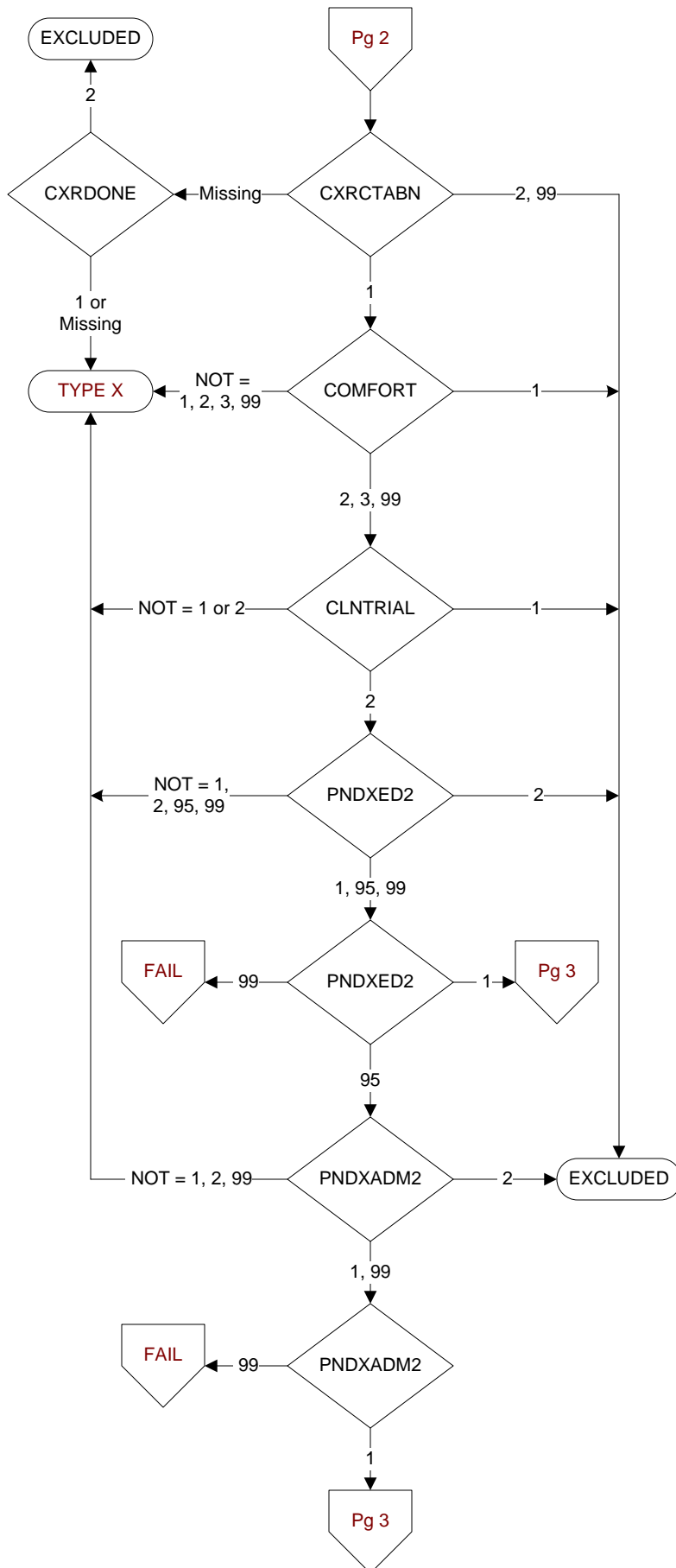
Date of admission to acute inpatient care

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

PNDXED2 (Validation)

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

1. There is documentation that pneumonia was a diagnosis/impression in the ED
2. There is NO documentation that pneumonia was a diagnosis/impression in the ED
95. Not applicable
99. Unable to determine from ED medical record documentation (only use if the ED diagnosis/impression is left blank in **ALL** Emergency Department sources)

PNDXADM2 (Validation)

Was there documentation of the diagnosis of pneumonia as an admission diagnosis/impression for the direct admit patient?

1. There is documentation that pneumonia was an admission diagnosis/impression upon direct admit.
2. There is NO documentation that pneumonia was an 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**)

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)

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.

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

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

DCDISPO (Validation)

What was the patient's discharge disposition on the day of discharge?

1. Home
 - Assisted Living Facilities (ALFs) – includes assisted living care at nursing home/facility
 - Court/Law Enforcement – includes detention facilities, jails, and prison
 - Home – includes board and care, domiciliary, foster or residential care, group or personal care homes, retirement communities, 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 (or other home setting as listed in #1 above)
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

