

**For CART Users
Pneumonia (PN) Abstraction Paper Tool**

General Data Elements

First Name _____

Last Name _____

What is the patient's sex? (Sex)

- F Female
 M Male
 U Unknown

What is the patient's date of birth? (Birthdate)

____ - ____ - ____ (UTD is **not** an allowable entry)

What is the patient's race? (Race)

Select one:

- 1 **White:** Patient's race is White or the patient has origins in Europe, the Middle East, or North Africa.
 2 **Black or African American:** Patient's race is Black or African American.
 3 **American Indian or Alaska Native:** Patient's race is American Indian/Alaska Native.
 4 **Asian:** Patient's race is Asian.
 5 **Native Hawaiian or Pacific Islander:** Patient's race is Native Hawaiian/Pacific Islander.
 6 **RETIRED VALUE** (effective 07-01-05 discharges)
 7 **UTD:** Unable to determine the patient's race or not stated (e.g., not documented, conflicting documentation or patient unwilling to provide).

Is the patient of Hispanic ethnicity or Latino? (Hispanic Ethnicity)

- Yes Patient is of Hispanic ethnicity or Latino.
 No Patient is not of Hispanic ethnicity or Latino or unable to determine from medical record documentation.

What was the number used by the hospital to identify this patient's stay? (Hospital Patient Identifier)

What is the date the patient was admitted to inpatient care? (Admission date)

____ - ____ - ____ (UTD is **not** an allowable entry)

What is the date the patient was discharged from acute care, left against medical advice (AMA) or expired? (Discharge date)

____ - ____ - ____ (UTD is **not** an allowable entry)

PN Data Elements

1. Would you like the questions to be enabled or disabled appropriately per the measure algorithms or do you want all questions enabled? (SCIPPATTERN)

- Enable/disable questions appropriately
 Enable all questions

2. What was the ICD-9-CM code selected as the principal diagnosis for this record? (ICD-9-CM Principal Diagnosis Code) (Refer to Appendix A for ICD-9-CM Code Tables)

_____ . _____

3. Were there ICD-9-CM Other Diagnosis Codes? (ORTHRDX#A)

- Yes
 No

If yes, what were the ICD-9-CM other diagnosis codes selected for this medical record? (*ICD-9-CM Other Diagnosis Codes*) (Refer to Appendix A for ICD-9-CM Code Tables)

_____._____ _____ . _____ _____ . _____
 _____ . _____ _____ . _____ _____ . _____
 _____ . _____ _____ . _____

4. Was there an ICD-9-CM code selected as the principal procedure for this record?

- Yes
 No

If yes, what was the ICD-9-CM as the principal procedure for this record? (*ICD-9-CM Principal Procedure Code*) (*ICD-9-CM Principal Procedure Dates*) (Refer to Appendix A for ICD-9-CM Code Tables)

Code _____ Date _____ or UTD

5. Were there ICD-9-CM Other Procedure Codes?

- 01 Yes
 02 No

If yes, what were the ICD-9-CM code(s) selected as other procedure(s) for this record? (*ICD-9-CM Other Procedure Codes*) (*ICD-9-CM Other Procedure Dates*) (Refer to Appendix A for ICD-9-CM Code Tables)

Code	Date	
_____ . _____	_____ - _____ - _____	or <input type="checkbox"/> UTD
_____ . _____	_____ - _____ - _____	or <input type="checkbox"/> UTD
_____ . _____	_____ - _____ - _____	or <input type="checkbox"/> UTD
_____ . _____	_____ - _____ - _____	or <input type="checkbox"/> UTD
_____ . _____	_____ - _____ - _____	or <input type="checkbox"/> UTD

6. What was the Point of Origin for Admission or Visit? (*Point of Origin for Admission or Visit*)

- | | |
|---|---|
| <input type="checkbox"/> 1 Non-Healthcare Facility Point of Origin | <input type="checkbox"/> 8 Court/Law Enforcement |
| <input type="checkbox"/> 2 Clinic referral | <input type="checkbox"/> 9 Information Not Available (UTD) |
| <input type="checkbox"/> 3 (Discontinued Effective 10/01/2007) | <input type="checkbox"/> A (Discontinued Effective 10/01/2007) |
| <input type="checkbox"/> 4 Transfer from a Hospital (Different Facility) | <input type="checkbox"/> D Transfer from One Distinct Unit Of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to the Payer |
| <input type="checkbox"/> 5 Transfer from Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) | <input type="checkbox"/> E Transfer from Ambulatory Surgery Center |
| <input type="checkbox"/> 6 Transfer from another Health Care Facility | <input type="checkbox"/> F Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program |
| <input type="checkbox"/> 7 Emergency Room | |

7. What is the source of payment for the patient's services? (*Payment Source*)

Record ALL payment sources:

- 1 **Medicare (Title 18):** Medicare is listed as a payment source and has a standard Patient HIC Number. This would include Medicare Fee for Service (include DRG or PPS), Black Lung, End Stage Renal Disease (ESRD), Railroad Retirement Board (RRB) and Medicare coverage as a secondary payer and may include Medicare HMO/Medicare Advantage.

- 2 **Medicaid (Title 19):** Medicaid is listed as a payment source.
- 3 **Other:** There is a payment source other than Medicare or Medicaid (e.g., Veterans Administration [VA], CHAMPUS [TRICARE], Workers' Compensation or private insurance).
- 4 **No Insurance/Not documented/Unable to Determine:** The patient has no insurance coverage, the payment source is not documented, unable to determine the payment source, or the payment source does not coincide with one of the above options.
- 5 **Medicare Other:** Medicare is listed as a payment source and does not have a standard Patient HIC Number. This would include Undocumented Alien (Illegal immigrant) status and may include Medicare HMO/Medicare Advantage.

8. What is the patient's Medicare/HIC number? (Patient HIC#) (Required only if payment source is Medicare. Refer to the CMS National Hospital Quality Measure Data Transmission sub-section, within the Transmission section, for valid patient HIC# format)

9. What is the postal code of the patient's residence? (Postal Code) (Any valid five or nine digit postal code or "HOMELESS" if the patient is determined not to have a permanent residence. If the patient is not a resident of the United States, use "NON-US.")

10. Does this case represent part of a sample? (Sample)

- Yes The data represents part of a sample.
- No The data is not part of a sample; this indicates the hospital is performing 100 percent of the discharges eligible for this topic.

11. What was the patient's discharge disposition? (Discharge Status) (Refer to Appendix H, Table 2.5 Discharge Status Disposition)

- 01 Discharged to home care or self care (routine discharge)
- 02 Discharged/transferred to a short term general hospital for inpatient care
- 03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
- 04 Discharged/transferred to an intermediate care facility (ICF)
- 05 Discharged/transferred to another type of health care institution not defined elsewhere in this code list
- 06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
- 07 Left against medical advice or discontinued care
- 20 Expired
- 41 Expired in a medical facility (e.g., hospital, SNF, ICF or freestanding hospice)
- 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 an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
- 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
- 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)

12. Did the patient have an abnormal chest x-ray/CT scan within 24 hours prior to hospital arrival or anytime during this hospitalization? (Chest X-Ray)

- Yes There is documentation the patient had an abnormal chest x-ray/ CT scan within 24 hours prior to hospital arrival or anytime during this hospitalization.
- No There is no documentation the patient had an abnormal chest x-ray/CT scan within 24 hours prior to hospital arrival or anytime during this hospitalization or unable to be determined from medical record documentation.

13. Is there physician/APN/PA documentation of comfort measures only during the hospital stay? (Comfort Measures Only)

- Yes There is physician/APN/PA documentation of “comfort measures only” during the hospital stay.
- No There is no physician/APN/PA documentation of “comfort measures only” during the hospital stay, or unable to determine from medical record documentation.

14. Was the patient involved in a clinical trial during this hospital stay relevant to the measure set for this admission (i.e. PN)? (Clinical Trial)

- Yes There is documentation that the patient was involved in a clinical trial during this hospital stay relevant to the measure set for this admission (i.e. PN).
- No There is no documentation that the patient was involved in a clinical trial during this hospital stay relevant to the measure set for this admission (i.e. PN), or unable to determine from medical record documentation.

15. Was the patient received as a transfer from an emergency department of another hospital? (Transfer From Another ED)

- Yes Patient received as a transfer from another hospital emergency department.
- No Patient not received as a transfer from another hospital emergency department or unable to determine from medical record documentation.

16. Is there documentation of a reason(s) that despite being seen by the physician/APN/PA, the patient’s clinical picture was questionable or unclear and not suggestive of pneumonia? (Diagnostic Uncertainty)

- Yes There is documentation of a reason(s) that despite being seen by the physician/APN/PA, the patient’s clinical picture was questionable or unclear and not suggestive of pneumonia.
- No There is no documentation of a reason(s) that despite being seen by the physician/APN/PA, the patient’s clinical picture was questionable or unclear and not suggestive of pneumonia or unable to determine from medical record documentation.

17. Is there documentation that the patient had a positive diagnostic test for pneumonia pathogen upon arrival or within 24 hours after arrival to the hospital? (Identified Pneumonia Pathogen)

- Yes There is documentation that the patient had a positive diagnostic test for pneumonia pathogen upon arrival or within 24 hours after arrival to the hospital.
- No There is no documentation that the patient had a positive diagnostic test for pneumonia pathogen upon arrival or within 24 hours after arrival to the hospital or unable to determine from medical record documentation.

18. Was there documentation of the diagnosis of pneumonia either as an Emergency Department final diagnosis/impression, or as an admission diagnosis/impression for the direct admit patient? (Pneumonia Diagnosis: ED/Direct Admit)

- 1 Pneumonia Diagnosis in the Emergency Department:
There is physician/advanced practice nurse/physician assistant (physician/APN/PA) documentation that pneumonia was a final diagnosis/impression on the ED form.
- 2 Pneumonia Diagnosis on Admission-Direct Admit:
There is physician/APN/PA documentation that pneumonia is listed as an initial diagnosis/impression.

- 3 There is no physician/APN/PA documentation of pneumonia as a final diagnosis/impression on the ED form, or listed as an initial diagnosis/impression upon direct admit.
- 4 Unable to determine from medical record documentation.

19. Was the patient admitted or transferred to the intensive care unit (ICU) within the first 24 hours following arrival at the hospital? (ICU Transfer or Admission Within First 24 Hours)

- 1 (Yes) The patient was admitted or transferred to the ICU within the first 24 hours after arrival. Any time spent in the ICU within the first 24 hours is included.
- 2 (No) The patient was not admitted or transferred to an ICU within the first 24 hours of the hospital arrival.
- 3 (UTD) Unable to determine from medical record documentation if the patient was transferred to ICU within the first 24 hours of hospital arrival.

20. What was the earliest documented date the patient arrived at the hospital? (Arrival Date)

____ - ____ - ____ (MM-DD-YYYY) or UTD

21. What was the earliest documented time the patient arrived at the hospital? (Arrival Time)

____: ____ (HH:MM military format) or UTD

22. Is there documentation the patient had risk for healthcare associated pneumonia? (Healthcare Associated PN)

- Yes The patient has documented risk for healthcare associated pneumonia.
- No The patient has no documented risk for healthcare associated pneumonia or unable to determine from medical record documentation.

23. Is there documentation the patient had a compromising condition? (Compromised)

- 1 A compromising condition.
- 2 Prior hospitalization within 14 days
- 3 Both 1 and 2
- 4 None of the above/Unable to Determine

24. Did the patient receive an antibiotic via an appropriate route (PN: PO, IV, IM)? (Antibiotic Received)
(Refer to Appendix C, Table 2.1 Antimicrobial Medications)

- 1 Antibiotic received only within 24 hours prior to arrival and not during hospital stay
- 2 Antibiotic received within 24 hours prior to arrival and during hospital stay (arrival through 36 hours)
- 3 Antibiotic received only during hospital stay (arrival through 36 hours)
- 4 Antibiotic not received (arrival through 36 hours) or unable to determine from medical record documentation

Antibiotic Name (trade or generic)	Antibiotic Administration Date MM-DD-YYYY or UTD	Antibiotic Administration Time (military format) HH:MM (with or without a colon) or UTD	Antibiotic Administration Route PO/NG/PEG tube, IV, IM or UTD

25. Did the patient have a documented risk factor(s) for drug-resistant pneumococcus? (*Risk Factors for Drug-Resistant Pneumococcus*)

- Yes There is documentation the patient had risk factors for drug-resistant pneumococcus.
- No There is no documentation the patient had risk factors for drug-resistant pneumococcus or unable to determine from medical record documentation.

26. Does the patient have risk of pseudomonas? (*Pseudomonas Risk*)

- Yes The patient has risk of pseudomonas as indicated by documentation of one or more of the above conditions.
- No The patient has no risk of pseudomonas as indicated by none of the above conditions being documented in the medical record or unable to determine from medical record documentation.

27. Did the patient have any allergies, sensitivities or intolerance to beta-lactam/penicillin antibiotic or cephalosporin medications? (*Antibiotic Allergy*)

- Yes Documentation that the patient has an antibiotic allergy to beta-lactam, penicillin or cephalosporins (e.g., either history or current finding).
- No No documentation that the patient had an allergy to beta-lactam, penicillin or cephalosporins or unable to determine from medical record documentation.

28. Was there another suspected source of infection in addition to pneumonia upon admission? (*Another Suspected Source of Infection*)

- Yes There was another suspected source of infection in addition to pneumonia within 24 hours after arrival.
- No There was no other suspected source of infection within 24 hours after arrival or unable to determine from medical record documentation.

29. What is the patient's influenza vaccination status? (*Influenza Vaccination Status*)

- 1 Influenza vaccine was given during this hospitalization: The patient received influenza vaccine during this hospitalization.
- 2 Influenza vaccine was received prior to admission during the current flu season*, not during this hospitalization: The patient received the influenza vaccine during the current flu season*, prior to hospitalization.
- 3 Documentation of patient's refusal of influenza vaccine: Documentation the patient refused influenza vaccine.
- 4 Allergy/sensitivity to influenza vaccine: There was documentation of an allergy/sensitivity to influenza vaccine OR is medically contraindicated because of bone marrow transplant within the past 12 months OR prior history of Guillian-Barré syndrome.
- 5 None of the above/Not documented/UTD: None of the allowable values above are appropriate, there was no documentation of an influenza vaccination status or unable to determine from medical record documentation.
- 6 Only select this allowable value if the vaccine has been ordered but has not yet been received by the hospital due to problems with vaccine production or distribution AND allowable values 1-5 are not selected.

30. What is the patient's pneumococcal vaccine status? (*Pneumococcal Vaccination Status*)

- 1 Pneumococcal vaccine was given during this hospitalization: The patient received pneumococcal vaccine during the current hospitalization, even if it was also given anytime in the past.

- 2 Pneumococcal vaccine was received in the past, not during this hospitalization: The patient received pneumococcal vaccine anytime in the past.
- 3 Documentation of patient's refusal of pneumococcal vaccine: There is documentation of the patient refusing pneumococcal vaccine.
- 4 Allergy/sensitivity to pneumococcal vaccine: There is documentation of an allergy/sensitivity to pneumococcal vaccine OR is medically contraindicated because of a bone marrow transplant within the past 12 months OR currently receiving a scheduled course of chemotherapy or radiation therapy, or received chemotherapy or radiation during this hospitalization.
- 5 None of the above/Not documented/UTD: None of the allowable values above are appropriate, there was no documentation of pneumococcal vaccination status or unable to determine from medical record documentation.

31. Did the patient have blood cultures collected within 24 hours prior to hospital arrival? (*Blood Cultures Prior to Arrival*)

- Yes Documentation that the patient had blood cultures collected within 24 hours prior to hospital arrival.
- No The patient did not have blood cultures collected within 24 hours prior to hospital arrival or unable to determine from medical record documentation.

32. Did the patient have blood cultures collected after hospital arrival? (*Blood Culture Collected After 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
- 3 No blood culture performed during this hospitalization or unable to determine from medical record documentation.

33. What is the date of the initial blood culture collected within 36 hours after hospital arrival? (*Initial Blood Culture Collection Date*)

___ __: ___ __ (HH:MM military format) or UTD

34. What is the time of the initial blood culture collected within 36 hours after hospital arrival? (*Initial Blood Culture Collection Time*)

___ __: ___ __ (HH:MM military format) or UTD

35. Is there documentation a pulse oximetry was done within 24 hours before or after hospital arrival?

- Yes Pulse oximetry was done within 24 hours before or after hospital arrival.
- No No pulse oximetry was done within 24 hours before or after hospital arrival or unable to determine from medical record documentation.

36. Is there documentation an arterial blood gas (ABG) was done within 24 hours before or after hospital arrival? (*ABG Done*)

- Yes ABG was done within 24 hours before or after hospital arrival.
- No ABG not done or unable to determine from medical record documentation.

37. Did the adult patient smoke cigarettes anytime during the year prior to hospital arrival? (*Adult Smoking History*)

- Yes There is documentation that the adult patient smoked cigarettes anytime during the year prior to hospital arrival.
- No There is documentation that the adult patient did not smoke cigarettes anytime during the year prior to hospital arrival, smoking history was not addressed or unable to determine from medical record documentation.

38. Was the adult patient/caregiver given smoking cessation advice or counseling during this hospital stay? (*Adult Smoking Counseling*)

- Yes Patient/caregiver received smoking cessation advice/counseling during hospital stay.

No Smoking cessation advice/counseling not given or unable to determine from medical record documentation.

39. What is the first physician identifier? (*Physician 1*)

40. What is the second physician identifier? (*Physician 2*)

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