

NATIONAL
PNEUMONIA
Medicare Quality Improvement Project

FACT SHEET

Summary of Pneumonia Measure Changes for 4/1/10+ Discharges

- PN 6 and PN 6a: All ICU patients with beta-lactam allergies are excluded from the measure.
- PN 3a and PN 6, PN 6a and PN 6b: Patients who have a duration of stay less than or equal to one day added to MIF as an exclusion. This was already in the algorithm for several years.
- Appendix A- Table 3.2 Septicemia ICD-9-CM shortened description code was updated to 038.12 MRSA SEPTICEMIA
- Appendix C- Table 2.2 Immunosuppressive Medications added to the table: SU 11248, Sunitinib and Sutent. Table 2.12 Clindamycin is no longer needed.

Summary of Pneumonia Measure Changes

The information below consists of new changes in abstraction and changes provided for clarification only.

Data Element: Adult Smoking Counseling

Change: Clarification

- Definition of caregiver in abstraction guidelines expanded to address prison officials or other law enforcement personnel.

Data Element: Adult Smoking History

Change: Clarification

- Abstraction guidelines changed to clarify that in a case where one of the Only Acceptable Sources lists current smoking or tobacco use (or use within the last year) and the type of product is not specified AND other documentation in an acceptable source indicates that the tobacco product is pipe, cigar, or chewing tobacco, this documentation would be disregarded (not considered a positive finding). E.g., “Current smoker” per H&P, “Tobacco history: Smokes 5 – 6 cigars/day” per nursing admission assessment. Note: Other documentation within the Only Acceptable Sources indicating the patient is a current **cigarette** smoker or has smoked **cigarettes** within the last year would still count as an Inclusion.

- Updated examples of positive documentation of smoking within past year in Inclusion list:
 - “+ tobacco use” (if no history context – e.g., “History” section of H&P)
 - “Former smoker. Quit recently.”
 - “History – Quit smoking 7 months ago”
 - “Quit smoking several months ago”
 - “Social Habits = current smoking”
 - “Tobacco history: current cigarette smoker”
- Updated examples of negative documentation of smoking within past year in Exclusion list:
 - Chewing tobacco use only
 - Cigar smoking only
 - “History: Smoker”
 - “History - Tobacco abuse”
 - Illegal drug use only (e.g., marijuana)
 - “Most likely quit 3 months ago”
 - Oral tobacco use only
 - Pipe smoking only
 - “Probable smoker”
 - “Remote smoker”
 - “Smoked in the last year: ?”
 - “Tobacco – 2 ppd x 22 yrs” (if no current context)

Data Element: Another Source of Infection

Change: New

- The data element Another Suspected Source of Infection has been combined with the data element Identified Pathogen since both data elements target the same population. Select YES if there is physician /apn/pa documentation within 24 hours of hospital arrival of a named bacterial infection outside of the respiratory tract OR lab results ONLY from the following positive diagnostic tests and pathogens:
 - Positive culture (blood, urine, sputum, wound, etc.) for bacteria
 - Positive urinary antigen test for *Streptococcus pneumoniae* or *Legionella pneumophila*
 - Positive Polymerase Chain Reaction (PCR) test for *Legionella pneumophila*
- A positive culture performed anytime within a week prior to arrival will be accepted.
- Yeast, viral and fungal infections are excluded.

Data Element: Blood Culture Collected**Change: Clarification**

- The allowable values are more clearly defined.
- A physician admit order is defined as a written physician/apn/pa order, a telephone/ verbal order written by a nurse or physician documented disposition or status change to admit.
- Select value 3 rather than value 2 if there is documentation of blood cultures performed the day prior to arrival or the day of arrival prior to presentation to the hospital AND within 24 hours after arrival to the hospital.

Data Element: Chest X-Ray**Change: Clarification**

- Value 4 is removed and UTD (Unable to Determine) is combined with value 3. Value 3 is defined as the patient did not have a chest x-ray or CT Scan the day prior to arrival through acute inpatient discharge OR UTD.
- Documentation of inclusion terms listed in Guidelines for Abstraction table will be used to define what is considered an abnormal Chest X-Ray /CT Scan with the exception of documentation of an inclusion term clearly described as negative, documentation of an inclusion term prefaced with wording such as 'no significant' or 'no definite, OR findings documented as normal or chronic.
- The term 'priority order' is changed to 'recommended order' for Suggested Data Sources.

Data Element: Comfort Measures Only**Change: New**

- A restraint order sheet is an excluded data source. An inclusion term found on a restraint order sheet will abstract as value 4.

Data Element: Compromised**Change: Clarification**

- If there is documentation of a 'hospitalization' or 'admission' assume it was an acute care hospitalization unless there is documentation that states otherwise.

Data Element: Healthcare Associated PN**Change: Clarification**

- If there is documentation of a 'hospitalization' or 'admission' assume it

was an acute care hospitalization unless there is documentation that states otherwise.

- If there is a preprinted form, such as a PN pathway, with a heading of HCAP, selection of antibiotics alone is not sufficient documentation to select yes. However, if there is a marked checkbox next to HCAP heading, this will be a Yes.

Data Element: Identified Pathogen

Change: New

- This data element is retired.

Data Element: Initial Blood Culture Collection Date AND Initial Blood Culture Collection Time

Change: Clarification

- If there is supportive documentation that a blood culture was collected and it is the earliest mention of a blood culture, this date and time can be used, e.g. 'BC sent to lab', 'blood culture received time'.

Data Element: Pneumonia Diagnosis: ED/Direct Admit

Change: Clarification

- An admit note or order with an admission diagnosis of pneumonia or a Pneumonia Pathway or equivalent that was initiated upon admission, select '2'.
- For medical records that do not contain an ED form or for Pneumonia Diagnosis on Admission-Direct Admit: Do not use an H&P labeled Admit H&P or an H&P that contains an admit note or order within the body of text.

For a complete list of changes please see the "Release Notes," located in the Specifications Manual for National Hospital Quality Measures for discharges 4/1/2010. The manual can be found at:

<http://www.qualitynet.org/dcs/ContentServer?cid=1192804535739&pagename=QnetPublic%2FPage%2FQnetTier3&c=Page>

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