Guideline for using the Community Acquired Pneumonia (CAP) Data Dictionary

In order to accurately assess inappropriate diagnosis of community acquired pneumonia (CAP), it is necessary to ensure that the correct population is being assessed. It is also important to apply a standard method for collecting data. The CAP data dictionary includes the information needed to ensure that appropriate standards are applied. This document provides additional guidance for using the CAP data dictionary.

**ICD-10 Codes Included Tab**

The first step to determining a list of patients eligible for abstraction is a review of pneumonia ICD-10 codes. This page includes a list of ICD-10 codes for which adult patients (≥18 years old) should be included in the sample, based on having a billed discharge ICD-10 code of pneumonia. A patient qualifies for inclusion at this point if they have any listed discharge diagnosis; it does not have to be the primary discharge diagnosis. Note. Your institution may be able to electronically produce a list of patients with these diagnostic codes.

**Inclusion Criteria Tab**

The next step is to determine if patients with an eligible billed discharge ICD-10 code of pneumonia meet additional inclusion criteria. There are five key factors that should be reviewed at this time. These include:

* age [adult patients only]
* service to which the patient is admitted [admitted to a general medicine service]
* receipt of an eligible antibiotic on day 1 or day 2 of hospital encounter
* status of immunocompetence [patient must be immunocompetent or only mildly immune compromised]
* presence of a concomitant infection [patient must not have a concomitant infection].

The inclusion criteria tab provides specific guidelines for each of these criteria. Note. Your institution may be able to incorporate these criteria electronically into your patient list.

**Exclusions Tab**

After review of inclusion criteria, exclusions must be reviewed to determine patient eligibility for abstraction. Excluded patients are:

* hospice/palliative care patients
* those who left against medical advice/refused medical advice [excluded]
* pregnant or breastfeeding
* patients with cystic fibrosis
* patients who have a pneumonia-related complication.

Additional details and guidelines can be found in the exclusions tab. Note, most of these criteria will require chart review.

**Radiographic Findings Tab**

This tab provides guidance on the documentation of radiographic findings. During medical records abstraction, chest CTs, abdominal CTs that show lung findings, and Chest X-Rays should all be evaluated. Imaging results should be abstracted in the window beginning two days prior to the hospital encounter through the first four days of the hospital encounter. All radiographic tests conducted during this time should be documented. Additional details and guidelines, including the terms to evaluate, are documented in the radiographic findings tab.

**Signs and Symptoms Tab**

This tab provides guidance on how signs and symptoms of CAP should be documented. The data collection window runs from the first two days of the hospital encounter (Day 1 and Day 2), as well as the two days prior to the hospital encounter (Day -1 and Day -2). Only documentation from physicians and/or advanced practice professionals (e.g., nurse practitioners, physician assistants) should be used when documenting data in this category. The data dictionary provides operationalized definitions for each sign and symptom that should be evaluated.

**Eligible Antibiotics Tab**

The eligible antibiotics tab lists the generic and brand names of antibiotics that should be recorded during data abstraction. Please document information on IV and oral antibiotics the patient received as an inpatient, as well as the antibiotics that were prescribed at discharge. You will be asked to document the name of the antibiotic, as well as the duration for which the antibiotic was administered. A full list of antibiotics is included in the eligible antibiotics tab.

**Co-Morbidities Tab**

This tab identifies which co-morbid conditions should be abstracted during chart review. Each co-morbid condition has guidance on the timeframe for inclusion as a co-morbidity. Full details are provided in the co-morbidities tab.

**SIRS Criteria Tab**

The SIRS criteria tab identifies additional data that should be abstracted from the medical record during chart review. Most of this information should be documented if the data element is present during the period of Day -2 to Day 2. Fully operationalized definitions are included in the SIRS criteria tab.

**Terms Tab**

This tab provides additional guidance on some of the terms necessary to abstract accurately, including date of hospital encounter, date of hospital admission, date of discharge, and information on antibiotic administration and duration.