Development and Testing of Breast Cancer Care Measures 2010
Specifications Manual for Breast Cancer Care (BCC) Measures Testing Project

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<tbody>
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<td>BCC-01</td>
<td>Pre-Treatment Assessment</td>
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<td>BCC-03</td>
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<tr>
<td>BCC-08</td>
<td>Colony Stimulation Factors (CSF) Prescribed</td>
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General Data Elements

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<thead>
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<tr>
<td>Age 18 or Greater</td>
<td>All Records,</td>
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<tr>
<td>CPT® Code</td>
<td>All Records,</td>
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<tr>
<td>First Chemotherapy Date</td>
<td>All Records,</td>
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<tr>
<td>ICD-9-CM Diagnosis Code</td>
<td>All Records,</td>
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<tr>
<td>Sex</td>
<td>All Records,</td>
</tr>
<tr>
<td>Unique Blinded Case Identifier</td>
<td>All Records, All Records (Used in transmission of anonymous patient-level data to the Joint Commission)</td>
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Measure Set Specific Data Elements

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<thead>
<tr>
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<td>BCC-06,</td>
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<td>Assessment for Distress</td>
<td>BCC-01,</td>
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<td>Assessment for Fatigue</td>
<td>BCC-01,</td>
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<tr>
<td>Assessment for Sleep-Wake Disturbance</td>
<td>BCC-01,</td>
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<tr>
<td>CSF Prescribed</td>
<td>BCC-08,</td>
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<td>Chemotherapy Cycle Number</td>
<td>BCC-08,</td>
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<td>Distress</td>
<td>BCC-03,</td>
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<td>Emetogenic Agents</td>
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<td>Exercise Program</td>
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<td>Instructions to Contact Provider</td>
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<td>Intervention for Distress</td>
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<td>Intervention for Sleep-Wake Disturbance</td>
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<td>Myelosuppressive Chemotherapy</td>
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<td>Neutropenia Risk Cycle</td>
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<td>Re-Assessment for Fatigue</td>
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<td>Reason for Not Prescribing CSF</td>
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<td>Reason for Not Recommending Exercise</td>
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<tr>
<td>Sleep-Wake Disturbance</td>
<td>BCC-05,</td>
</tr>
</tbody>
</table>
Breast Cancer Care (BCC) Initial Patient Population

The BCC Measure Set Population (common to all BCC measures) is defined as newly diagnosed, biopsy-proven, breast cancer patients, or breast cancer patients with newly diagnosed metastatic disease, who are age 18 years or greater, whose treatment plan includes IV chemotherapy treatments in the ambulatory care setting.

The population of the Breast Cancer Care (BCC) measure set can be identified by using data elements that are common to all of the performance measures in the set:

ICD-9-CM Principal Diagnosis Code:
- 174.0 Malig neo nipple
- 174.1 Mal neo breast-central
- 174.2 Mal neo breast up-inner
- 174.3 Mal neo breast low-inner
- 174.4 Mal neo breast up-outer
- 174.5 Mal neo breast low-outer
- 174.6 Mal neo breast-axillary
- 174.8 Malign neopl breast NEC
- 174.9 Malign neo pl breast NOS
- 175.0 Mal neo male nipple
- 175.9 Mal neo male breast NEC

CPT® Code:
- 96360 Intravenous (IV) infusion, hydration
- 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis
- 96374 Therapeutic, prophylactic or diagnostic injection; IV push
- 96409 Chemotherapy administration; IV, push technique
- 96413 Chemotherapy administration, IV infusion technique
- 96416 Initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump

Initial Patient Population Algorithm

To be determined

Sampling / Sample Size Requirements

Abstract 10 cases per month (e.g. 10 for Jan 2009, 10 Feb 2009… 10 June 2009)

- If a site has a population of less than 10 cases per month, abstract all cases.
- If a site has greater than 10 cases per month select a sample of 10 cases to abstract.
- If a site is able to find records by type of chemotherapy administered, select 5 cases in which the patient received emetogenic agents (see data element Emetogenic Agents) and 5 cases in which the patient received a potentially myelosuppressive chemotherapy (see data element Myelosuppressive Chemotherapy).

Examples:

1. A patient receives their first chemotherapy infusion on January 2, 2009. The pre-treatment assessment period, to capture measure BCC-01, began on December 1, 2008, when the pathology report came back indicating invasive ductal carcinoma. So, the data for BCC-01 would come from the period Dec. 1, 2008 to Jan. 1, 2009. Their case would then be followed for all of the other measures from Jan. 2, 2009 for the next 6 months, or the completion of the chemo regimen, whichever came first.

2. A patient receives their first chemotherapy infusion on June 29, 2009. The pre-treatment assessment period, to capture measure BCC-01, began on May 5, 2009, when the pathology report came back indicating invasive...
ductal carcinoma. So, the data for BCC-01 would come from the period May 5, 2009 to June 28, 2009. Their case would then be followed for all of the other measures from June 29, 2009 for the next 6 months, or the completion of the chemo regimen, whichever came first.

2010 Pilot Test Data Collection Period

Patients in the initial population, who have their first chemotherapy treatment at this facility, for this episode of care, from January 2009 through June 2009. Data should be collected for the first six months of care or through completion of this episode of care, which ever comes first.

- Abstract record for the pre-treatment time period dates from breast cancer diagnosis date until first chemotherapy infusion is administered. For patients with recurrent disease look at visits related to this episode of chemotherapy treatment only.
- Abstract record for the time period of the first chemotherapy administration date through the first six month of treatment.

Note: For purposes of the Breast Cancer Care measure set Episode of Care is defined as:

- Patients newly diagnosed with Stage I through III breast cancer – from the date of the first pathology report indicating an invasive breast cancer through a) the completion of the prescribed intravenous chemotherapy or b) the first six months of the prescribed intravenous chemotherapy regimen, whichever comes first.
- Patients newly diagnosed with Stage IV breast cancer
  - For those treated for Stage I through III breast cancer in the past - from the date Stage IV disease is documented through the first six months of a prescribed intravenous chemotherapy regimen.
  - For those who present with Stage IV at initial staging – from the date of the first pathology report indicating invasive breast cancer through the first six months of the prescribed chemotherapy regimen.
Measure Information Form

Measure Set: Breast Cancer Care (BCC)

Set Measure ID: BCC-01

<table>
<thead>
<tr>
<th>Set Measure ID</th>
<th>Performance Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCC-01a</td>
<td>Pre-Treatment Assessment - Overall Rate</td>
</tr>
<tr>
<td>BCC-01b</td>
<td>Pre-Treatment Assessment - Distress</td>
</tr>
<tr>
<td>BCC-01c</td>
<td>Pre-Treatment Assessment - Fatigue</td>
</tr>
<tr>
<td>BCC-01d</td>
<td>Pre-Treatment Assessment - Sleep-Wake Disturbance</td>
</tr>
</tbody>
</table>

**Performance Measure Name:** Pre-Treatment Assessment

**Description:** Documented assessment for Distress, Fatigue and Sleep-Wake Disturbance after breast cancer diagnosis and prior to the first chemotherapy treatment.

**Rationale:** Distress: In cancer care distress is defined as a “multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with ability to cope effectively with cancer, its physical symptoms and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis” (NCCN, 2010b). Anxiety is a common response to a cancer diagnosis, and though it usually decreases over time after the initial diagnosis, 20%–30% of people with cancer continue to experience increased levels of anxiety and distress after treatment and into survivorship (Howard & Harvey, 1998; Maher, Mackenzie, Young, & Marks, 1996; Nordin & Glimelius, 1998; Zabora, Brinzenhofezoc, Curbow, Hooker & Piantadosi, 2000, Marrs, 2006). Uncontrolled anxiety can be disabling and may interfere with treatment response, psychosocial functioning, decision-making and quality of life (Bush, 2006). Prevalence of depression in people with cancer is noted to be as high as 58%, with 25% considered the clinical rule of thumb (Miller & Massie, 2006). Depression can diminish both one’s will to live and quality of life and is associated with more functional impairment (Greenberg, 2004), and an increased risk of suicide (Misono, 2008). Depressed patients with cancer are three times more likely to be noncompliant with their treatment regimens than nondepressed patients (DiMatteo, Lepper and Croghan, 2000), and demand more time, make more phone calls, and are more likely to frustrate busy healthcare providers than nondepressed patients with equivalent diagnoses and illness severity (Bultz, & Holland, 2006). The NCCN (National Comprehensive Cancer Network) and ASCO/ONS (American Society of Clinical Oncology/Oncology Nursing Society) Chemotherapy Safety Standards recommend that cancer patients be assessed for emotional distress at every visit with an oncology health care provider (NCCN, 2010b; Jacobson et al., 2009).

Fatigue: Cancer-related fatigue (CRF) is a “distressing persistent, subjective sense of physical, emotional and/or cognitive tiredness or exhaustion related to cancer or cancer treatment that is not proportional to recent activity and that interferes with usual functioning” (NCCN, 2010a). Unlike the assessment of pain intensity, which is a requirement for accreditation by The Joint Commission, assessment of CRF is not mandated, and therefore is frequently not assessed in many practice settings (Knowles, 2000). Assessment of fatigue should be initiated by the provider as waiting for a patient to volunteer that she is fatigued is a known barrier to diagnosis and successful management (Piper et al., 2008, Homsi et al., 2006).

Sleep-Wake Disturbances: Sleep-wake disturbances are reported in 30-50% of patients newly diagnosed and treated with breast cancer, double the rate in the general population. (Berger et al., 2005; Clark, Cunningham, McMillan, Vena, & Parker, 2004; Lee, Cho, Miaskowski, & Dodd, 2004; Savard & Morin, 2001) Sleep-wake disturbances left undiagnosed and untreated can impact pain, mood, cognition, functioning and survival across the disease trajectory. (Berger et al., 2005; Clark et al., 2004; Fiorentino & Ancoli-Israel, 2007; Groenvold et al., 2007; Lee et al., 2004; O’Donnell, 2004; Savard & Morin, 2001; Vena, Parker, Cunningham, Clark, & McMillan, 2004).

**Type of Measure:** Process
Improvement Noted As: Increase in the rate

Numerator Statement: Patients who received documented assessment for Distress, Fatigue and Sleep-Wake Disturbance.

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- Assessment for Distress
- Assessment for Fatigue
- Assessment for Sleep-Wake Disturbance

Denominator Statement: Breast cancer patients, prior to the first chemotherapy treatment at this facility for this episode of care.

Included Populations: Not applicable

Excluded Populations: Patients less than 18 years of age

Data Elements:

- Age 18 or Greater
- CPT® Code
- First Chemotherapy Date
- ICD-9-CM Diagnosis Code
- Sex
- Unique Blinded Case Identifier

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative/billing data and medical records.

Data Accuracy:

- The pre-treatment time period dates from patient diagnosis with breast cancer until first chemotherapy infusion is administered.
- For distress screening/assessment, the following tools are recommended:
  - NCCN distress thermometer (DT)
  - Hospital Anxiety and Depression Scale (HADS)
  - Brief Symptom Inventory (BSI-18)
  - Physical Health Questionnaire-9 (PHQ-9)
  - PROMIS tools
  - Clinician narrative documentation of statements referring to current “coping,” “distress,” “emotional,” “depression,” or “anxiety” status of patient. Reference to past history is insufficient – documentation must be in reference to current patient status (Jacobsen, 2009).
- For fatigue assessment a 0-10 scale is recommended.
- For sleep-wake disturbance assessments the PROMIS scale is recommended.
- Breast cancer diagnosis date is the date on the first pathology report for confirmed malignancy. For patients with recurrent disease use date stage 4 disease is confirmed.
- Abstract record for the pre-treatment time period dates from breast cancer diagnosis date until first chemotherapy infusion is administered. For patients with recurrent disease look at visits related to this episode of chemotherapy treatment only.
- The overall rate (BCC-1a) includes those patients who received documented assessments for all three of the assessment areas identified in the strata. For example:
  - A patient who received assessments for Distress and Fatigue and Sleep-Wake Disturbance is in the numerator for BCC-1a.
  - A patient who received assessment for Distress and Fatigue, but not for Sleep-Wake Disturbance is not
in the numerator for BCC-1a.

**Measure Analysis Suggestions:** To be determined

**Sampling:** Yes. For additional information see the Sampling Section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**

guidelines into practice. Clinical Journal of Oncology Nursing, 12, 37-47. doi:10.1188/08.CJON.S2.37-47

Measure Algorithm:

BCC-01: Pre-treatment Assessment
Numerator: Patient who received documented assessment for Distress, Fatigue and Sleep-Wake Disturbance
Denominator: Breast cancer patients, prior to the first chemotherapy treatment at this facility for this episode of care

![Diagram of Measure Algorithm]

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Stratified By</th>
<th>Allowable Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCC-01a</td>
<td>Overall Rate</td>
<td>1 or 2</td>
</tr>
<tr>
<td>BCC-01b</td>
<td>Assessment for Distress</td>
<td>1 or 2</td>
</tr>
<tr>
<td>BCC-01c</td>
<td>Assessment for Fatigue</td>
<td>1 or 2</td>
</tr>
<tr>
<td>BCC-01d</td>
<td>Assessment for Sleep-Wake Disturbance</td>
<td>1 or 2</td>
</tr>
</tbody>
</table>

* Each case will be stratified according to the allowable values of Assessment for Distress, Assessment for Fatigue, and Assessment for Sleep-Wake Disturbance.
Initialize the Measure Category Assignment for each strata measure (i.e. C) = 'C'.

Do not change the Measure Category Assignment that was already calculated for the overall rate (BCC-01a).

The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (BCC-01a) Measure Category Assignment.

Overall Rate Category Assignment

- = 0 or E

Assessment for Distress

1 or 2

For Stratified Measure BCC-01b
(Assessment for Distress Rate)

Set the Measure Category Assignment for measure BCC-01b = 'C'

Assessment for Fatigue

1 or 2

For Stratified Measure BCC-01c
(Assessment for Fatigue Rate)

Set the Measure Category Assignment for measure BCC-01c = 'C'

Assessment for Sleep-Wake Disturbance

1 or 2

For Stratified Measure BCC-01d
(Assessment for Sleep-Wake Disturbance Rate)

Set the Measure Category Assignment for measure BCC-01d = 'C'

Stop

For Stratified Measure BCC-01d
(Assessment for Distress Rate)

Set the Measure Category Assignment for the strata measures (BCC-01b through BCC-01d) = 'C'

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Related Topics
Measure Information Form

Measure Set: Breast Cancer Care (BCC)

Set Measure ID: BCC-02

<table>
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<tr>
<th>Set Measure ID</th>
<th>Performance Measure Name</th>
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<td>BCC-02a</td>
<td>Continuing Assessment - Overall Rate</td>
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<tr>
<td>BCC-02b</td>
<td>Continuing Assessment - Distress</td>
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<tr>
<td>BCC-02c</td>
<td>Continuing Assessment - Fatigue</td>
</tr>
<tr>
<td>BCC-02d</td>
<td>Continuing Assessment - Sleep-Wake Disturbance</td>
</tr>
</tbody>
</table>

Performance Measure Name: Continuing Assessment

Description: Documented re-assessment for Distress, Fatigue and Sleep-Wake Disturbance at least one time each chemotherapy cycle.

Rationale: Distress: In Cancer distress is defined as a “multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with ability to cope effectively with cancer, its physical symptoms and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis” (NCCN, 2010b). Anxiety is a common response to a cancer diagnosis, and though it usually decreases over time after the initial diagnosis, 20%–30% of people with cancer continue to experience increased levels of anxiety and distress after treatment and into survivorship (Howard & Harvey, 1998; Maher, Mackenzie, Young, & Marks, 1996; Nordin & Glimelius, 1998, Zabora, Brintzenhofezoc, Curbow, Hooker & Plantadosi, 2000, Marrs, 2006). Uncontrolled anxiety can be disabling and may interfere with treatment response, psychosocial functioning, decision-making and quality of life (Bush, 2006).

Prevalence of depression in people with cancer is noted to be as high as 58%, with 25% considered the clinical rule of thumb (Miller & Massie, 2006). Depression can diminish both one’s will to live and quality of life and is associated with more functional impairment (Greenberg, 2004), and an increased risk of suicide (Misono, 2008). Depressed patients with cancer are three times more likely to be noncompliant with their treatment regimens than nondepressed patients (DiMatteo, Lepper and Croghan, 2000), and demand more time, make more phone calls, and are more likely to frustrate busy healthcare providers than nondepressed patients with equivalent diagnoses and illness severity (Bultz, & Holland, 2006). The NCCN (National Comprehensive Cancer Network) and ASCO/ONS (American Society of Clinical Oncology/Oncology Nursing Society) Chemotherapy Safety Standards recommend that cancer patients be assessed for emotional distress at every visit with an oncology health care provider (NCCN, 2010b; Jacobson et al., 2009).

Fatigue: Cancer-related fatigue (CRF) is a “distressing persistent, subjective sense of physical, emotional and/or cognitive tiredness or exhaustion related to cancer or cancer treatment that is not proportional to recent activity and that interferes with usual functioning” (NCCN, 2010a). Unlike the assessment of pain intensity, which is a requirement for accreditation by The Joint Commission, assessment of CRF is not mandated, and therefore is frequently not assessed in many practice settings (Knowles, 2000). Assessment of fatigue should be initiated by the provider as waiting for a patient to volunteer that she is fatigued is a known barrier to diagnosis and successful management (Piper et al., 2008, Homsi et al., 2006).

Sleep-Wake Disturbances: Sleep-wake disturbances are reported in 30-50% of patients newly diagnosed and treated with breast cancer, double the rate in the general population.(Berger et al., 2005; Clark, Cunningham, McMillan, Vena, & Parker, 2004; Lee, Cho, Miaskowski, & Dodd, 2004; Savard & Morin, 2001) Sleep-wake disturbances left undiagnosed and untreated can impact pain, mood, cognition, functioning and survival across the disease trajectory. (Berger et al., 2005; Clark et al., 2004; Fiorentino & Ancoli-Israel, 2007; Groenvold et al., 2007; Lee et al., 2004; O'Donnell, 2004; Savard & Morin, 2001; Vena, Parker, Cunningham, Clark, & McMillan, 2004)

Type of Measure: Process
Improvement Noted As: Increase in the rate

Numerator Statement: Patients who received documented re-assessment for Distress, Fatigue and Sleep-Wake Disturbance at least one time each chemotherapy cycle.

Included Populations: Not applicable
Excluded Populations: None

Data Elements:
- Re-Assessment for Distress
- Re-Assessment for Fatigue
- Re-Assessment for Sleep-Wake Disturbance

Denominator Statement: Breast cancer patients receiving chemotherapy.

Included Populations: Not applicable
Excluded Populations: Patients less than 18 years of age

Data Elements:
- Age 18 or Greater
- CPT® Code
- First Chemotherapy Date
- ICD-9-CM Diagnosis Code
- Sex
- Unique Blinded Case Identifier

Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative/billing data and medical records.

Data Accuracy:
- For the purposes of this measure, documentation of screening and/or assessment is required at least once within each chemotherapy cycle dating from first chemotherapy infusion.
- For distress screening/assessment, the following tools are recommended:
  - NCCN distress thermometer (DT)
  - Hospital Anxiety and Depression Scale (HADS)
  - Brief Symptom Inventory (BSI-18)
  - Physical Health Questionnaire-9 (PHQ-9)
  - PROMIS tools
  - Clinician narrative documentation of statements referring to current “coping,” “distress,” “emotional,” “depression,” or “anxiety” status of patient. Reference to past history is insufficient – documentation must be in reference to current patient status (Jacobsen, 2009).
- For fatigue assessment a 0-10 scale is recommended.
- For sleep-wake disturbance assessments the PROMIS scale is recommended.
- Abstract record for the time period of the first chemotherapy administration date through the first six month of treatment.
- The overall rate (BCC-1a) includes those patients who received documented re-assessments for all three of the assessment areas identified in the strata. For example:
  - A patient who received re-assessments for Distress and Fatigue and Sleep-Wake Disturbance is in the numerator for BCC-1a.
  - A patient who received re-assessment for Distress and Fatigue, but not for Sleep-Wake Disturbance is not in the numerator for BCC-1a.

Measure Analysis Suggestions: To be determined
**Sampling:** Yes. For additional information see the Sampling Section.

**Data Reported As:** Aggregate rate generated from count data reported as a proportion.

**Selected References:**

- Vena, C., Parker, K., Cunningham, M., Clark, J., & McMillan, S. (2004). Sleep-wake disturbances in people...

Measure Algorithm:

BCC-02: Continuing Assessment

Numerator: Patient who received documented re-assessment for Distress, Fatigue and Sleep-Wake Disturbance at least one time each chemotherapy cycle

Denominator: Breast cancer patients receiving chemotherapy

**Stratification Table:**

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Stratified By</th>
<th>Allowable Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCC-02a</td>
<td>Overall Rate</td>
<td>1 or 2</td>
</tr>
<tr>
<td>BCC-02b</td>
<td>Re-Assessment for Distress</td>
<td>1 or 2</td>
</tr>
<tr>
<td>BCC-02c</td>
<td>Re-Assessment for Fatigue</td>
<td>1 or 2</td>
</tr>
<tr>
<td>BCC-02d</td>
<td>Re-Assessment for Sleep-Wake Disturbance</td>
<td>1 or 2</td>
</tr>
</tbody>
</table>

*Each case will be stratified according to the allowable value of Re-Assessment for Distress, Re-Assessment for Fatigue, and Re-Assessment for Sleep-Wake Disturbance.*
Initialize the Measure Category Assignment for each strata measure (c=) = ‘B’.

Do not change the Measure Category Assignment that was already calculated for the overall rate (BCC-02a).

The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate’s (BCC-02a) Measure Category Assignment.

Overall Rate Category Assignment

= D or E

Re-Assessment for Distress

= 1 or 2

For Stratified Measure BCC-02b (Re-Assessment for Distress Rate)

Set the Measure Category Assignment for measure BCC-02b = ‘E’

For Stratified Measure BCC-02c (Re-Assessment for Fatigue Rate)

Set the Measure Category Assignment for measure BCC-02c = ‘E’

Re-assessment for Fatigue

= 1 or 2

Set the Measure Category Assignment for measure BCC-02b = ‘D’

For Stratified Measure BCC-02d (Re-Assessment for Sleep-Wake Disturbance Rate)

Re-assessment for Sleep-Wake Disturbance

= 1 or 2

Set the Measure Category Assignment for measure BCC-02d = ‘E’

Set the Measure Category Assignment for the strata measures (BCC-02b through BCC-02d) = ‘E’

Stop

Related Topics
Measure Information Form

Measure Set: Breast Cancer Care (BCC)

Set Measure ID: BCC-03

Performance Measure Name: Intervention for Distress

Description: Documented intervention for distress score of 4 or greater on the NCCN distress thermometer or moderate or greater distress via any other validated tool or narrative note at any visit.

Rationale: The National Comprehensive Cancer Network (NCCN) has developed Standards of Care for Distress Management and developed a tool for measuring types of distress, including anxiety, in cancer patients (NCCN, 2010). The one-page tool has two components: a visual analog scale (Distress Thermometer) with a scale from 0 to 10 (0 = No distress to 10 = Extreme distress). The Distress Thermometer asks the patient to circle the number that best describes how much distress you have been experiencing in the last week including today. A score of 4 or greater on the Distress Thermometer is indication for further assessment, referral and, if indicated, therapeutic interventions. The second part of the tool contains a checklist of concerns including practical, family, emotional, physical and spiritual/religious concerns (yes/no response for each item). On the checklist, the emotional concerns include depression, fears, nervousness, sadness, worry and loss of interest in usual activities. This tool is easily used on each visit and has a range of applications for assessment of distress.

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Patients with at least one documented intervention to manage distress.

   Included Populations: Not applicable

   Excluded Populations: None

Data Elements:

   - Intervention for Distress

Denominator Statement: Breast cancer patients with a distress score of 4 or greater on the NCCN distress thermometer or moderate or greater distress via any other validated tool or narrative note at any visit.

   Included Populations: Not applicable

Excluded Populations:

   - Patients less than 18 years of age
   - Patients with a distress score of less than 4 on the NCCN distress thermometer or mild / no distress via any validated tool or narrative notes.

Data Elements:

   - Age 18 or Greater
   - CPT® Code
   - Distress
   - First Chemotherapy Date
   - ICD-9-CM Diagnosis Code
   - Sex
   - Unique Blinded Case Identifier
Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative/billing data and medical records.

Data Accuracy:

- For distress screening/assessment, the following tools are recommended:
  - NCCN distress thermometer (DT)
  - Hospital Anxiety and Depression Scale (HADS)
  - Brief Symptom Inventory (BSI-18)
  - Physical Health Questionnaire-9 (PHQ-9)
  - PROMIS tools
  - Clinician narrative documentation of statements referring to current “coping,” “distress,” “emotional,” “depression,” or “anxiety” status of patient. Reference to past history is insufficient – documentation must be in reference to current patient status (Jacobsen, 2009).

- Recommended intervention examples for distress: (Recommendations cited in Swanson, et al., 2009 and Fulcher et al., 2009)
  - Provision of or referral for cognitive behavioral therapy, counseling or psychotherapy
  - Patient education and information provision on self-management
  - Provision of social support, or referral to a support group
  - Prescription of antidepressant or anxiolytic
  - Massage therapy for anxiety

Measure Analysis Suggestions: To be determined

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:


Measure Algorithm:
BCC-03: Intervention for Distress

**Numerator:** Patient with at least one documented intervention to manage distress

**Denominator:** Breast cancer patients with a distress score of 4 or greater on the NCCN distress thermometer or moderate or greater distress via any other validated tool or narrative note at any visit

---

**Flowchart Description:**

1. **Start**
2. Run cases that are included in the BCC Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.
3. **Distress**
   - If Distress is 1, 2, or 4, proceed with the next step.
   - If Distress is 1 or 2, proceed with the next step.
4. **Intervention for Distress**
   - If Intervention for Distress is missing, proceed with the next step.
   - If Intervention for Distress is present, check if it meets the criteria:
     - If yes (Y), proceed with the next step.
     - If no (N), proceed with the next step.
5. **Case Will Be Rejected**
6. **In Numerator Population**
7. **In Measure Population**
8. **Not In Measure Population**
9. **Stop**
**Test**

**Measure Information Form**

**Measure Set:** Breast Cancer Care (BCC)

**Set Measure ID:** BCC-04

**Performance Measure Name:** Intervention for Fatigue

**Description:** Breast Cancer patients who received a recommendation for an exercise program prior to the first chemotherapy treatment.

**Rationale:** Evidence at the highest level (Courneya & Friedenreich, 1999; Galvao & Newton, 2005; Knols, Aaronson, Uebelhart, Fransen & Aufdemkampe, 2005; Oldervoll, Kaasa, Hjermstad, Lund & Loge, 2004; Schmitz, Holtzman, Courneya, Masse, Duval, & Kane, 2005; Stricker, Drake, Hoyer, & Mock, 2004; Thorsen, Courneya, Stevinson & Fossà, 2008) supports the benefit of exercise in the management of fatigue during and following cancer treatment in patients with breast cancer, patients with solid tumors, and those undergoing hematopoietic stem cell transplantation. Although positive results for the outcome of fatigue have not always been observed consistently across studies, the general pattern of results indicates that exercising (including walking, cycling, swimming, resistive exercise, or combined exercise) several times per week can be effective in reducing fatigue in patients during and following cancer treatment. More research is needed to systematically assess the safety of exercise (both aerobic exercise and strength training) and to tailor the intensity, frequency, duration, and type of exercise prescribed for different oncology subpopulations.

**Type of Measure:** Process

**Improvement Noted As:** Increase in the rate

**Numerator Statement:** Patients with an exercise program recommended prior to the first chemotherapy treatment.

- **Included Populations:** Not applicable
- **Excluded Populations:** None

**Data Elements:**
- Exercise Program

**Denominator Statement:** Breast cancer patients who have begun chemotherapy.

- **Included Populations:** Not applicable
- **Excluded Populations:**
  - Contraindications to exercise
  - Patients less than 18 years of age

**Data Elements:**
- Age 18 or Greater
- CPT® Code
- First Chemotherapy Date
- ICD-9-CM Diagnosis Code
- Reason for Not Recommending Exercise
- Sex
- Unique Blinded Case Identifier
Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative/billing data and medical records.

Data Accuracy:

- Examples of exercise recommendations: Perform aerobic, resistance or a combination of both types of exercise several times per week, such as walking, cycling, swimming, etc. (Recommendation cited in Mitchell, et al., 2009)
- Exercise recommendation may be made by a Physician, PA, APN, RN, PT or OT staff member.
- Recommended activities include any aerobic and/or resistance exercise noted in the patient record as performed more than once per week.

Measure Analysis Suggestions: To be determined

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:


Measure Algorithm:
**BCC-04: Intervention for Fatigue**

**Numerator:** Patients with an exercise program recommended prior to the first chemotherapy treatment

**Denominator:** Breast cancer patients who have begun chemotherapy

---

**Diagram:**

```
Start

Run cases that are included in the BCC Initial Patient Population and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.

Exercise Program

- N: Reason for Not Recommending Exercise
- Y: Case Will Be Rejected

In Numerator Population

- E: In Measure Population
- D: Not In Measure Population

Stop
```

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**Related Topics**
Measure Information Form

Measure Set: Breast Cancer Care (BCC)

Set Measure ID: BCC-05

Performance Measure Name: Intervention for Sleep-Wake Disturbance

Description: Documented intervention for sleep-wake disturbance of 4 or greater on the PROMIS scale, or moderate or greater sleep-wake disturbance determined via any validated tool or narrative note at any visit.

Rationale: Sleep-wake disturbances are reported in 30-50% of patients newly diagnosed and treated with breast cancer, double the rate in the general population. (Berger, 2009; Clark, Cunningham, McMillan, Vena, & Parker, 2004; Lee, Cho, Miaskowski, & Dodd, 2004; Savard & Morin, 2001) Sleep-wake disturbances left undiagnosed and untreated can impact pain, mood, cognition, functioning and survival across the disease trajectory. (Berger, et al., 2005; Berger, 2009; Clark et al., 2004; Erickson & Berger, 2010; Fiorentino & Ancoli-Israel, 2007; Groenvold et al., 2007; Lee et al., 2004; O'Donnell, 2004; Savard & Morin, 2001; Vena, Parker, Cunningham, Clark, & McMillan, 2004). In addition, daytime, social and occupational functioning can be adversely affected by mild sleepiness. (Berger, 2009; Lee et al., 2004; Savard & Morin, 2001) More severe daytime sleepiness may adversely affect psychiatric and quality of life, while severe sleepiness can be life threatening, by lowering levels of alertness and reactivity (Vena et al., 2004). There are over 40 intervention studies in cancer patients and survivors that report sleep disturbance as an outcome and of these, cognitive behavioral therapies have been classified as Likely to be Beneficial by the ONS Putting Evidence into Practice (PEP) program (Page, Berger, Johnson & Eaton, 2009).

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Patients with at least one documented intervention to manage sleep-wake disturbance.

   Included Populations: Not applicable

   Excluded Populations: None

Data Elements:

   • Intervention for Sleep-Wake Disturbance

Denominator Statement: Breast cancer patients with sleep-wake disturbance of 4 or greater on the PROMIS scale, or moderate or greater sleep-wake disturbance determined via any validated tool or narrative note at any visit.

   Included Populations: Not applicable

   Excluded Populations:

   • Patients less than 18 years of age
   • Patient with a sleep-wake disturbance of less than 4 on the PROMIS scale or mild/no sleep-wake disturbance via any validated tool or narrative note

Data Elements:

   • Age 18 or Greater
   • CPT® Code
   • ICD-9-CM Diagnosis Code
   • Sex
   • Sleep-Wake Disturbance
Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative/billing data and medical records.

Data Accuracy:

- For sleep-wake disturbance assessments the following two items from the PROMIS scale Sleep Disturbance item bank v1.0 are recommended:
  - “I had problems during the day because of poor sleep”
  - “In the past 7 days, I had trouble sleeping…”
  - Response range:
    1. = Not at all
    2. = A little bit
    3. = Somewhat
    4. = Quite a bit
    5. = Very much
  - For the purposes of this measure, intervention is recommended for patient responses of 4 = Quite a bit or 5 = Very much
- Other methods of measurement are acceptable if the clinical level that initiates recommendation for intervention is consistent and documented (e.g. a tool or other narrative documentation that specifies recommendation for intervention at a moderate of severe level of sleep-wake disturbance or daytime impairment related to poor sleep).
- Though sleep-wake disturbances and fatigue may be noted in the same patient record, when utilizing clinician narrative to meet this measure requirement, it is necessary to locate statements indicating poor sleep as the main etiology of the fatigue.
- Clinician (Physician, PA, APN, RN) narrative documentation of statements referring to current status of patient such as: trouble falling or staying sleeping at night, trouble staying awake during daytime activities related to poor sleep, decreased daytime alertness, poor sleep quality, insomnia.

Measure Analysis Suggestions: To be determined

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

Pittsburgh, PA: Oncology Nursing Society.

Measure Algorithm:

BCC-05: Intervention for Sleep-Wake Disturbance
Numerator: Patients with at least one documented intervention to manage sleep-wake disturbance.
Denominator: Breast cancer patients with sleep-wake disturbance of 4 or greater on the PROMIS scale, or moderate or greater sleep-wake disturbance determined via any validated tool or narrative note.

[Diagram of the measure algorithm is shown here.]
Measure Information Form

**Measure Set:** Breast Cancer Care (BCC)

**Set Measure ID:** BCC-06

**Performance Measure Name:** Assessment for Chemotherapy Induced Nausea and Vomiting

**Description:** Documented assessment for chemotherapy induced nausea and vomiting prior to the second round of moderately or highly emetogenic chemotherapy treatment.

**Rationale:** Delayed CINV develops between 2-5 days but may last up to 7 days, depending on the emetogenic potential of the chemotherapy regimen administered, antiemetics utilized and individual patient risk factors (Booth, 2007). Patients need to be protected from CINV throughout the expected time period of risk (NCCN, 2010). Some chemotherapy agents are more likely to cause delayed CINV, including cyclophosphamide, ifosfamide, doxorubicin, epirubicin, cisplatin, and carboplatin (Lohr, 2008). Reassessment and evaluation of the patient’s experience with the previous cycle is critical to appropriate, timely modifications to the antiemetic regimen, to maintain patient on treatment, and prevent withdrawal from cancer treatment due to consequences of CINV (NCCN 2010). Several assessment tools are available for CINV. Aspects such as occurrence of episodes of CINV, frequency and intensity linked with duration are particularly important for the clinicians’ understanding of the patient’s experience of nausea and vomiting. Self-report tools and diaries are examples of appropriate tools for reassessment (Brearly, et al, 2008).

**Type of Measure:** Process

**Improvement Noted As:** Increase in the rate

**Numerator Statement:** Patients who received documented assessment for chemotherapy induced nausea and vomiting.

- **Included Populations:** Not applicable
- **Excluded Populations:** None

**Data Elements:**
- Assessment for Chemotherapy Induced Nausea and Vomiting

**Denominator Statement:** Breast cancer patients prior to the second moderately or highly emetogenic chemotherapy treatment at this facility.

- **Included Populations:** Not applicable
- **Excluded Populations:**
  - Patients less than 18 years of age
  - Patients who did not receive moderately or highly emetogenic chemotherapy treatments
  - Patients who did not receive a second moderately or highly emetogenic chemotherapy treatment at this facility

**Data Elements:**
- Age 18 or Greater
- CPT® Code
- Emetogenic Agents
- First Chemotherapy Date
Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative/billing data and medical records.

Data Accuracy:

- For the purposes of this measure, the following tools are recommended (but not limited to):
  - MANE – Morrow Assessment of Nausea and Emesis (Morrow, 1992)
  - INVR - Index of Nausea, Vomiting, and Retching (Roscoe, Morrow, Hickok, Stern, 2000)
  - FLIE - Functional Living Index-Emesis (Lo & Hayman, 1999; Martin, Pearson, Cai, Elmer, Horgan, & Lindley, 2000)
  - MAT - MASCC Antiemesis Tool (Molassiotis, Coventry, Stricker, Clements, Eaby, Velders, Rittenberg & Gralla, 2007)
- Clinician narrative documenting assessment of incidence and severity of nausea and/or vomiting during the period between first and second chemotherapy infusions, including any of the terms “nausea,” “vomiting,” “retching,” “emesis,” “queasy,” “sick to stomach” or “throwing up.”

Measure Analysis Suggestions: To be determined

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:

**BCC-06: Assessment for Chemotherapy Induced Nausea and Vomiting**

**Numerator:** Patients who received documented assessment for chemotherapy induced nausea and vomiting

**Denominator:** Breast cancer patients prior to the second moderately or highly emetogenic chemotherapy treatment at this facility

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**Related Topics**

Breast Cancer Care Measures Specifications Manual

ONS Foundation/The Joint Commission, 2010

MIFs and Data Elements - 26
Measure Information Form

Measure Set: Breast Cancer Care (BCC)

Set Measure ID: BCC-07

Performance Measure Name: Education on Neutropenia Precautions

Description: Documented education on neutropenia precautions prior to or at the time of the first myelosuppressive chemotherapy administration. Instructions include hand washing and to contact health care provider in the event of the development of a practice-defined specific level of fever.

Rationale: Patients who receive myelosuppressive chemotherapy as part of treatment for breast cancer are at risk of infection, especially during the expected ANC nadir period (Zitella et al., 2006). Though guidelines for the management of established cancer-related infections exist, less evidence is available regarding outcomes of frequently provided patient education. However, it is generally accepted that education regarding hand washing and the degree of fever during expected neutropenia that should initiate an immediate call from the patient to the oncology practice, should occur and that nurses are the primary providers of this type of instruction (Dickerson & Carson, 2006). Instruction on hand washing by patients and their caregivers includes the need to wash hands with warm water, soap (or alcohol based cleansers) and friction before and after toileting, eating or touching the face, wounds or catheters (Boyce & Pittet, 2002; ACS, 2008). The impact on mitigation of septic shock by instructing patients to enter the health care system immediately upon discovery of febrile neutropenia is also not well-documented across patient populations, but guidelines clearly recommend that patients be instructed to contact their providers for risk assessment and treatment to prevent septic shock upon discovery of fever, which can be defined as a single oral temperature of 38.3°C or greater, or 38°C or greater sustained over a one hour period or more) during periods of expected neutropenia (NCCN, 2009), though variation remains in the literature regarding the exact temperature that should trigger a patient to call (Nirenberg, 2006).

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Patients that have documented instruction on hand washing and to contact his or her health care provider in the event of the development of a practice-defined specific level of fever.

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- Instructions on Hand Washing
- Instructions to Contact Provider

Denominator Statement: Breast cancer patients who received potentially myelosuppressive chemotherapy regimen.

Included Populations: Not applicable

Excluded Populations:

- Patients less than 18 years of age
- Patients who did not receive a potentially myelosuppressive chemotherapy regimen

Data Elements: 

Breast Cancer Care Measures Specifications Manual

ONS Foundation/The Joint Commission, 2010

MIFs and Data Elements - 27
Risk Adjustment: No.

Data Collection Approach: Retrospective data sources for required data elements include administrative/billing data and medical records.

Data Accuracy:

- A potentially myelosuppressive chemotherapy administration is defined as one that confers a 20% or greater risk of febrile neutropenia.
- Chemotherapy regimens that confer a greater than 20% chance of febrile neutropenia (NCCN, 2010), such as but not limited to:
  - Docetaxel + trastuzumab (metastatic or relapsed)
  - Dose dense doxorubicin and cyclophosphamide followed by paclitaxel (adjuvant)
  - Doxorubicin + paclitaxel (metastatic or relapsed)
  - Doxorubicin + docetaxel (metastatic or relapsed)
  - Docetaxel + doxorubicin + cyclophosphamide (adjuvant)
- The practice must define the level of fever that would require the patient to call the health care provider. This level must be consistent for all patients. Education instruction must specify that provider should be called immediately when practice-defined level of fever occurs.
- Optimally documentation will include all of the following: the need to wash hands with warm water, soap (or alcohol based cleansers) and friction before and after toileting, eating or touching the face, wounds or catheters.
- Optimally a return demonstration should be conducted and documented.
- Instruction on both hand washing and provider contact for fever must be present for the case to be in the numerator.

Measure Analysis Suggestions: To be determined

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:


Measure Algorithm:

Breast Cancer Care Measures
Specifications Manual
ONS Foundation/The Joint Commission, 2010
MIFs and Data Elements - 28
BCC-07: Education on Neutropenia Precautions

**Numerator:** Patients that have documented instruction on hand washing and to contact his or her health care provider in the event of the development of a practice-defined specific level of fever

**Denominator:** Breast cancer patients who received potentially myelosuppressive chemotherapy regimen

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**Related Topics**
Measure Information Form

Measure Set: Breast Cancer Care(BCC)

Set Measure ID: BCC-08

Performance Measure Name: Colony Stimulation Factors (CSF) Prescribed

Description: Percentage of cycles where patients who are prescribed a potentially myelosuppressive chemotherapy regimen receive a prescription for CSF to begin within 24-72 hours after chemotherapy administration. A potentially myelosuppressive chemotherapy administration cycle is defined as a chemotherapy cycle with a 20% or greater risk of febrile neutropenia.

Rationale: Colony-stimulating factor (CSF) administration decreases the risk of infection and helps to maintain dose intensity in patients with breast cancer receiving cytotoxic chemotherapy with a >20% risk of febrile neutropenia (Aapro, et al., 2006; NCCN, 2010; Smith, et al., 2006). Colony-stimulating factor (CSF) decreases the risk of neutropenia, febrile neutropenia, infection, hospitalization, and chemotherapy dose reduction or delay in patients with breast cancer undergoing chemotherapy (Khan, Dhadda, Fyfe, & Sundar, 2008; Kuderer, Dale, Crawford, & Lyman, 2007; M. Martin et al., 2006; Miguel Martin et al., 2005; Sung, Nathan, Alibhai, Tomlinson, & Beyene, 2007; Vogel et al., 2005; von Minckwitz et al., 2008; von Minckwitz et al.). The National Cancer Comprehensive Cancer Network (NCCN) guidelines, the American Society of Clinical Oncology (ASCO), and the European Organization for Research and Treatment of Cancer (EORTC) recommend the use of CSF with all chemotherapy regimens with a >20% risk of febrile neutropenia in order to minimize the risk of infection and maintain the ability to administer planned doses of chemotherapy (Aapro, et al., 2006; NCCN, 2010; Smith, et al., 2006).

Type of Measure: Process

Improvement Noted As: Increase in the rate

Numerator Statement: Number of cycles for which patients were prescribed CSF.

Included Populations: Not applicable

Excluded Populations: None

Data Elements:

- CSF Prescribed
- Chemotherapy Cycle Number

Denominator Statement: Number of cycles for which breast cancer patients received a potentially myelosuppressive chemotherapy regimen.

Included Populations: Not applicable

Excluded Populations:

- Patients less than 18 years of age
- Contraindications to CSF: contraindicated in patients with known hypersensitivity to E coli-derived proteins, pegfilgrastim, filgrastim, or any component of the product.
- Patients who did not receive a potentially myelosuppressive chemotherapy treatment at this facility

Data Elements:

- Age 18 or Greater
- CPT® Code
Risk Adjustment: No.

Data Accuracy:

- White blood cell colony stimulating factors include:
  - Filgrastim, G-CSF (Neupogen®, Amgen, Inc)
  - Pegfilgrastim, pegG-CSF (Neulasta®, Amgen, Inc.)
  - Sargramostim, GM-CSF (Leukine®, Wyeth, Inc.)
- Chemotherapy regimens that confer a greater than 20% chance of febrile neutropenia (NCCN, 2010), such as but not limited to:
  - Docetaxel + trastuzumab (metastatic or relapsed)
  - Dose dense doxorubicin and cyclophosphamide followed by paclitaxel (adjuvant)
  - Doxorubicin + paclitaxel (metastatic or relapsed)
  - Doxorubicin + docetaxel (metastatic or relapsed)
  - Docetaxel + doxorubicin + cyclophosphamide (adjuvant)

Measure Analysis Suggestions: To be determined

Sampling: Yes. For additional information see the Sampling Section.

Data Reported As: Aggregate rate generated from count data reported as a proportion.

Selected References:


Measure Algorithm:

**BCC-08: Colony Stimulation Factors (CSF) Prescribed**

**Numerator:** Number of cycles for which patients were prescribed CSF  
**Denominator:** Number of cycles for which breast cancer patients received a potentially myelosuppressive chemotherapy regimen

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**Related Topics**

Breast Cancer Care Measures Specifications Manual  
ONS Foundation/The Joint Commission, 2010  
MIFs and Data Elements - 32
**Data Element Name:** Age 18 or Greater

**Collected For:** All Records

**Definition:** Patient's age (in years) on the First Chemotherapy Date is age 18 or greater.

**Suggested Data Collection Question:** Was the patient's age 18 or greater on the First Chemotherapy Date?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- Y (Yes) The patient was age 18 or greater on the first chemotherapy date.
- N (No) The patient was age 17 or less on the first chemotherapy date.

**Notes for Abstraction:**
Patient's age (in years) is calculated by First Chemotherapy Date minus birth date. To calculate age use the month and day portion of admission date and birth date to yield the most accurate age.

**Suggested Data Sources:**
- History and physical
- Face sheet
- Registration forms

**Additional Notes:**

**Guidelines for Abstraction:**

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Data Element Name: Assessment for Chemotherapy Induced Nausea and Vomiting

Collected For: BCC-06.

Definition: Documentation that the patient was assessed for chemotherapy induced nausea and vomiting after the first administration but prior to the second chemotherapy treatment. Reassessment and evaluation of the patient’s experience with the previous cycle is critical to appropriate, timely modifications to the antiemetic regimen, to maintain patient on treatment, and prevent withdrawal from cancer treatment due to consequences of CINV. (National Comprehensive Cancer Network, 2010a).

Suggested Data Collection Question: Was an assessment for chemotherapy induced nausea and vomiting documented after the first administration but prior to the second chemotherapy treatment?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1. There is documentation of assessment between the first and second chemotherapy treatment for chemotherapy induced nausea and vomiting using a systematic validated tool/method.

2. There is documentation of assessment between the first and second chemotherapy treatment for chemotherapy induced nausea and vomiting using narrative notes.

3. There is no documentation of assessment for chemotherapy induced nausea and vomiting between the first and second chemotherapy treatment or unable to determine form the medical record documentation.

4. Did not receive a second cycle of chemotherapy treatment at this facility.

Notes for Abstraction:

- For chemotherapy induced nausea and vomiting assessments the following tools are recommended (but not limited to):
  - MANE – Morrow Assessment of Nausea and Emesis (Morrow, 1992)
  - INVR - Index of Nausea, Vomiting, and Retching (Roscoe, Morrow, Hickok, Stern, 2000)
  - FLIE - Functional Living Index-Emesis (Lo & Hayman, 1999; Martin, Pearson, Cai, Elmer, Horgan, & Lindley, 2000)
  - MAT - MASCC Antiemesis Tool (Molassiotis, Coventry, Stricker, Clements, Eaby, Velders, Rittenberg & Gralla, 2007)
- Clinician (Physician, PA, APN, RN) narrative documentation of statements referring to current status of patient such as: nausea, vomiting, retching, emesis, queasy, sick to stomach or throwing up. Choose allowable value 2.
- Informal tools are forms, worksheets and guided documentation tools developed by an individual organization to collect patient-related data. May be completed by the patient or provider, and becomes part of the medical record. Informal tools typically have not undergone formal validity or reliability testing. If an informal tool is used select “2”.
- Reference to past history is insufficient; documentation must be in reference to current patient status.
- Some chemotherapy agents are more likely to cause delayed CINV, including cyclophosphamide, ifosfamide, doxorubicin, epirubicin, cisplatin, and carboplatin (Lohr, 2008). Reassessment and evaluation of the patient’s experience with the previous cycle is critical to appropriate, timely modifications to the antiemetic regimen, maintain patient on treatment, and prevent withdrawal from cancer treatment due to consequences of CINV (NCCN 2009).
**Data Element**

*Name:* Assessment for Distress  

**Collected For:** BCC-01,  

**Definition:** Documentation that the patient was assessed for distress after breast cancer diagnosis and prior to the first chemotherapy treatment. Distress in cancer is defined as a “multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with ability to cope effectively with cancer, its physical symptoms and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis” (National Comprehensive Cancer Network, 2010c).

**Suggested Data Collection Question:** Was an assessment for distress documented after breast cancer diagnosis and prior to the first chemotherapy treatment?

**Format:**  

- **Length:** 1  
- **Type:** Alphanumeric  
- **Occurs:** 1

**Allowable Values:**

1. There is documentation of assessment for distress prior to the first chemotherapy treatment using a systematic validated tool.
2. There is documentation of assessment for distress prior to the first chemotherapy treatment using narrative notes.
3. There is no documentation of an assessment for distress prior to the first chemotherapy treatment or unable to determine form the medical record documentation.

**Notes for Abstraction:**

- For distress screening/assessment, if one of the following tools is used select "1":  
  - NCCN distress thermometer (DT)  
  - Hospital Anxiety and Depression Scale (HADS)  
  - Brief Symptom Inventory (BSI-18)  
  - Physical Health Questionnaire-9 (PHQ-9)  
  - PROMIS tools  
- Clinician (Physician, PA, APN, RN) narrative documentation of statements referring to current status of patient such as: coping, distress, emotional, depression, or anxiety. Choose allowable value "2".
- Informal tools are forms, worksheets and guided documentation tools developed by an individual organization to collect patient-related data. May be completed by the patient or provider, and becomes part of the medical record. Informal tools typically have not undergone formal validity or reliability testing. If an informal tool is used select "2".
- Reference to past history is insufficient; documentation must be in reference to current patient status.
- Breast cancer diagnosis date is the date on the first pathology report for confirmed malignancy. For patients with recurrent disease use date stage 4 disease is confirmed.
- Abstract record for the pre-treatment time period dates from breast cancer diagnosis date until first chemotherapy infusion is administered. For patients with recurrent disease look at visits related to this episode of chemotherapy treatment only.

**Suggested Data Sources:**

- Nursing notes  
- Progress notes  
- Physician’s notes
• Chemotherapy flow sheets

Additional Notes:

Guidelines for Abstraction:

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Data Element Name: Assessment for Fatigue

Collected For: BCC-01

Definition: Documentation that the patient was assessed for fatigue after breast cancer diagnosis and prior to the first chemotherapy treatment. Cancer-related fatigue (CRF) is a “distressing persistent, subjective sense of physical, emotional and/or cognitive tiredness or exhaustion related to cancer or cancer treatment that is not proportional to recent activity and that interferes with usual functioning” (National Comprehensive Cancer Network, 2010c).

Suggested Data Collection Question: Was an assessment for fatigue documented after diagnosis and prior to the first chemotherapy treatment?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1 There is documentation of pre-treatment assessment for fatigue using a 0-10 scale.
2 There is documentation of pre-treatment assessment for fatigue using narrative notes.
3 There is no documentation of pre-treatment assessment for fatigue or unable to determine form the medical record documentation.

Notes for Abstraction:
- For fatigue assessment a 0-10 scale is recommended.
- Clinician (Physician, PA, APN, RN) narrative documentation of statements referring to current status of patient such as: lack of energy, fatigue, tired, exhaustion, choose allowable value "2".
- Reference to past history is insufficient; documentation must be in reference to current patient status.
- Breast cancer diagnosis date is the date on the first pathology report for confirmed malignancy. For patients with recurrent disease use date stage 4 disease is confirmed.
- Abstract record for the pre-treatment time period dates from breast cancer diagnosis date until first chemotherapy infusion is administered. For patients with recurrent disease look at visits related to this episode of chemotherapy treatment only.

Suggested Data Sources:
- Nursing notes
- Progress notes
- Physician’s notes
- Chemotherapy flow sheets

Additional Notes:

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</table>
Data Element

Name: Assessment for Sleep-Wake Disturbance

Collected For: BCC-01

Definition: Documentation that the patient was assessed for sleep-wake disturbance after breast cancer diagnosis and prior to the first chemotherapy treatment. Sleep-wake disturbances left undiagnosed and untreated can impact pain, mood, cognition, functioning and survival across the disease trajectory. (Berger et al., 2005; Berger, 2009; Clark, Cunningham, McMillan, Vena, & Parker, 2004; Erickson & Berger, 2010; Lee, Cho, Miaskowski, & Dodd, 2004; Savard & Morin, 2001).

Suggested Data Collection Question: Was an assessment for sleep-wake disturbance documented after diagnosis and prior to the first chemotherapy treatment?

Format:

Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:

1 There is documentation of pre-treatment assessment for sleep-wake disturbance using the PROMIS scale.

2 There is documentation of pre-treatment assessment for sleep-wake disturbance using narrative notes.

3 There is no documentation of pre-treatment assessment for sleep-wake disturbance or unable to determine from the medical record documentation.

Notes for Abstraction:

• For sleep-wake disturbance assessments the PROMIS scale is recommended.
• Though sleep-wake disturbances and fatigue may be noted in the same patient record, when utilizing clinician narrative to meet this measure requirement, it is necessary to locate statements indicating poor sleep as the main etiology of the fatigue.
• Clinician (Physician, PA, APN, RN) narrative documentation of statements referring to current status of patient such as: trouble falling or staying sleeping at night, trouble staying awake during daytime activities related to poor sleep, decreased daytime alertness, poor sleep quality, insomnia, choose allowable value "2".
• Reference to past history is insufficient; documentation must be in reference to current patient status.
• Breast cancer diagnosis date is the date on the first pathology report for confirmed malignancy. For patients with recurrent disease use date stage 4 disease is confirmed.
• Abstract record for the pre-treatment time period dates from breast cancer diagnosis date until first chemotherapy infusion is administered. For patients with recurrent disease look at visits related to this episode of chemotherapy treatment only.

Suggested Data Sources:

• Nursing notes
• Progress notes
• Physician’s notes
• Chemotherapy flow sheets

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
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<tr>
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<td>None</td>
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</tbody>
</table>
Data Element Name: CPT® Code

Collected For: All Records


Suggested Data Collection Question: What was the CPT® code selected for this outpatient encounter?

Format: Length: 5
Type: Alphanumeric
Occurs: 1

Allowable Values: Any valid CPT® code from the inclusion list below:

- 96360 Intravenous (IV) infusion, hydration
- 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis
- 96374 Therapeutic, prophylactic or diagnostic injection; IV push
- 96409 Chemotherapy administration; IV, push technique
- 96413 Chemotherapy administration, IV infusion technique
- 96416 Initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump

Notes for Abstraction: None

Suggested Data Sources:

- Nursing notes
- Progress notes
- Medication administration record (MAR)
- Billing records
- Chemotherapy flow sheets

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
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<tbody>
<tr>
<td>CPT® Code:</td>
<td>None</td>
</tr>
<tr>
<td>- 96360 Intravenous (IV) infusion, hydration</td>
<td></td>
</tr>
<tr>
<td>- 96365 Intravenous infusion, for therapy, prophylaxis, or diagnosis</td>
<td></td>
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<tr>
<td>- 96374 Therapeutic, prophylactic or diagnostic injection; IV push</td>
<td></td>
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<tr>
<td>- 96409 Chemotherapy administration; IV, push technique</td>
<td></td>
</tr>
<tr>
<td>- 96413 Chemotherapy administration, IV infusion technique</td>
<td></td>
</tr>
<tr>
<td>- 96416 Initiation of prolonged chemotherapy infusion (more than 8 hours)</td>
<td></td>
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<tr>
<td>requiring use of a portable or implantable pump</td>
<td></td>
</tr>
</tbody>
</table>
Data Element Name: CSF Prescribed

Collected For: BCC-08

Definition: The patient received a prescription for colony-stimulating factor (CSF) to begin within 24-72 hours after a potentially myelosuppressive chemotherapy administration cycle. A potentially myelosuppressive chemotherapy administration cycle is defined as a chemotherapy cycle with a 20% or greater risk of febrile neutropenia. Colony-stimulating factor (CSF) decreases the risk of neutropenia, febrile neutropenia, infection, hospitalization, and chemotherapy dose reduction or delay in patients with breast cancer undergoing chemotherapy (National Comprehensive Cancer Network, 2010d).

Suggested Data Collection Question: Did the patient receive a prescription for colony-stimulating factor (CSF) to begin within 24-72 hours after a potentially myelosuppressive chemotherapy administration cycle?

Format:
Length: 1
Type: Alphanumeric
Occurs: 26

Allowable Values:
Y (Yes) There is documentation of a prescription for a colony-stimulating factor (CSF) to begin within 24-72 hours after a potentially myelosuppressive chemotherapy administration cycle.

N (No) There is no documentation of a prescription for a colony-stimulating factor (CSF) to begin within 24-72 hours after a potentially myelosuppressive chemotherapy administration cycle or unable to determine from the medical record documentation.

Notes for Abstraction:
• In order to meet the requirements for this measure, the CSF must be prescribed according to the package insert instructions, unless part of a clinical trial.
• If there is documentation that the prescription for CSF was recommended, however the patient refused the prescription, select “Yes”.
• If CSF was prescribed, but patient did not receive for that cycle due to inability to resolve a financial barrier, select “Yes.”

Suggested Data Sources:
• Nursing notes
• Progress notes
• Physician orders
• Physician’s notes
• Medication administration record (MAR)
• Medication lists
• Chemotherapy flow sheets

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>White blood cell colony stimulating factors include:</td>
<td></td>
</tr>
<tr>
<td>• Filgrastim, G-CSF (Neupogen®, Amgen, Inc)</td>
<td></td>
</tr>
<tr>
<td>• Pegfilgrastim, pegG-CSF (Neulasta®, Amgen, Inc.)</td>
<td></td>
</tr>
<tr>
<td>• Sargramostim, GM-CSF (Leukine®, Wyeth, Inc.)</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
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</tbody>
</table>
**Data Element Name:** Chemotherapy Cycle Number

**Collected For:** BCC-08

**Definition:** The chemotherapy cycle number. This number is used to link associated questions to a specific cycle (CSF Prescription, Reason for Not Prescribing CSF).

**Suggested Data Collection Question:** What is the chemotherapy cycle number (in chronological order).

**Format:**
- **Length:** 2
- **Type:** Numeric
- **Occurs:** 26

**Allowable Values:** 1-26

**Notes for Abstraction:**
- This number is used to link associated questions to a specific cycle (CSF Prescription, Reason for Not Prescribing CSF).
- Up to 26 cycles may be entered.

**Suggested Data Sources:**
- Nursing notes
- Progress notes
- Physician’s notes
- Medication administration record (MAR)
- Chemotherapy flow sheets

**Additional Notes:**

**Guidelines for Abstraction:**

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<tr>
<td>None</td>
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</table>
Data Element Name: Distress

Collected For: BCC-03

Definition: Documentation that the patient had a distress score of 4 or greater on the NCCN distress thermometer or moderate or greater distress via any other validated tool or narrative note at any visit.

Suggested Data Collection Question: Did the patient have a distress score of 4 or greater on the NCCN distress thermometer or moderate or greater distress via any other validated tool or narrative note at any visit?

Format:
Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1. There is documentation that the patient had a distress score of 4 or greater on the NCCN distress thermometer or moderate or greater distress via any other validated tool at any visit.
2. There is documentation that the patient had moderate or greater distress via narrative notes at any visit.
3. There is documentation that the patient had a distress score of less than 4 on the NCCN distress thermometer or mild / no distress via any validated tool or narrative notes.
4. There is no documentation of distress assessment or unable to determine from the medical record documentation.

Notes for Abstraction:
- For distress screening/assessment, the following tools are recommended:
  - NCCN distress thermometer (DT)
  - Hospital Anxiety and Depression Scale (HADS)
  - Brief Symptom Inventory (BSI-18)
  - Physical Health Questionnaire-9 (PHQ-9)
  - PROMIS tools
- Reference to past history is insufficient; documentation must be in reference to current patient status.
- Clinician (Physician, PA, APN, RN) narrative documentation of statements referring to current status of patient such as: coping, distress, emotional, depression, or anxiety, choose allowable value "2".
- Informal tools are forms, worksheets and guided documentation tools developed by an individual organization to collect patient-related data. May be completed by the patient or provider, and becomes part of the medical record. Informal tools typically have not undergone formal validity or reliability testing. If an informal tool is used select "2".

Suggested Data Sources:
- Nursing notes
- Progress notes
- Physician’s notes
- Chemotherapy flow sheets

Additional Notes:

Guidelines for Abstraction:
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</table>
Data Element Name: Emetogenic Agents

Collected For: BCC-06

Definition: Documentation that the patient received a moderately or highly emetogenic chemotherapy agent. Delayed chemotherapy induced nausea and vomiting (CINV) develops between 2-5 days but may last up to 7 days, depending on the emetogenic potential of the chemotherapy regimen administered, antiemetics utilized, and individual patient risk factors (Booth et al., 2007). Patients need to be protected from CINV throughout the expected time period of risk (National Comprehensive Cancer Network, 2010a). Some chemotherapy agents are more likely to cause delayed CINV, including cyclophosphamide, ifosfamide, doxorubicin, epirubicin, cisplatin, and carboplatin (Lohr, 2008).

Suggested Data Collection Question: Did the patient receive a moderately or highly emetogenic chemotherapy agent?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
Y (Yes) The patient received a moderately or highly emetogenic chemotherapy agent.
N (No) The patient did not receive a moderately or highly emetogenic chemotherapy agent or unable to determine from the medical record documentation.

Notes for Abstraction: None

Suggested Data Sources:
- Nursing notes
- Progress notes
- Physician orders
- Physician’s notes
- Medication administration record (MAR)
- Chemotherapy flow sheets

Additional Notes:

Guidelines for Abstraction:

<table>
<thead>
<tr>
<th>Inclusion</th>
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</thead>
<tbody>
<tr>
<td>Moderate and highly emetogenic agents commonly used in breast cancer</td>
<td>None</td>
</tr>
<tr>
<td>- Carboplatin</td>
<td></td>
</tr>
<tr>
<td>- Cisplatin</td>
<td></td>
</tr>
<tr>
<td>- Cyclophosphamide</td>
<td></td>
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<tr>
<td>- Doxorubicin</td>
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<tr>
<td>- Epirubicin</td>
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</table>
**Data Element Name:** Exercise Program

**Collected For:** BCC-04.

**Definition:** Documentation that an exercise program was recommended prior to the first chemotherapy treatment.

**Suggested Data Collection Question:** Was an exercise program recommended prior to the first chemotherapy treatment?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**

- **Y (Yes)** There is documentation that the patient:
  - Received a recommendation for an exercise program prior to the first chemotherapy treatment. OR
  - The patient already had one established.

- **N (No)** There is:
  - Documentation that the patient received a recommended exercise program, however not prior to the first chemotherapy treatment. OR
  - No documentation that the patient received a recommended exercise program. OR
  - Unable to determine from the medical record documentation.

**Notes for Abstraction:**
- Examples of exercise recommendations: Perform aerobic, resistance or a combination of both types of exercise several times per week, such as walking, cycling, swimming, etc. (Recommendation cited in Mitchell, et al., 2009)
- Exercise recommendation may be made by a Physician, PA, APN, RN, PT or OT staff member.
- Recommended activities include any aerobic and/or resistance exercise noted in the patient record as performed more than once per week.
- If patient received an exercise program recommendation, but not prior to the first chemotherapy treatment, select no. Organizations may choose to track the number of cases that do not get the recommendation in a timely manner.
- If there is documentation that an exercise program was recommended, however the patient refused the recommendation, select "Yes".

**Suggested Data Sources:**
- Nursing notes
- Progress notes
- Physician’s notes
- Chemotherapy flow sheets

**Additional Notes:**

**Guidelines for Abstraction:**

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</table>
Data Element Name: First Chemotherapy Date

Collected For: All Records

Definition: The documented month, day and year the patient received the first chemotherapy treatment at this facility for this episode of care.

Suggested Data Collection Question: What was date the patient received the first chemotherapy treatment at this facility for this episode of care?

Format:
Length: 10 – MM-DD-YYYY (includes dashes)
Type: Date
Occurs: 1

Allowable Values:
- MM = Month (01-12)
- DD = Day (01-31)
- YYYY = Year (1880-9999)

Notes for Abstraction:
- UTD is NOT an allowable value.
- Breast cancer diagnosis date is the date on the first pathology report for confirmed malignancy. For patients with recurrent disease use date stage 4 disease is confirmed.
- For patients with recurrent disease look at visits related to this episode of chemotherapy treatment only.

Suggested Data Sources:
- Nursing notes
- Progress notes
- Physician orders
- Medication administration record (MAR)
- Chemotherapy flow sheets

Additional Notes:

Guidelines for Abstraction:

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</table>
Data Element Name: ICD-9-CM Diagnosis Code

Collected For: All Records

Definition: The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes associated with the diagnosis for this record and episode of care.

Suggested Data Collection Question: What was the ICD-9-CM diagnosis code selected for this medical record?

Format: 

- Length: 6
- Type: Alphanumeric
- Occurs: 11

Allowable Values: Any diagnosis code from the list below:

- 174.0 - Malig neo nipple
- 174.1 - Mal neo breast-central
- 174.2 - Mal neo breast up-inner
- 174.3 - Mal neo breast low-inner
- 174.4 - Mal neo breast up-outer
- 174.5 - Mal neo breast low-outer
- 174.6 - Mal neo breast-axillary
- 174.8 - Malign neopl breast NEC
- 174.9 - Malign neopl breast NOS
- 175.0 - Mal neo male nipple
- 175.9 - Mal neo male breast NEC
- None - No ICD-9 code for breast cancer

Notes for Abstraction: None

Suggested Data Sources:

- Nursing notes
- Progress notes
- Physician's notes
- Billing records
- Chemotherapy flow sheets

Additional Notes:

Guidelines for Abstraction:

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</table>
**Data Element Name:** Instructions on Hand Washing

**Collected For:** BCC-07.

**Definition:** Documentation that the patient received instructions on hand washing prior to or at the time of the first chemotherapy administration. Instruction on hand washing by patients and their caregivers includes the need to wash hands with warm water, soap (or alcohol based cleansers) and friction before and after toileting, eating or touching the face, wounds or catheters (American Cancer Society, 2008; Boyce & Pittet, 2002).

**Suggested Data Collection Question:** Did the patient receive instructions on hand washing prior to or at the time of the first chemotherapy administration?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- Y (Yes) There is documentation that the patient received instructions on hand washing prior to or at the time of the first chemotherapy administration.
- N (No) There is no documentation that the patient received instructions on hand washing prior to or at the time of the first chemotherapy administration. OR There is documentation that the patient received instructions on hand washing but not prior to or at the time of the first chemotherapy administration. OR Unable to determine from the medical record documentation.

**Notes for Abstraction:**
- Documentation must explicitly refer to hand washing, or describe a secondary source where this content was provided. For example, a teaching sheet on neutropenic precautions that states hand washing, or participation in a patient education class that includes hand washing in the curriculum.
- Optimally documentation will include all of the following: the need to wash hands with warm water, soap (or alcohol based cleansers) and friction before and after toileting, eating or touching the face, wounds or catheters.
- Optimally a return demonstration should be conducted and documented.

**Suggested Data Sources:**
- Nursing notes
- Progress notes
- Physician’s notes
- Chemotherapy flow sheets
- Education records
- Discharge sheet

**Additional Notes:**

**Guidelines for Abstraction:**

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<tr>
<td>None</td>
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</table>
Data Element Name: Instructions to Contact Provider

Collected For: BCC-07,

Definition: Prior to or at the time of the first chemotherapy administration, the patient received instructions to contact his or her health care provider in the event of the development of a practice-defined specific level of fever. Guidelines recommend that patients be instructed to contact their providers for risk assessment and treatment to prevent septic shock upon discovery of fever, defined as a single oral temperature of 38.3° C or greater, or 38° C or greater sustained over a one hour period or more during periods of expected neutropenia (though variation remains in the literature regarding the exact temperature that should trigger a patient to call) (Dickerson & Carson, 2006; National Comprehensive Cancer Network, 2008; Nirenberg et al., 2006).

Suggested Data Collection Question: Prior to or at the time of the first chemotherapy administration, did the patient receive instructions to contact his or her health care provider in the event of development of a fever?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values: Y (Yes) Prior to or at the time of the first chemotherapy administration, there is documentation of instructions to contact the health care provider in the event of the development of a practice-defined specific level of fever.

N (No) There is no documentation that the patient received instructions to contact the health care provider in the event of the development of a practice-defined specific level of fever. OR There is documentation of instructions to contact the health care provider in the event of the development of a practice-defined specific level of fever, but not prior to or at the time of the first chemotherapy administration. OR Unable to determine from the medical record documentation.

Notes for Abstraction: • The practice must define the level of fever that would require the patient to call the health care provider. This level must be consistent for all patients.
• In order to answer “Yes” to this data element, documentation must explicitly include the level of fever that should trigger the provider contact (e.g., “call office if you have a fever of 100.4” or greater”).
• Documentation that the patient was instructed to call the provider in the event of a “fever” without a specific level defined, choose allowable value “No”.
• Education instruction must specify that provider should be called immediately when practice-defined level of fever occurs.
• Documentation must explicitly refer to the provider-defined fever level, or describe a secondary source where this content was provided. For example, a teaching sheet on neutropenic precautions that states “call us immediately with a fever of 100.4”, or participation in a patient education class that includes this information in the curriculum.

Suggested Data Sources: • Nursing notes
• Progress notes
• Physician’s notes
• Chemotherapy flow sheets
• Education record
• Discharge sheet
Guidelines for Abstraction:

<table>
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<tr>
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<tbody>
<tr>
<td>None</td>
<td>None</td>
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</table>
Data Element Name: Intervention for Distress

Collected For: BCC-03.

Definition: Documentation that the patient received at least one documented intervention to manage moderate or greater distress.

Suggested Data Collection Question: Did the patient receive at least one documented intervention to manage moderate or greater distress?

Format: Length: 1  
Type: Alphanumeric  
Occurs: 1

Allowable Values:

Y (Yes) There is documentation that the patient received at least one documented intervention to manage moderate or greater distress.

N (No) There is no documentation that the patient received at least one documented intervention to manage moderate or greater distress or unable to determine from the medical record documentation.

Notes for Abstraction:

- Documented intervention for distress score of 4 or greater on the NCCN distress thermometer or moderate or greater distress via any other validated tool or narrative note at any visit.
- Interventions to manage distress may include pharmacological, nonpharmacological or referral to another health care professional.
- Practitioners performing nonpharmacologic interventions are not restricted to physicians/physician assistants, APNs.
- If there is documentation that at least one intervention to manage moderate or greater distress was prescribed or recommended, however the patient refused the intervention, select "Yes".
- In cases where an intervention is underway, but moderate or greater levels of distress continue for the same problem, documentation should indicate this. For example, “Pt. continues to see Dr. XYZ for management of depression.”

Suggested Data Sources:

- Nursing notes
- Progress notes
- Physician’s notes
- Medication administration record (MAR)
- Chemotherapy flow sheets
- Education record
- Medication record

Additional Notes:

Guidelines for Abstraction:

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| Recommended intervention examples for distress: (Recommendations cited in Swanson, et al., 2009 and Fulcher et al., 2009)  
  - Provision of or referral for cognitive behavioral therapy, counseling or psychotherapy | None |
- Patient education and information provision on self-management
- Provision of social support, or referral to a support group
- Prescription of antidepressant or anxiolytic
- Massage therapy for anxiety
**Data Element Name:** Intervention for Sleep-Wake Disturbance

**Collected For:** BCC-05.

**Definition:** Documentation that the patient received at least one documented intervention to manage moderate or greater sleep-wake disturbance.

**Suggested Data Collection Question:** Did the patient receive at least one documented intervention to manage moderate or greater sleep-wake disturbance?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- Y (Yes) There is documentation that the patient received at least one documented intervention to manage moderate or greater sleep-wake disturbance.
- N (No) There is no documentation that the patient received at least one documented intervention to manage moderate or greater sleep-wake disturbance or unable to determine from the medical record documentation.

**Notes for Abstraction:**
- Documented intervention for sleep-wake disturbance score of 4 or greater on the PROMIS scale or moderate or greater distress via any other validated tool or narrative note at any visit.
- There are over 40 intervention studies in cancer patients and survivors that report sleep disturbance as an outcome and of these, cognitive behavioral therapies have been classified as Likely to be Beneficial by the ONS Putting Evidence into Practice (PEP) program.
- Interventions to manage sleep-wake disturbance may include pharmacological, nonpharmacological or referral to another health care professional.
- If there is documentation that at least one intervention to manage moderate or greater sleep-wake disturbance was prescribed or recommended, however the patient refused the intervention, select "Yes".
- Practitioners performing nonpharmacologic interventions are not restricted to physicians/physician assistants, APNs.
- In cases where an intervention is underway, but moderate or greater levels of distress continue for the same problem, documentation should indicate this. For example, "Pt. continues to see Dr. XYZ for management of depression."

**Suggested Data Sources:**
- Nursing notes
- Progress notes
- Physician’s notes
- Chemotherapy flow sheets
- Education record
- Medication record

**Additional Notes:**

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<tr>
<td><strong>Guidelines for Abstraction:</strong></td>
<td>None</td>
</tr>
<tr>
<td>Recommended intervention examples for Sleep-Wake Disturbance: (Recommendations cited in Page, Berger, Johnson, &amp; Eaton, 2009)</td>
<td></td>
</tr>
</tbody>
</table>
- Provision of or referral for cognitive behavioral therapy
- Referral to a Sleep-Wake specialist
**Data Element Name:** Myelosuppressive Chemotherapy

**Collected For:** BCC-07

**Definition:** Documentation that the patient received a potentially myelosuppressive chemotherapy regimen that conferred a 20% risk or greater of febrile neutropenia. Patients who receive myelosuppressive chemotherapy as part of treatment for breast cancer are at risk of infection, especially during the expected absolute neutrophil count (ANC) nadir period (National Comprehensive Cancer Network, 2010d).

**Suggested Data Collection Question:** Did the patient receive a potentially myelosuppressive chemotherapy regimen?

**Format:**
- **Length:** 1
- **Type:** Alphanumeric
- **Occurs:** 1

**Allowable Values:**
- Y (Yes) The patient received a potentially myelosuppressive chemotherapy regimen.
- N (No) The patient did not receive a potentially myelosuppressive chemotherapy regimen or unable to determine from the medical record documentation.

**Notes for Abstraction:** None

**Suggested Data Sources:**
- Nursing notes
- Progress notes
- Physician orders
- Medication administration record (MAR)
- Chemotherapy flow sheets

**Guidelines for Abstraction:**

<table>
<thead>
<tr>
<th>Inclusion</th>
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<tbody>
<tr>
<td>Chemotherapy regimens that confer a greater than 20% chance of febrile neutropenia (NCCN, 2010), such as but not limited to:</td>
<td>None</td>
</tr>
<tr>
<td>- Docetaxel + trastuzumab (metastatic or relapsed)</td>
<td></td>
</tr>
<tr>
<td>- Dose dense doxorubicin and cyclophosphamide followed by paclitaxel (adjuvant)</td>
<td></td>
</tr>
<tr>
<td>- Doxorubicin + paclitaxel (metastatic or relapsed)</td>
<td></td>
</tr>
<tr>
<td>- Doxorubicin + docetaxel (metastatic or relapsed)</td>
<td></td>
</tr>
<tr>
<td>- Docetaxel + doxorubicin + cyclophosphamide (adjuvant)</td>
<td></td>
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</tbody>
</table>
Data Element Name: Neutropenia Risk Cycle

Collected For: BCC-08.

Definition: The chemotherapy cycle number in which the patient received a potentially myelosuppressive chemotherapy administration. A potentially myelosuppressive chemotherapy administration cycle is defined as one that confers a 20% or greater risk of febrile neutropenia.

Suggested Data Collection Question: What was the total number of chemotherapy cycles in which the patient received a potentially myelosuppressive chemotherapy administration?

Format: Length: 3  
Type: Alphanumeric  
Occurs: 1

Allowable Values: 0-26 or UTD

Notes for Abstraction:
- This data element is used for tracking the number of potentially myelosuppressive chemotherapy administration cycles in the six month data collection time period starting with the first chemotherapy cycle.
- For patients that did not receive a potentially myelosuppressive chemotherapy administration cycle select “0”.
- If unable to determine from the medical record documentation if the patient received a potentially myelosuppressive chemotherapy administration cycle during any cycle select “UTD”.
- Adjuvant regimen example: AC (doxorubicin, cyclophosphamide) x4 followed by paclitaxel x4, given every 14 days. The AC (but not the paclitaxel) cycles are considered potentially myelosuppressive according the guidelines cited for this project, therefore the data element “neutropenic risk cycles” would be answered as “4.”
- Metastatic regimen example: AT (doxorubicin, docetaxel), given every 21 days. Each cycle would be considered potentially myelosuppressive according to the guidelines cited for this project, therefore the data element “neutropenic risk cycles” would include a total of the number of cycles infused during the 6 month period during which the case was followed. For example, the patient was diagnosed with Stage IV disease on February 19, 2009, and received the first infusion of AT on March 2, 2009. Total neutropenic risk cycles would be “9” – (3/2, 3/23, 4/13, 5/4, 5/25, 6/15, 7/6, 7/27, 8/17/2009 – note that though the doxorubicin was discontinued in July to avoid exceeding the recommended cumulative dose, docetaxel as a single agent meets the criteria, so the remaining cycles are counted).

Additional Notes:

Suggested Data Sources: 
- Nursing notes  
- Progress notes  
- Physician orders  
- Medication administration record (MAR)  
- Chemotherapy flow sheets

Guidelines for Abstraction:

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<tr>
<th>Inclusion</th>
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<tr>
<td>Chemotherapy regimens that confer a greater than 20% chance of febrile neutropenia (NCCN, 2010), such</td>
<td>None</td>
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</table>
as but not limited to:

- Docetaxel + trastuzumab (metastatic or relapsed)
- Dose dense doxorubicin and cyclophosphamide followed by paclitaxel (adjuvant)
- Doxorubicin + paclitaxel (metastatic or relapsed)
- Doxorubicin + docetaxel (metastatic or relapsed)
- Docetaxel + doxorubicin + cyclophosphamide (adjuvant)
Data Element Name:  Re-Assessment for Distress

Collected For:  BCC-02

Definition:  Documentation that the patient was re-assessed for distress at least one time each chemotherapy cycle. Distress in cancer is defined as a “multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with ability to cope effectively with cancer, its physical symptoms and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis” (National Comprehensive Cancer Network, 2010c).

Suggested Data Collection Question:  Was the patient re-assessed for distress at least one time each chemotherapy cycle?

Format:  
Length:  1  
Type:  Alphanumeric  
Occurs:  1

Allowable Values:  
1  There is documentation of re-assessment for distress at least one time each chemotherapy cycle using a systematic validated tool.
2  There is documentation of re-assessment for distress at least one time each chemotherapy cycle using narrative notes.
3  There is no documentation of re-assessment for distress at least one time each chemotherapy cycle or unable to determine form the medical record documentation.

Notes for Abstraction:  
- For distress screening/assessment, if one of the following tools is used select "1":  
  ○ NCCN distress thermometer (DT)  
  ○ Hospital Anxiety and Depression Scale (HADS)  
  ○ Brief Symptom Inventory (BSI-18)  
  ○ Physical Health Questionnaire-9 (PHQ-9)  
  ○ PROMIS tools  
- Clinician (Physician, PA, APN, RN) narrative documentation of statements referring to current status of patient such as: coping, distress, emotional, depression, or anxiety. Choose allowable value "2".  
- Informal tools are forms, worksheets and guided documentation tools developed by an individual organization to collect patient-related data. May be completed by the patient or provider, and becomes part of the medical record. Informal tools typically have not undergone formal validity or reliability testing. If an informal tool is used select "2".  
- Reference to past history is insufficient; documentation must be in reference to current patient status.  
- Abstract record for the time period of the first chemotherapy administration date through the first six month of treatment.

Suggested Data Sources:  
- Nursing notes  
- Progress notes  
- Physician’s notes  
- Chemotherapy flow sheets

Additional Notes:  

Guidelines for Abstraction:
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</table>
Data Element Name: Re-Assessment for Fatigue

Collected For: BCC-02

Definition: Documentation that the patient was re-assessed for fatigue at least one time each chemotherapy cycle. Cancer-related fatigue (CRF) is a “distressing persistent, subjective sense of physical, emotional and/or cognitive tiredness or exhaustion related to cancer or cancer treatment that is not proportional to recent activity and that interferes with usual functioning” (National Comprehensive Cancer Network, 2010b).

Suggested Data Collection Question: Was the patient re-assessed for fatigue at least one time each chemotherapy cycle?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1 There is documentation of re-assessment for fatigue at least one time each chemotherapy cycle using a 0-10 scale.
2 There is documentation of re-assessment for fatigue at least one time each chemotherapy cycle using narrative notes.
3 There is no documentation of re-assessment for fatigue at least one time each chemotherapy cycle or unable to determine form the medical record documentation.

Notes for Abstraction:
• For fatigue assessment a 0-10 scale is recommended.
• Clinician (Physician, PA, APN, RN) narrative documentation of statements referring to current status of patient such as: fatigue, tired, exhaustion. Choose allowable value “2”.
• Reference to past history is insufficient; documentation must be in reference to current patient status.
• Abstract record for the time period of the first chemotherapy administration date through the first six month of treatment.

Suggested Data Sources:
• Nursing notes
• Progress notes
• Physician’s notes
• Chemotherapy flow sheets

Additional Notes:

Guidelines for Abstraction:

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Data Element Name: Re-Assessment for Sleep-Wake Disturbance

Collected For: BCC-02

Definition: Documentation that the patient was re-assessed for sleep-wake disturbance at least one time each chemotherapy cycle. Sleep-wake disturbances left undiagnosed and untreated can impact pain, mood, cognition, functioning and survival across the disease trajectory (Berger et al., 2005; Berger, 2009; Clark et al., 2004; Erickson & Berger, 2010; Lee et al., 2004; Savard & Morin, 2001).

Suggested Data Collection Question: Was the patient re-assessed for sleep-wake disturbance at least one time each chemotherapy cycle?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1  There is documentation of re-assessment for sleep-wake disturbance at least one time each chemotherapy cycle using the PROMIS scale.
2  There is documentation of re-assessment for sleep-wake disturbance at least one time each chemotherapy cycle using narrative notes.
3  There is no documentation of re-assessment for sleep-wake disturbance at least one time each chemotherapy cycle or unable to determine from the medical record documentation.

Notes for Abstraction:
- For sleep-wake disturbance assessments the PROMIS scale is recommended.
- Though sleep-wake disturbances and fatigue may be noted in the same patient record, when utilizing clinician narrative to meet this measure requirement, it is necessary to locate statements indicating poor sleep as the main etiology of the fatigue.
- Clinician (Physician, PA, APN, RN) narrative documentation of statements referring to current status of patient such as: trouble falling or staying sleeping at night, trouble staying awake during daytime activities related to poor sleep, decreased daytime alertness, poor sleep quality, insomnia, choose allowable value "2".
- Reference to past history is insufficient; documentation must be in reference to current patient status.
- Abstract record for the time period of the first chemotherapy administration date through the first six month of treatment.

Suggested Data Sources:
- Nursing notes
- Progress notes
- Physician’s notes
- Chemotherapy flow sheets

Additional Notes:

Guidelines for Abstraction:

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</table>
Data Element Name: **Reason for Not Prescribing CSF**

Collected For: **BCC-08.**

Definition: Documentation of a reason for not prescribing a colony-stimulating factor (CSF) to begin within 24-72 hours after chemotherapy administration cycle. Reasons for not prescribing CSF:

- Allergy to CSF
- Other reasons documented by physician/APN/PA or pharmacist

Suggested Data Collection Question: Is there documentation of a reason for not prescribing a colony-stimulating factor (CSF) to begin within 24-72 hours after chemotherapy administration cycle?

Format: Length: 1

- Type: Alphanumeric
- Occurs: 1

Allowable Values:

- Y (Yes) There is documentation of a reason for not prescribing a Colony-stimulating factor (CSF) to begin within 24-72 hours after potentially myelosuppressive chemotherapy administration cycle.

- N (No) There is no documentation of a reason for not prescribing a Colony-stimulating factor (CSF) to begin within 24-72 hours after potentially myelosuppressive chemotherapy administration cycle or unable to determine from the medical record documentation.

Notes for Abstraction:

- When there is documentation of an "allergy", "sensitivity", "intolerance", "adverse or side effects", etc., regard this as documentation of a reason for not prescribing CSF regardless of what type of reaction might be noted. Do not attempt to distinguish between true allergies, sensitivities, intolerances, adverse or side effects, etc. (e.g., "Allergies: CSF" – select "Yes").
- When conflicting information is documented in a medical record, select "Yes".
- When determining whether there is a reason documented by a clinician (Physician, PA, APN) for not not prescribing a colony-stimulating factor (CSF):
  - Reasons must be explicitly documented or clearly implied (e.g., "intolerance to CSF" or "problems with CSF in past").
- If CSF was not prescribed based on assumption that a financial barrier existed, select "No."
- Organizations may wish to track the frequency with which patients did not receive drug due to unresolved financial barriers.

Suggested Data Sources:

- Nursing notes
- Progress notes
- Physician orders
- Physician’s notes
- Medication administration record (MAR)
- Chemotherapy flow sheets

Additional Notes:

**Guidelines for Abstraction:**

Breast Cancer Care Measures Specifications Manual

ONS Foundation/The Joint Commission, 2010 MIFs and Data Elements - 62
<table>
<thead>
<tr>
<th>Inclusion</th>
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<tbody>
<tr>
<td>Contraindications to CSF may include but are not limited to patients with known hypersensitivity to:</td>
<td>None</td>
</tr>
<tr>
<td>• E coli-derived proteins,</td>
<td></td>
</tr>
<tr>
<td>• Pegfilgrastim,</td>
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<tr>
<td>• Filgrastim,</td>
<td></td>
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<tr>
<td>• Or any component of the product</td>
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</table>
Data Element Name: Reason for Not Recommending Exercise

Collected For: BCC-04.

Definition: Documentation of a reason for not recommending an exercise program prior to the first chemotherapy treatment. Reasons for not recommending an exercise program must be documented by the clinician (Physician, PA, APN, RN, and PT).

Suggested Data Collection Question: Is there clinician (Physician, PA, APN, RN, PT) documentation of a reason for not recommending an exercise program prior to the first chemotherapy treatment?

Format: Length: 1  
Type: Alphanumeric  
Occurs: 1

Allowable Values:  
Y (Yes) There is documentation of a reason for not recommending an exercise program prior to the first chemotherapy treatment.

N (No) There is no documentation of a reason for not recommending an exercise program prior to the first chemotherapy treatment or unable to determine from the medical record documentation.

Notes for Abstraction:  
• When conflicting information is documented in a medical record, select “Yes”.
• When determining whether there is a reason documented by a clinician (Physician, PA, APN, RN or PT) for not recommending an exercise program:
  ○ Reasons must be explicitly documented or clearly implied (e.g., “exercise contraindicated due to cardiac condition”).
• If documentation reflects the recommendation was not made because the patient already has an exercise program established, select “Yes”.

Suggested Data Sources:  
• Nursing notes  
• Progress notes  
• Physician’s notes  
• Chemotherapy flow sheets

Additional Notes:

Guidelines for Abstraction:

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<tr>
<td>• Contraindications to exercise</td>
<td>None</td>
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</table>
Data Element Name: Sex

Collected For: All Records

Definition: The patient's documented sex on arrival at the hospital.

Suggested Data Collection Question: What is the patient's sex?

Format:

<table>
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<tr>
<th>Length</th>
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<td>Character</td>
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</tbody>
</table>

Allowable Values:

- M = Male
- F = Female
- U = Unknown

Notes for Abstraction:

- Collect the documented patient's sex at admission or the first documentation after arrival.
- Consider the sex to be unable to be determined and select “Unknown” if:
  - The patient refuses to provide their sex.
  - Documentation is contradictory.
  - Documentation indicates the patient is a Transexual.
  - Documentation indicates the patient is a Hermaphrodite.

Suggested Data Sources:

- Consultation notes
- Emergency department record
- History and physical
- Face sheet
- Progress notes
- UB-04 Field Location: 11
- Nursing admission notes

Additional Notes:

Guidelines for Abstraction:

<table>
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<tr>
<td>• None</td>
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Data Element Name: Sleep-Wake Disturbance

Collected For: BCC-05

Definition: Documentation that the patient had sleep-wake disturbance of 4 or greater on the PROMIS scale, or moderate or greater sleep-wake disturbance determined via any validated tool or narrative note at any visit.

Suggested Data Collection Question: Did the patient have sleep-wake disturbance of 4 or greater on the PROMIS scale, or moderate or greater sleep-wake disturbance determined via any validated tool or narrative note at any visit?

Format: Length: 1
Type: Alphanumeric
Occurs: 1

Allowable Values:
1. There is documentation that the patient had sleep-wake disturbance score of 4 or greater on the PROMIS scale or moderate or greater sleep-wake disturbance via any other validated tool at any visit.
2. There is documentation that the patient had moderate or greater sleep-wake disturbance via narrative notes at any visit.
3. There is documentation that the patient had a sleep-wake disturbance of less than 4 on the PROMIS scale or mild / no sleep-wake disturbance via any validated tool or narrative note.
4. There is no documentation of sleep-wake disturbance assessment or unable to determine from the medical record documentation.

Notes for Abstraction:
- For sleep-wake disturbance assessments the following two items from the PROMIS scale Sleep Disturbance item bank v1.0 are recommended:
  - “I had problems during the day because of poor sleep”
  - “In the past 7 days, I had trouble sleeping…”
  - Response range:
    1. = Not at all
    2. = A little bit
    3. = Somewhat
    4. = Quite a bit
    5. = Very much
  - For the purposes of this measure answer "1" for patient responses of 4 = Quite a bit or 5 = Very much.
- Other methods of measurement are acceptable if the clinical level that initiates recommendation for intervention is consistent and documented (e.g. a tool or other narrative documentation that specifies recommendation for intervention at a moderate or severe level of sleep-wake disturbance or daytime impairment related to poor sleep).
- Though sleep-wake disturbances and fatigue may be noted in the same patient record, when utilizing clinician narrative to meet this measure requirement, it is necessary to locate statements indicating poor sleep as the main etiology of the fatigue.
- Clinician (Physician, PA, APN, RN) narrative documentation of statements referring to current status of patient such as: trouble falling or staying sleeping at night, trouble staying awake during daytime activities related to poor sleep, decreased daytime alertness, poor sleep quality, insomnia, choose allowable value "2".
- Informal tools are forms, worksheets and guided documentation tools developed by an individual organization to collect patient-related data. May be completed by the patient or provider, and becomes part of the medical record. Informal tools typically have not
undergone formal validity or reliability testing. If an informal tool is used select "2".

**Suggested Data Sources:**
- Nursing notes
- Progress notes
- Physician’s notes
- Chemotherapy flow sheets

**Additional Notes:**

**Guidelines for Abstraction:**

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</table>
**Data Element Name:** Unique Blinded Case Identifier

**Collected For:** All Records, All Records (Used in transmission of anonymous patient-level data to the Joint Commission)

**Definition:** An identifier that is assigned to each patient by the hospital that uniquely identifies the patient for the episode of care. It is a fictitious identifier used to differentiate between individual patient records.

**Suggested Data Collection Question:** What number has been assigned to identify the patient?

**Format:**
- **Length:** 9
- **Type:** Numeric
- **Occurs:** 1

**Allowable Values:** Any valid positive number up to nine digits

- This identifier should not be derived from or related to information about the patient in such a way that it is possible to identify the patient via a review or manipulation of the data.
- Since a unique identifier is used for each medical record that is abstracted for the Joint Commission pilot, hospitals need to link this tracking identifier to the original patient record. This link will be important in the event that data quality issues arise and it is requested that the episode of care data be reviewed or if the patient is chosen to be included in the data reliability study.

**Notes for Abstraction:**

**Suggested Data Sources:**

**Additional Notes:** Does not apply, determined by the hospital.

**Guidelines for Abstraction:**

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</table>
Glossary

BCC Specific Terms:

Cancer-Related Fatigue (CRF)  A “distressing persistent, subjective sense of physical, emotional and/or cognitive tiredness or exhaustion related to cancer or cancer treatment that is not proportional to recent activity and that interferes with usual functioning” (NCCN, 2010b).

Chemotherapy Course  The total planned regimen of chemotherapy cycles prescribed, typically in the adjuvant and neoadjuvant setting, such as dose-dense AC followed by T (total course = 8 cycles). Note that most metastatic regimens are provided for an unspecified number of cycles, pending periodic response assessment.

Chemotherapy Induced Nausea and Vomiting (CINV)  a common side effect of chemotherapy, in which the patient experiences the subjective sensation of nausea, or the objective sign of vomiting. CINV may be acute, delayed, anticipatory, breakthrough or refractory, and may occur in up to 70-80% of patients without adequate prevention (Morrow et al., 1998; NCCN, 2010a)

Distress  Distress in cancer is defined as a “multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with ability to cope effectively with cancer, its physical symptoms and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis” (NCCN, 2010c).

Episode of Care  For purposes of the Breast Cancer Care measure set:

- Patients newly diagnosed with Stage I through III breast cancer – from the date of the first pathology report indicating an invasive breast cancer through a) the completion of the prescribed intravenous chemotherapy or b) the first six months of the prescribed intravenous chemotherapy regimen, whichever comes first.
- Patients newly diagnosed with Stage IV breast cancer
  - For those treated for Stage I through III breast cancer in the past - from the date Stage IV disease is documented through the first six months of a prescribed intravenous chemotherapy regimen.
  - For those who present with Stage IV at initial staging – from the date of the first pathology report indicating invasive breast cancer through the first six months of the prescribed chemotherapy regimen.

Informal Tool  Forms, worksheets and guided documentation tools developed by an individual organization to collect patient-related data. May be completed by the patient or provider, and becomes part of the medical record. Informal tools typically have not undergone formal validity or reliability testing.
Narrative Note    Clinician documentation found in sentence form in note types such as the review of systems and progress notes.

Neutropenic Risk Cycles    A potentially myelosuppressive chemotherapy administration cycle is one that confers a 20% or greater risk of febrile neutropenia.

Sleep-Wake Disturbance    are perceived or actual alterations in night sleep with resultant daytime impairment, and are reported in 30-75% of people with cancer (Berger, et al.; 2005).

Validated Instrument or Tool    A tool that was developed to measure specific concepts or attributes, has been tested for validity and reliability, the results of which are published in the peer-reviewed literature. Examples include the NCCN Distress Thermometer, the Symptom Distress Scale, the Hospital Anxiety and Depression Scale (HADS), etc.

Measurement Terms:

accuracy (of data)    The extent to which data are free of identifiable errors.

administrative/billing data (data source)    Administrative data are patient-identifiable data used for administrative, regulatory, and payment (financial) purposes. Administrative data that generally reflect the content of discharge abstracts (for example, demographic information on patients such as age, sex, zip code; information about the episode of care such as admission source, length of stay, charges, discharge status; and ICD-9-CM diagnostic and procedure codes). Namely, the Uniform Hospital Discharge Data Set and the Uniform Bill of the Health Care Financing Administration (UB-04) provides specifications for the abstraction of administrative/billing data.

Agency for Healthcare Research and Quality (AHRQ)    The Agency for Healthcare Research and Quality (AHRQ) is the health services research arm of the U.S. Department of Health and Human Services (HHS), complementing the biomedical research mission of its sister agency, the National Institutes of Health. AHRQ is a home to research centers that specialize in major areas of health care research such as quality improvement and patient safety, outcomes and effectiveness of care, clinical practice and technology assessment, and health care organization and delivery systems.
aggregate (organization data) Aggregate data elements derived for a specific organization from the results of each measure’s algorithm over a given time period (e.g., monthly, quarterly).

aggregate risk-adjusted data elements Aggregate data elements derived from episode of care (EOC) records that result from the application of risk adjustment models.

algorithm An ordered sequence of data element retrieval and aggregation through which numerator and denominator events or continuous variable values are identified by a measure. The algorithms are depicted using flowcharting symbols.

allowable value A list of acceptable responses for a data element.

binary outcome Events or conditions that occur in one or two possible states often labeled 0 or 1. Such data are frequently encountered in medical research. Common examples include dead or alive, and improved or not improved.

caregiver The patient’s family or any other person who will be responsible for care of the patient after discharge.

central tendency A property of the distribution of a variable, usually measured by statistics such as the mean, median, and mode.

clinical measures Measures designed to evaluate the processes or outcomes of care associated with the delivery of clinical services; allow for intra- and interorganizational comparisons to be used to continuously improve patient health outcomes; may focus on the appropriateness of clinical decision making and implementation of these decisions; must be condition specific, procedure specific, or address important functions of patient care (e.g., medication use, infection control, patient assessment, etc.).

comparison group The group of health care organizations to which an individual health care organization is compared.

confounding factors Intervening variables that distort the true relationship between/among the variables of interest. They are related to the outcome of interest, but extraneous to the study question and are non-randomly distributed among the groups being compared. They can hide a true correlation or give the appearance of a correlation when none actually exists.

continuous variable An aggregate data measure in which the value of each measurement can fall anywhere along a continuous scale (e.g., the time [in minutes] from hospital arrival to administration of thrombolysis).

continuous variable data elements Those data elements required to construct the measure as stated in the section labeled “Continuous Variable Statement.”
**contraindication** A factor or condition that may render the administration of a drug or agent or the performance of a procedure or other practice inadvisable, improper, and/or undesirable.

**data collection** The act or process of capturing raw or primary data from a single or number of sources. Also called “data gathering.”

**data collection effort** The availability and accessibility of the required data elements, the relative effort required, and associated cost of abstracting or collecting the data.

**data element** A discrete piece of data, such as patient birthdate or principal diagnosis. See also *denominator data elements*, *numerator data elements*, *continuous variable data elements*, and *risk adjustment data elements*.

**data entry** The process by which data are transcribed or transferred into an electronic format.

**data quality** The accuracy and completeness of measure data on performance in the context of the analytic purposes for which they will be used.

**data transmission** The process by which data are electronically sent from one organization to another. For example, a hospital sending patient-level data to their selected ORYX® Vendor, and the vendor sending measure-level data to The Joint Commission or patient-level data to the QIO Clinical Warehouse.

**denominator** The lower part of a fraction used to calculate a rate, proportion, or ratio. Also the population for a rate based measure.

**denominator data elements** Those data elements required to construct the denominator.

**discrete variable** See *rate-based measure*.

**electronic data interchange (EDI)** An instance of data being sent electronically between parties, normally according to predefined industry standards.

**episode of care (EOC)** A patient or case-level record submitted to the database.

**excluded populations** Detailed information describing the populations that should not be included in the indicator. For example, specific age groups, ICD-9-CM procedure or diagnostic codes, or certain time periods could be excluded from the general population drawn upon by the indicator.

**extranet** A private network using the Internet protocol to securely share business information or operations with vendors, customers, and/or other businesses. “The Joint Commission Connect TM” is the name given to the Joint Commission’s extranet site.
**event** An occurrence a specific issue of interest. Events that occur during the patient's stay do not define new episodes of care.

**format** Specifies the character length of a specific data element; the type of information the data element contains: numeric, decimal, number, date, time, character, or alphanumeric; and the frequency with which the data element occurs.

**general data elements** Those data elements that have wide application and are collected for every patient that is included in any measure population.

**health care organization (HCO)** The business entity which is participating in measure collection (e.g., health care organization level data describes information about the business entity).

**health care organization (HCO) level data** Aggregation of patient level data to summarize the performance of an individual health care organization on a performance measure.

**hospital** According to the American Hospital Association, hospitals are licensed institutions with at least six beds whose primary function is to provide diagnostic and therapeutic patient services for medical conditions by an organized physician staff, and have continuous nursing services under the supervision of registered nurses.

**ICD-9-CM codes** A two-part classification system in current use for coding patient medical information used in abstracting systems and for classifying patients into diagnosis-related groups (DRGs). The first part is a comprehensive list of diseases with corresponding codes compatible with the World Health Organization’s list of disease codes. The second part contains procedure codes independent of the disease codes.

**initial patient populations** Detailed information describing the population(s) that the indicator intends to measure. Details could include such information as specific age groups, diagnoses, ICD-9-CM diagnostic and procedure codes, CPT codes, revenue codes, enrollment periods, insurance and health plan groups, etc.

**invalid data** Values for data elements that are required for calculating and/or risk adjusting a core measure that fall outside of the acceptable range of values defined for that data element. Refer to the Missing and Invalid Data section for further information.

**mean** A measure of central tendency for a continuous variable measure. The mean is the sum of the values divided by the number of observations.

**measure data elements** Data elements used by one specific measure or several measures in two or more measure sets, such as Clinical Trial.

**measure information form** Tool to provide specific clinical and technical information on a measure. The information contained includes: performance measure name,
description, rationale, numerator/denominator/continuous variable statements, included populations, excluded populations, data elements, risk adjustment, sampling, data accuracy, and selected references.

**measure of performance** See *performance measure*.

**measure-specific data elements** Data elements used by one specific measure or several measures in one specific measure set, such as Laparoscope in the SCIP measures.

**median** The value in a group of ranked observations that divides the data into two equal parts.

**medical record (data source)** Data obtained from the records or documentation maintained on a patient in any health care setting (for example, hospital, home care, long term care, practitioner office). Includes automated and paper medical record systems.

**military time** A 24-hour period from midnight to midnight using a 4-digit number of which the first two digits indicate the hour and the last two digits indicate the minute.

**missing data** No values present for one or more data elements that are required for calculating and/or risk adjusting a national quality measure. Refer to the Missing and Invalid Data section for further information.

**mode** The most frequently occurring response for that data element.

**module** A set of measures under a common group/topic area (e.g., infection module).

**national quality measure** A standardized performance measure that meets the Centers for Medicare & Medicaid Services and Joint Commission evaluation criteria, has precisely defined specifications, can be uniformly embedded in extant systems, has standardized data collection protocols to permit uniform implementation by health care organizations and permit comparisons of health care organization performance over time through the establishment of a national comparative data base.

**national quality measure set** A unique grouping of performance measures carefully selected to provide, when viewed together, a robust picture of the care provided in a given area (e.g., cardiovascular care, pregnancy).

**numerator** The upper portion of a fraction used to calculate a rate, proportion, or ratio.

**numerator data elements** Those data elements necessary or required to construct the numerator.
observed rate The observed rate is the measure rate that is based on a hospital’s aggregated data for the reporting period. This is calculated as the number of measure numerator cases for the reporting period divided by the number of denominator cases. Observed rates are used to measure hospital performances.

patient level data Collection of data elements that depict the health care services provided to an individual (patient). Patient level data are aggregated to generate hospital level data and comparison group data.

patient survey (data source) Survey data are exclusively obtained from patients and/or their family members/significant others.

percentile A value on a scale of 100 that indicates the percentage of a distribution that is equal to or below it.

performance measure A quantitative tool (for example, rate, ratio, index, percentage) that provides an indication of an organization’s performance in relation to a specified process or outcome. Refer to process measure and the outcome measure in Appendix D.

predicted value The statistically expected response or outcome for a patient after the risk adjustment model has been applied and the patient’s unique set of risk factors have been taken into account.

P.R.N. Abbreviation for pro re nata, Latin term for "as needed".

process An interrelated series of events, activities, actions, mechanisms, or steps that transform inputs into outputs.

process measure A measure which focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.

proportion measure A measure which shows the number of occurrences over the entire group within which the occurrence should take place (e.g., patients delivered by cesarean section over all deliveries).

protected (personal) health information (PHI) A subset of health information, including demographics, that identifies the individual or for which there is a reasonable basis to believe that it can be used to identify the individual.

randomization A technique for selecting or assigning cases such that each case has an equal probability of being selected or assigned. It is done to stimulate chance distribution, reduce the effects of confounding factors, and produce unbiased statistical data.
**range** A measure of the spread of a data set. The difference between the smallest and largest observation.

**rate** Derived by dividing the numerator (e.g., cases that meet the criterion for good or poor care) by the denominator (e.g., all cases to which the criterion applies) within a given time frame. In other words, the numerator is a subset of the denominator.

**rate based (measure)** An aggregate data measure in which the value of each measurement is expressed as a proportion or as a ratio. In a proportion, the numerator is expressed as a subset of the denominator (for example, patients with cesarean section, divided by all patient who deliver). In a ratio, the numerator and denominator measure different phenomena (for example, the number of patients with central lines who develop infections divided by the number of central line days).

**ratio** A relationship between two counted sets of data, which may have a value of zero or greater. In a ratio, the numerator is not necessarily a subset of the denominator (e.g., pints of blood transfused to number of patients discharged).

**reliability** The ability of the indicator to accurately and consistently identify the events it was designed to identify across multiple health care settings.

**reporting period** The defined time period which describes the patient’s end-of-service.

**risk adjusted measures** Measures that are risk adjusted using statistical modeling or stratification methods.

**risk adjusted rate** A rate that takes into account differences in case mix to allow for more valid comparisons between groups.

**risk adjustment** A statistical process for reducing, removing, or clarifying the influences of confounding factors that differ among comparison groups (for example, logistic regression, stratification).

**risk adjustment data elements** Those data elements used to risk adjust a performance measure (e.g., reduce, remove, or clarify the influences of confounding patient factors that differ among comparison groups). Such data elements may be used exclusively for risk adjustment (e.g., not required to construct the numerator or denominator) or may be required for numerator or denominator construction as well as risk adjustment.

**risk adjustment model** The statistical algorithm that specifies the numerical values and the sequence of calculations used to risk adjust (e.g., reduce or remove the influence of confounding factors) performance measures.
**risk factor** A factor that produces or influences a result. In statistics, an independent variable used to identify membership of qualitatively different groups. Refer to Appendix B for risk factor definitions.

**risk factor value** A specific value assigned to a risk factor for a given episode of care (EOC) record.

**risk model** The statistical algorithm that specifies the numerical values and the sequence of calculations used to risk adjust (e.g., reduce or remove the influence of confounding factors) performance measures.

**sampling frequency** If a hospital chooses to sample, they may sample data on either a monthly or quarterly basis. Refer to the “Sample Size Requirements” discussion in the Population and Sampling Specifications section for further information.

**sampling method** Describes the process used to select a sample. Possible approaches to sampling include simple random sampling, cluster sampling, systematic sampling and judgment sampling.

**sample size** The number of individuals or particular patients included in a study. Usually chosen so that the study has a particular statistical power of detecting an effect of a particular size. For measure set specific "Sample Size Requirements" refer to Measure Information section.

**score** A rating, usually expressed as a number, and based on the degree to which certain qualities or attributes are present (e.g., Glasgow coma, ASA scores).

**severity** The degree of biomedical risk, or mortality of medical treatment.

**simple random sample** A process in which a sample of data is selected from the total population in such a way that every case has the same chance of being selected and that the sample size is met. Refer to the “Sampling Approaches” discussion in the Population and Sampling Specifications section for further information.

**standard deviation** A measure of variability that indicates the dispersion, spread, or variation in a distribution.

**strata** See stratified measure.

**stratification** A form of risk adjustment which involves classifying data into subgroups based on one or more characteristics, variables, or other categories.

**stratification based approach for risk adjustment** The process of dividing or classifying subgroups known as strata in order to facilitate more valid comparisons. For example, a measure’s outcome may be divided into type of surgery-specific categories or strata.
**stratified measure** A performance measure that is classified into a number of subgroups to assist in analysis and interpretation. The overall or un-stratified measure evaluates all subgroups together. The stratified measure consists of a subset of the overall measure. For example, surgical patients who received a prophylactic antibiotic within one hour prior to surgical incision can be reported as all surgical patients who received the prophylactic antibiotic within one hour prior to surgical incision; however, the stratified measure(s) for SCIP-Inf-1 could be reported by specific allowable values for the data element Infection Procedure of Interest, such as 1 – CABG (SCIP-Inf-1b) or 2 – Other Cardiac Surgery (SCIP-Inf-1c).

**stratum** See stratified measure.

**sub-population** A population that is part of a larger population. For example, the measure set Perinatal Care evaluates the obstetrical population in the hospital. This measure set is broken into two distinct sub-populations, mothers (PC-01, PC-02 and PC-33) and newborns (PC-04 and PC-05).

**systematic random sampling** A process in which the starting case is selected randomly, and the next cases are selected according to a fixed interval that is based upon the number of cases in the population. For example, the starting case is the second patient that arrives at the hospital. This patient and every subsequent fifth patient becomes part of the random sample until the sample size is reached. Refer to the “Sampling Approaches” discussion in the Population and Sampling Specifications section for further information.

**transmission schedule** The schedule of dates on which data are expected to be transmitted to The Joint Commission and the QIO Clinical Warehouse.

**unable to be determined (UTD)** Each data element that is applicable per the algorithm for each of the measures within a topic must be “touched” by the abstractor. While there is an expectation that all data elements are collected, it is recognized that in certain situations information may not be available (i.e., dates, times, codes, etc.). If, after due diligence, the abstractor determines that a value is not documented or is not able to determine the answer value, the abstractor must select “Unable to Determine (UTD)” as the answer.

**validation** The process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data are collected. The Centers for Medicare & Medicaid Services (CMS) chart level validation will validate the data at several levels. There are consistency and internal edit checks to assure the integrity of the submitted data; there are external edit checks to verify expectations about the volume of the data received, and, there will be chart level audits to assure the reliability of the submitted data. Information on these procedures is available on www.qualitynet.org.
validity Ability to identify opportunities for improvement in the quality of care; demonstration that the indicator use results in improvements in outcomes and/or quality of care.

variance Equal to the square of the standard deviation.

verification The process used to ensure consistent implementation of core measure algorithms specified in this manual across disparate ORYX Vendors.

Selected Sources:


McHorney, CA, Kosinski, M, and Ware, Jr., JE, “Comparisons of the Cost and Quality of Norms for the SF 36 Health Survey Collected by Mail Versus Telephone Interview: Results From a National Survey,” Medical Care, 32, (1994), 551 567.


*2006 Accreditation Manual(s)*, Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations, 2005.
Using the Specifications Manual

This portion of *The Specifications Manual* provides a brief overview of the information contained within each section of the manual. It is intended for use as a quick reference to assist in the implementation of the quality measures. The sections of this manual are interrelated and are most useful when considered together.

**Data Dictionary**
The Data Dictionary describes the patient-level data elements required to capture and calculate individual measurements. It specifies those data elements that must be collected for each patient that falls into any of the selected Initial Patient Populations and those data elements needed for a specific measure.

**Population and Sampling Specifications**
Sampling is an available option for quality measures if certain requirements are met. This section provides general guidance on defining the Initial Patient Population and information on sample size requirements, and sampling approaches.

**Glossary of Terms**
Definitions as related to this project.

**Overview of Measure Information Form and Flowchart Formats for Collected Measures**

**Measure Information Form Introduction**

**Measure Set**
The specific national hospital quality inpatient measure set to which an individual measure belongs (e.g., acute myocardial infarction, pneumonia).

**Set Measure ID #**
A unique alpha-numeric identifier assigned to a measure. Information associated with a measure is identified by this unique alpha-numeric number.

**Performance Measure Name**
A brief title that uniquely identifies the measure.

**Description**
A brief explanation of the measure’s focus, such as the activity or the area on which the measure centers attention (e.g., surgical patients who received prophylactic antibiotics consistent with current guidelines).

**Rationale**
The reason for performing a specified process to improve the quality of care outcome. This may include specific literature references, evidence based information, expert consensus, etc.

**Type of Measure**
Indicates whether the measure is used to examine a process or an outcome over time.

- **Process**: A measure used to assess a goal directed, interrelated series of actions, events, mechanisms, or steps, such as a measure of performance that describes what is done to, for, or by patients, as in performance of a procedure.
- **Outcome**: A measure that indicates the result of performance (or non-performance) of a function(s) or process(es).

**Improvement Noted As**
Describes how improvement would be indicated by the measure.

- An increase in the rate/score/number of occurrences (e.g., immunizations).
- A decrease in the rate/score/number of occurrences (e.g., surgical site infections).
- Either an increase or a decrease in the rate/score/number of occurrences, depending upon the context of the measure (e.g., utilization).

**Numerator Statement**
Represents the portion of the denominator that satisfies the conditions of the performance measure.
Note: If the measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statement are completed. If a performance measure does not have both a numerator and a denominator, then a Continuous Variable Statement is completed.

- **Included Population in Numerator**: Specific information describing the population(s) comprising the numerator, not contained in the numerator statement, or not applicable.
- **Excluded Population in Numerator**: Specific information describing the population(s) that should not be included in the numerator, or none.
- **Data Elements**: Those data elements necessary or required to determine (or establish) the numerator.

**Denominator Statement**
Represents the population evaluated by the performance measure.
Note: If measure is reported as a rate (proportion or ratio), the Numerator and Denominator Statement are completed. If a performance measure does not have both a numerator and a denominator, then a Continuous Variable Statement is completed.

- **Included Population in Denominator**: Specific information describing the population(s) comprising the denominator, not contained in the denominator statement or not applicable.
- **Excluded Population in Denominator**: Specific information describing the population(s) that should not be included in the denominator, or none.
**Data Elements:** Those data elements required to determine (or establish) the denominator.

**Continuous Variable Statement**
Describes an aggregate data measure in which the value of each measurement can fall anywhere along a continuous scale.

Note: If measure is reported as a central tendency, Continuous Variable Statement is completed. This item is only completed when the performance measure does not have numerator and denominator statements.

**Included Population in Continuous Variable:** Specific information describing the population(s) comprising the performance measure, not contained in the continuous variable statement or not applicable.

**Excluded Population in Continuous Variable:** Specific information describing the population(s) that should not be included in the performance measure or none.

**Data Elements:** Those data elements required to determine (or establish) the measure for a continuous variable.

**Risk Adjustment**
Indicates whether a measure is subject to the statistical process for reducing, removing, or clarifying the influences of confounding factors to allow more useful comparisons.

**Data Collection Approach**
Recommended timing for when data should be collected for a measure. Data collection approaches include retrospective, concurrent, prospective or Medicare Claims data collection.

- **Retrospective** data collection involves collecting data for events that have already occurred.
- **Concurrent** data collection is the process of gathering data on how a process works or is working while a patient is in active treatment.
- **Prospective** data collection is data collection in anticipation of an event or occurrence.
- **Medicare Claims** data collection is use of data that is administratively derived from CMS claims and does not require any abstraction.

**Model Validation**
Model validation is the process of verifying that all documents in a model are valid with respect to the model’s definition documents.

**Data Accuracy**
Recommendations to reduce identifiable data errors, to the extent possible.
Measure Analysis Suggestions
Recommendations to assist in the process of interpreting data and drawing valid conclusions.

Sampling
Indicates whether or not a measure can be sampled. Sampling is a process of selecting a representative part of the population in order to estimate the hospital’s performance, without collecting data for its entire population.

Data Reported As
Indicates how data will be reported for a measure.
- Aggregate rate generated from count data reported as a proportion (e.g., rate-based measures which report summary data generated from the number of AMI patients who received aspirin within 24 hours before or after hospital arrival over all AMI patients).
- Aggregate rate generated from count data reported as a ratio (e.g., bloodstream infection per 1,000 line days).
- Aggregate measures of central tendency (e.g., continuous variables which report means and medians such as median time to fibrinolysis).
- Claims data reported as condition-specific, hospital-specific, or risk-standardized (e.g., 30-day readmission rates).

Selected References
Specific literature references that are used to support the importance of the performance measure.