

# Data Elements for PCPI eSpecification

## [0094] Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation

QDM* Standard Category	QDM* Data Type	Standard Terminology (Value Set OID)	Constraints	Value Set Name	Value of Data Element	Data Source	Comments/Rationale
Measure Timing	N/A	N/A	TBD by measure implementer	Measurement Start Date			
Measure Timing	N/A	N/A	TBD by measure implementer	Measurement End Date			
Individual Characteristic	Patient Characteristic	Gender HL7 Value Set (2.16.840.1.113883.1.11.1)	during measurement period	Gender		• Electronic Health Record (EHR)	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Race CDC Value Set (2.16.840.1.114222.4.11.836)	during measurement period	Race		• Electronic Health Record (EHR)	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Ethnicity CDC Value Set (2.16.840.1.114222.4.11.837)	during measurement period	Ethnicity		• Electronic Health Record (EHR)	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Payer Source of Payment Typology Value Set (2.16.840.1.113883.3.221.5)	during measurement period	Payer		• Electronic Health Record (EHR)	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Primary spoken language (2.16.840.1.114222.4.11.831)	during measurement period	Preferred Language		• Electronic Health Record (EHR)	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	LOINC (2.16.840.1.113883.3.560.100.4)	starts before the start of measurement period	Birth date		• Electronic Health Record (EHR)	
Individual Characteristic	Patient Characteristic	Calculated	starts before the start of measurement period	Age	≥ 18	• Electronic Health Record (EHR)	
Condition / Diagnosis / Problem	Diagnosis, Active	ICD-9-CM, ICD-10-CM, SNOMED-CT (TBD)	during measurement period	Community-Acquired Bacterial Pneumonia (CAP)		• Electronic Health Record (EHR)	A patient may have more than one episode of CAP per measurement period. For the purposes of this measure, an episode is 45 days from the date of visit first diagnosed.
Encounter	Encounter, Performed	CPT (2.16.840.1.113883.3.464.0003.01.01.0005)	during measurement period	Office Visit, Occurrence A		• Electronic Health Record (EHR)	
Encounter	Encounter, Performed	CPT (2.16.840.1.113883.3.464.0003.01.01.0050)	during measurement period	Emergency Department Visit, Occurrence A		• Electronic Health Record (EHR)	
Encounter	Encounter, Performed	CPT (2.16.840.1.113883.3.464.0003.01.01.0055)	during measurement period	Critical Care Management, Occurrence A		• Electronic Health Record (EHR)	
Attribute	Attribute: Facility Location	SNOMED-CT (2.16.840.1.113883.3.526.02.1142)	during measurement period	Hospital Measures-Emergency Department and Critical Care		• Electronic Health Record (EHR)	This attribute is applied to OID: 2.16.840.1.113883.3.464.0003.01.01.0055
Encounter	Encounter, Performed	CPT (2.16.840.1.113883.3.464.0003.01.01.0070)	during measurement period	Care Services in Long-Term Residential Facility, Occurrence A		• Electronic Health Record (EHR)	
Encounter	Encounter, Performed	CPT (2.16.840.1.113883.3.464.0003.01.01.0080)	during measurement period	Home Healthcare Services, Occurrence A		• Electronic Health Record (EHR)	
Encounter	Encounter, Performed	SNOMED-CT (2.16.840.1.113883.3.526.03.1012)	during measurement period	Patient Provider Interaction, Occurrence A		• Electronic Health Record (EHR)	

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QDM* Standard Category	QDM* Data Type	Standard Terminology (Value Set OID)	Constraints	Value Set Name	Value of Data Element	Data Source	Comments/Rationale
Intervention	Intervention, Performed	LOINC (TBD)	during [Encounter, Performed: Office Visit], Occurrence A; during [Encounter, Performed: Emergency Department Visit] Occurrence A; during [Encounter, Performed: Critical Care Management], Occurrence A; during [Encounter, Performed: Care Services in Long-Term Residential Facility], Occurrence A; during [Encounter, Performed: Home Healthcare Services], Occurrence A; during [Encounter, Performed: Patient Provider Interaction], Occurrence A;	Pulse Oximetry		• Electronic Health Record (EHR)	It is expected that this numerator action will be performed and reported once for EACH episode (occurrence) of CAP. If there is more than one Encounter within 45 days, report the first Encounter during the 45 day episode period.
Laboratory Test	Laboratory Test, Performed	LOINC (TBD)	during [Encounter, Performed: Office Visit], Occurrence A; during [Encounter, Performed: Emergency Department Visit] Occurrence A; during [Encounter, Performed: Critical Care Management], Occurrence A; during [Encounter, Performed: Care Services in Long-Term Residential Facility], Occurrence A; during [Encounter, Performed: Home Healthcare Services], Occurrence A; during [Encounter, Performed: Patient Provider Interaction], Occurrence A;	Arterial Blood Gas		• Electronic Health Record (EHR)	It is expected that this numerator action will be performed and reported once for EACH episode (occurrence) of CAP. If there is more than one Encounter within 45 days, report the first Encounter during the 45 day episode period.
Attribute	Attribute: Result	n/a	n/a	Present "X"		• Electronic Health Record (EHR)	This attribute is applied to OID: TBD [Intervention, Performed: Pulse Oximetry] TBD [Laboratory Test, Performed: Arterial Blood Gas]  There is no code list associated with this QDM type -- but is solely in place to capture that a result is present.
Intervention	Intervention, Performed	SNOMED-CT (TBD)	during [Encounter, Performed: Office Visit], Occurrence A; during [Encounter, Performed: Emergency Department Visit] Occurrence A; during [Encounter, Performed: Critical Care Management], Occurrence A; during [Encounter, Performed: Care Services in Long-Term Residential Facility], Occurrence A; during [Encounter, Performed: Home Healthcare Services], Occurrence A; during [Encounter, Performed: Patient Provider Interaction], Occurrence A;	'Documented and Reviewed'		• Electronic Health Record (EHR)	Must include one of the following: • Clinician documentation that oxygen saturation was reviewed • Dictation by the clinician including oxygen saturation • Clinician initials in the chart that oxygen saturation was reviewed • Other indication that oxygen saturation had been acknowledged by the clinician  Discussion surrounding the capture of this concept - PENDING.
Attribute	Attribute: Negation Rationale	SNOMED-CT (2.16.840.1.113883.3.526.03.1007)	during measurement period	Medical reason		• Electronic Health Record (EHR)	
Attribute	Attribute: Negation Rationale	SNOMED-CT (2.16.840.1.113883.3.526.03.1008)	during measurement period	Patient reason		• Electronic Health Record (EHR)	
Attribute	Attribute: Negation Rationale	SNOMED-CT (2.16.840.1.113883.3.526.03.1009)	during measurement period	System reason		• Electronic Health Record (EHR)	