Attachment 4: EHR data collection tool and instructions

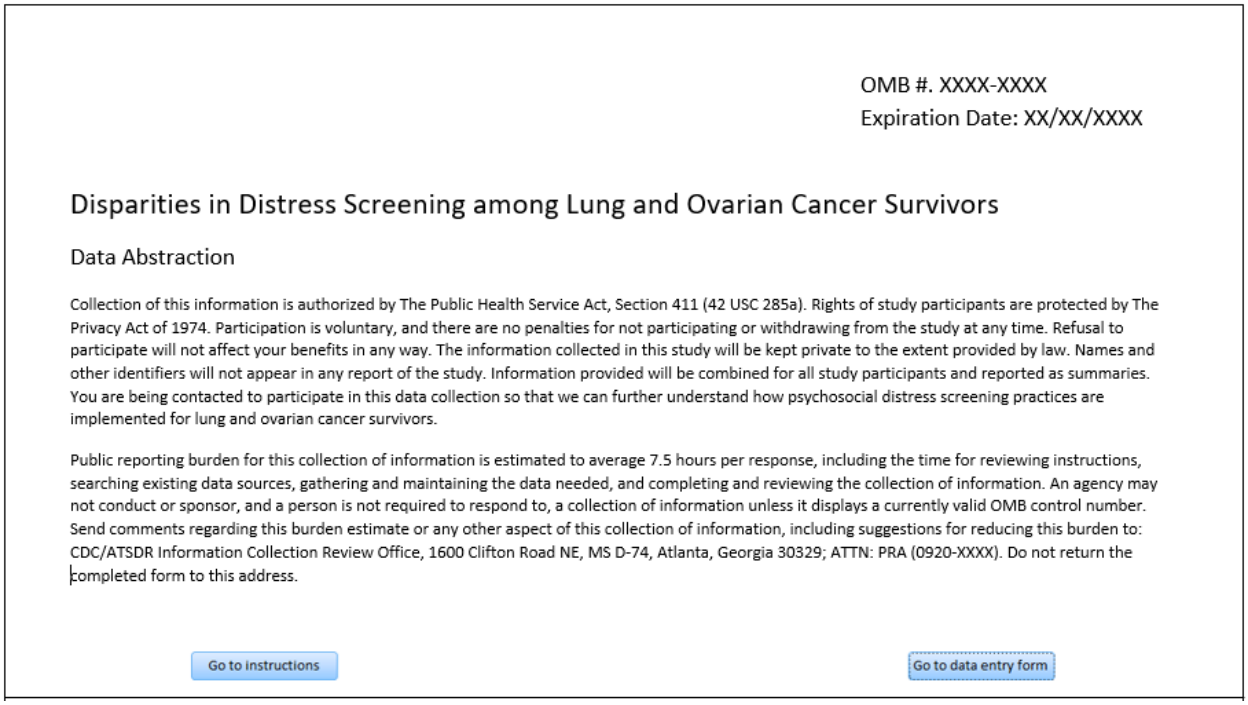
EHR Abstraction Tool for Distress Screening and Outcome Data

Elements

Notes:

- The MS Access tool is designed to accommodate a one to many (1:m) relationship between the patient's first screen and the assessments and interventions, respectively, where one patient case may be linked to one distress screening but multiple assessments and multiple interventions based on the single distress screening.
- The data can be queried and exported at any of the three levels (patient, screening, intervention). For instance, intervention-level data may be reshaped so that each row represents one patient in the exported database.

Screenshot of MS Access introductory screen with burden statement:



OMB #. XXXX-XXXX
Expiration Date: XX/XX/XXXX

Disparities in Distress Screening among Lung and Ovarian Cancer Survivors

Data Abstraction

Collection of this information is authorized by The Public Health Service Act, Section 411 (42 USC 285a). Rights of study participants are protected by The Privacy Act of 1974. Participation is voluntary, and there are no penalties for not participating or withdrawing from the study at any time. Refusal to participate will not affect your benefits in any way. The information collected in this study will be kept private to the extent provided by law. Names and other identifiers will not appear in any report of the study. Information provided will be combined for all study participants and reported as summaries. You are being contacted to participate in this data collection so that we can further understand how psychosocial distress screening practices are implemented for lung and ovarian cancer survivors.

Public reporting burden for this collection of information is estimated to average 7.5 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-XXXX). Do not return the completed form to this address.

Go to instructions

Go to data entry form

Screenshot of MS Access introductory screen with burden statement:

OMB #. XXXX-XXXX
Expiration Date: XX/XX/XXXX

Disparities in Distress Screening among Lung and Ovarian Cancer Survivors

Instructions

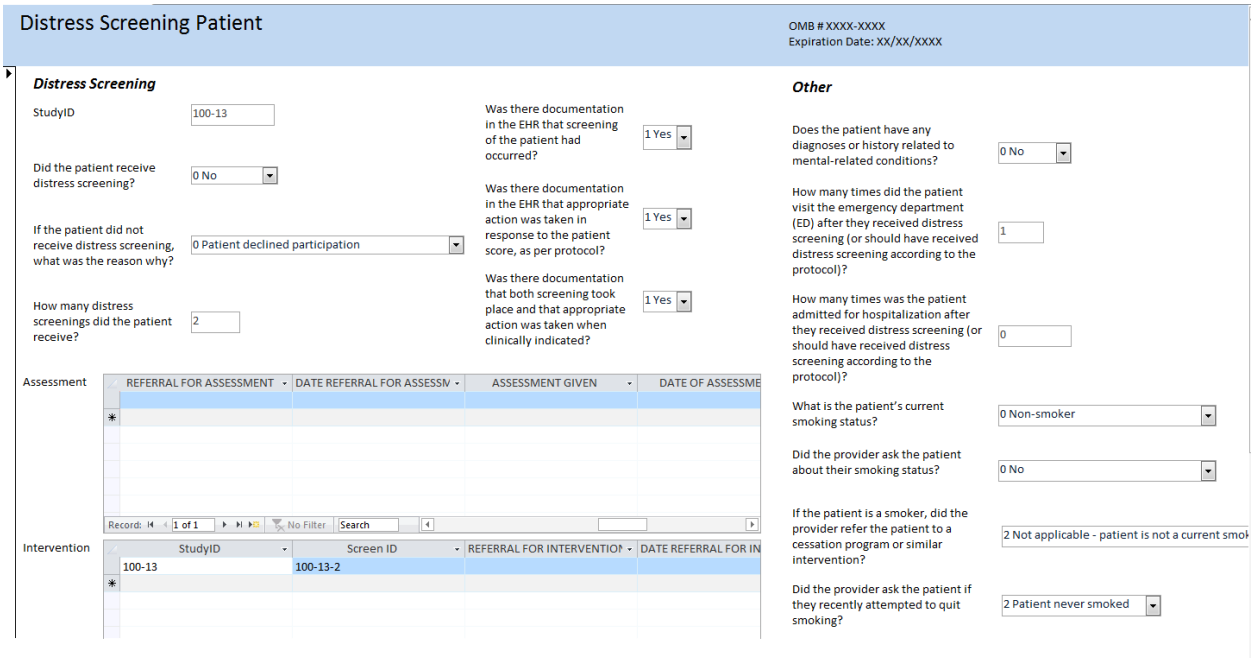
The Centers for Disease Control and Prevention (CDC) has contracted with Westat, an independent research firm located in Rockville, Maryland, to collect data for the "Disparities in Distress Screening among Lung and Ovarian Cancer Survivors" study. The purpose of the data collection is to further understand how psychosocial distress screening practices are implemented for lung and ovarian cancer survivors.

Data will be collected using an abstraction tool built by Westat with the intent of capturing information to be abstracted from data found in a facility's electronic health record (EHR) system. The abstractor will review the relevant patients' EHRs and will code the appropriate information related to the patient, their cancer, whether they received distress screening, and associated information related to distress screening received. Please refer to the accompanying document "EHR Abstraction Data Entry Guide" for more information about how each data element should be coded into the abstraction tool.

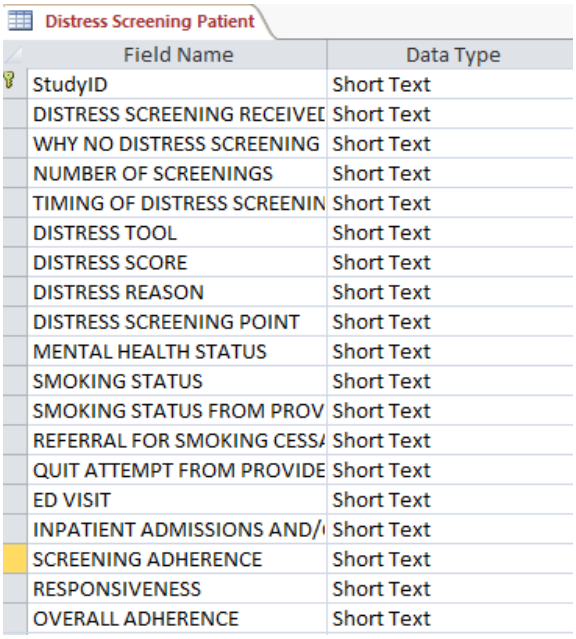
If you have any questions or comments, please contact Diane Ng at Westat at 301-279-4518 or DianeNg@westat.com.

Go to data entry form

Screenshot of MS Access data entry for distress screening:



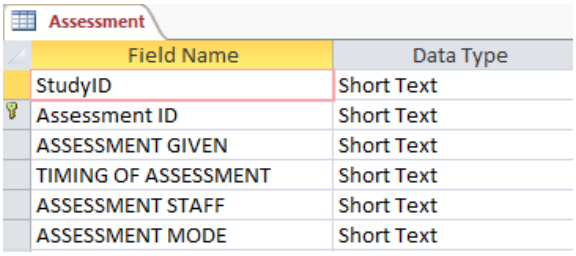
Screenshot of Patient-level table:



Distress Screening Patient

Field Name	Data Type
StudyID	Short Text
DISTRESS SCREENING RECEIVED	Short Text
WHY NO DISTRESS SCREENING	Short Text
NUMBER OF SCREENINGS	Short Text
TIMING OF DISTRESS SCREENIN	Short Text
DISTRESS TOOL	Short Text
DISTRESS SCORE	Short Text
DISTRESS REASON	Short Text
DISTRESS SCREENING POINT	Short Text
MENTAL HEALTH STATUS	Short Text
SMOKING STATUS	Short Text
SMOKING STATUS FROM PROV	Short Text
REFERRAL FOR SMOKING CESS/	Short Text
QUIT ATTEMPT FROM PROVIDE	Short Text
ED VISIT	Short Text
INPATIENT ADMISSIONS AND/(	Short Text
SCREENING ADHERENCE	Short Text
RESPONSIVENESS	Short Text
OVERALL ADHERENCE	Short Text

Screenshot of Assessment-level table:



Assessment

Field Name	Data Type
StudyID	Short Text
Assessment ID	Short Text
ASSESSMENT GIVEN	Short Text
TIMING OF ASSESSMENT	Short Text
ASSESSMENT STAFF	Short Text
ASSESSMENT MODE	Short Text

Screenshot of Intervention-level table:

Intervention

Field Name	Data Type
StudyID	Short Text
Assessment ID	Short Text
REFERRAL FOR INTERVENTION/SERVICES	Short Text
TIMING OF REFERRAL FOR INTERVENTION/SERVICES	Short Text
REFERRAL FOR INTERVENTION/SERVICES STAFF	Short Text
REFERRAL FOR INTERVENTION/SERVICES TYPE	Short Text
INTERVENTION/SERVICES GIVEN	Short Text
TIMING OF INTERVENTION/SERVICES	Short Text
INTERVENTION/SERVICES STAFF	Short Text
INTERVENTION/SERVICES TYPE	Short Text
REPEAT VISITS FOR INTERVENTION/SERVICES	Short Text

Instructions for healthcare facility IT department to extract data from EHR

The Centers for Disease Control and Prevention (CDC) is sponsoring a study to examine the distress screening procedures among ovarian and lung cancer patients at cancer treatment facilities and programs across the country. Westat, a research organization located in Maryland, is working with the CDC on data collection for the study.

For this study, we are requesting an extraction of specific data items from your healthcare facility's EHR system. We understand that your healthcare facility may have discrete fields that use specific code systems or standardized formats for data items in your EHR system, while you may collect other data in less standardized ways. Therefore, we are requesting an extract of demographic and cancer-related data items that EHR systems are likely to capture in a more standardized manner. For other data items that EHR systems are not as likely to capture in specific data fields but may capture in other ways such as in a notes section or as a scanned document, we will work with your healthcare facility to choose an ideal method for abstracting this data from the EHR. The following document will focus on the extraction of more standardized data items.

Follow the instruction below to identify the cases that you should select for the study, to create a report with the extract of data items of interest, and to submit the report to Westat.

I. Selection Criteria

1. Select cancer cases that meet the following criteria:
   - Ovarian cancer cases with ICD-9-CM diagnosis code 183.0 or ICD-10-CM diagnosis code C56.-
   - Lung cancer cases with ICD-9-CM diagnosis codes 162.2, 162.3, 162.4, 162.5, 162.8, 162.9 or ICD-10-CM diagnosis codes C34.0-, C34.1-, C34.2, C34.3-, C34.8-, C34.9-
2. Of the cancer cases selected above, only select those cases where the date of the first encounter related to the cancer diagnosis (using the associated diagnosis codes above) occurred in 2016 or 2017
3. Provide the number of cases to study staff. If the number of cases is large, they will work with you to randomly select a subset of cases.

II. Data items to extract for report

We are requesting an extract of specific data items in a standardized format, as defined in the table below. However, if your EHR uses a different code set for a data item and you are unable to translate your data to fit the code set we specified, please let study staff know.

Create a report that includes the following data elements and code them or format them as defined below. You only need to include the code and not the label associated with the code (for example, for the data item “Sex”, please code “1” and not “1 Male”. Please create the report in a delimited or fixed-width format such as .csv, .xls, or .xlsx.

Data Element	Description	Choice List (if applicable) or Format	Calculation (if applicable)	Source and other notes
RACE	The patient's race	0 White 1 Black or African American 2 Asian 3 Native Hawaiian or Other Pacific Islander 4 American Indian or Alaska Native 5 Other Race		Race & Ethnicity – CDC (https://phinvads.cdc.gov/vads/ViewValueSet.action?id=67D34BBC-617F-DD11-B38D-00188B398520)

Data Element	Description	Choice List (if applicable) or Format	Calculation (if applicable)	Source and other notes
SPANISH/ HISPANIC ORIGIN	Whether the patient is of Spanish/Hispanic origin	0 Not Hispanic or Latino 1 Hispanic or Latino		Race & Ethnicity – CDC (https://phinvads.cdc.gov/vads/ViewValueSet.action?id=35D34BBC-617F-DD11-B38D-00188B398520)
SEX	The sex of the patient	1 Male 2 Female 3 Female-to-Male (FTM)/ Transgender Male 4 Male-to-Female (MTF)/ Transgender Female 5 Genderqueer, neither exclusively male nor female 6 Other		SNOMED CT (https://www.healthit.gov/isa/representing-patient-gender-identity)
AGE AT DIAGNOSIS	The age of the patient at the time of the diagnosis for the specific tumor of interest	Number format	Use the patient's birthdate and subtract it from the patient's date of diagnosis to determine the patient's age at diagnosis	
CURRENT AGE	The age of the patient at the time that the data was extracted/abstracted from the facility	Number format	Use the patient's birthdate and subtract it from the current date to determine the patient's age at diagnosis	
POSTAL/ZIP CODE	The postal/ zip code of the patient at the time of diagnosis	Five-digit postal/zip code		

Data Element	Description	Choice List (if applicable) or Format	Calculation (if applicable)	Source and other notes
PAYMENT SOURCE	The source of payment used during time of diagnosis/treatment at the healthcare facility	1 Medicare 2 Medicaid 3 Other Government (Federal/State/Local) 4 Departments of Corrections 5 Private Health Insurance 6 Blue Cross/Blue Shield 7 Managed Care, Unspecified 8 No payment from an organization/agency/program/private payer listed 9 Miscellaneous/other		Source of Payment Typology (PHDSC) (http://www.phdsc.org/standards/payer-typology-source.asp)
DATE OF DIAGNOSIS	The date that the tumor was diagnosed, whether through clinical means (such as physical exam or imaging), biopsy or other microscopic methods	YYYYMMDD		
DATE OF FIRST CANCER ENCOUNTER	The date of the patient's first encounter at the facility where cancer is the primary diagnosis/reason for the encounter	YYYYMMDD		Use the date of the patient's earliest encounter where the primary diagnosis/reason for the encounter was coded using the ICD-9-CM or ICD-10-CM code associated with ovarian or lung cancer

Data Element	Description	Choice List (if applicable) or Format	Calculation (if applicable)	Source and other notes
PRIMARY SITE	The primary site (organ or location) that the cancer originated from	**Ovary** ICD-9-CM: 183.0 ICD-10-CM: C56.- **Lung** ICD-9-CM: 162.2, 162.3, 162.4, 162.5, 162.8, 162.9 ICD-10-CM: C34.0-, C34.1-, C34.2, C34.3-, C34.8-, C34.9-		ICD-9-CM (applicable for claims on or before September 30, 2015), ICD-10-CM (applicable for claims on or after October 1, 2017) NOTE: ICD-9 and ICD-10 codes only provide topography, not histology/morphology
CANCER STAGE CLINICAL	The stage of the cancer according to the AJCC TNM staging schema; staging schemas differ by primary site and are assigned by the physician; Clinical stage is typically assigned based on the evidence available before treatment	**Ovary** I Stage 1 Not Otherwise Specified (NOS) (localized) IA Stage 1A (localized) IB Stage 1B (localized) IC Stage 1C (localized) II Stage 2 NOS (localized) IIA Stage 2A (localized) IIB Stage 2B (localized) IIC Stage 2C (localized) III Stage 3 NOS(localized) IIIA Stage 3A (localized) IIIB Stage 3B (localized) IIIC Stage 3C (localized) IV Stage 4 (metastasis) **Lung** 0 Stage 0 (in situ) IA Stage 1A (localized) IB Stage 1B (localized) IIA Stage 2A (localized) IIB Stage 2B (localized) IIIA Stage 3A (localized) IIIB Stage 3B (localized) IV Stage 4 (metastasis)		AJCC TNM Staging; NOTE: Small cell lung cancer is sometime staged as either limited or extensive. Beginning with AJCC TNM 7th edition, small cell and non-small cell lung cancer were able to be staged using the same schema.

Data Element	Description	Choice List (if applicable) or Format	Calculation (if applicable)	Source and other notes
CANCER STAGE PATHOLOGIC	The stage of the cancer according to the AJCC TNM staging schema; staging schemas differ by primary site and are assigned by the physician; pathologic stage is assigned using the evidence available before treatment, in addition to additional evidence during and after surgery	**Ovary** I Stage 1 Not Otherwise Specified (NOS) (localized) IA Stage 1A (localized) IB Stage 1B (localized) IC Stage 1C (localized) II Stage 2 NOS (localized) IIA Stage 2A (localized) IIB Stage 2B (localized) IIC Stage 2C (localized) III Stage 3 NOS(localized) IIIA Stage 3A (localized) IIIB Stage 3B (localized) IIIC Stage 3C (localized) IV Stage 4 (metastasis) **Lung** 0 Stage 0 (in situ) IA Stage 1A (localized) IB Stage 1B (localized) IIA Stage 2A (localized) IIB Stage 2B (localized) IIIA Stage 3A (localized) IIIB Stage 3B (localized) IV Stage 4 (metastasis)		AJCC TNM Staging NOTE: Small cell lung cancer is sometime staged as either limited or extensive. Beginning with AJCC TNM 7th edition, small cell and non-small cell lung cancer were able to be staged using the same schema.

III. Submitting data through Secure File Transfer Protocol (SFTP)

Please follow the steps outlined below to submit your data extract report through Westat's SFTP.

1. Name the file:
    - We will provide you with a two-digit healthcare facility code that you will use to name your file
    - Use the naming convention [Two digit healthcare facility code]_Distress_EHR
        - Example: 11_Distress_EHR
2. Submit the file:
    - Upload the file to Westat's Secure File Transfer Protocol website: https://securetransfer2.westat.com/
        - We will provide you with the username and password associated with the account that you will use to upload, as

well as the name of the folder that you will upload the file to

- After logging in to the site (and resetting your password, if you have not done so already), click on “Folders” on the panel to the left side of the screen
- Navigate to the folder that was created for your specific healthcare facility (/Distribution/[HEALTHCARE FACILITY SPECIFIC FOLDER])
- Click “Launch the Upload Wizard” and use the tool to choose the file for the report that you would like to upload and follow the prompts to upload the file

EHR Abstraction Data Entry Guide for Distress Screening and

Outcome Data Elements

Abstract data elements using available documentation in the patient's EHR.

Question [Data element]	Response Options	What We're Looking For
GENERAL		
Study ID	Two character/digit hospital code followed by three digit patient code (Ex: 01-001)	Unique ID assigned by Westat to the patient solely for use in this study
Date Case Entered	Enter a date using the format MM/DD/YYYY	Date case was abstracted into the abstraction tool
Abstractor	Initials of abstractor	Enter your initials for cases that you abstract into the abstraction tool
DEMOGRAPHICS AND CANCER		
[Race]	0 White 1 Black or African American 2 Asian 3 Native Hawaiian or Other Pacific Islander 4 American Indian or Alaska Native 5 Other Race	Code patient race; this may be standardly coded at the hospital level or may be available in a patient's personal history
[Spanish/Hispanic Origin]	0 Not Hispanic or Latino 1 Hispanic or Latino	Code patient Spanish/Hispanic origin; this may be standardly coded at the hospital level or may be available in a patient's personal history
[Sex]	1 Male 2 Female 3 Female-to-Male (FTM)/Transgender Male 4 Male-to-Female (MTF)/Transgender Female 5 Genderqueer, neither exclusively male nor female 6 Other	Code patient sex; this may be standardly coded at the hospital level or may be available in other documentation in EHR

Question [Data element]	**Response Options**	**What We're Looking For**
[Age at diagnosis]	Enter a number	Use the patient's diagnosis date and birth date as documented in EHR and calculate the patient's age based on the difference between the two dates (date of diagnosis – birth date)
[Current age]	Enter a number	Use the current date (when extracting or abstracting EHR data) and the patient's birth date as documented in EHR and calculate the patient's current age based on the difference between the two dates. (current date – birth date)
[Postal/zip code]	Enter the five-digit postal/zip code	Enter the patient's five-digit postal/zip code
[Payment source]	1 Medicare 2 Medicaid 3 Other Government (Federal/ State/Local) 4 Departments of Corrections 5 Private Health Insurance 6 Blue Cross/Blue Shield 7 Managed Care, Unspecified 8 No payment from an organization/agency/program/private payer listed 9 Miscellaneous/other	Record the primary payment source for the patient's care, if available
[Date of diagnosis]	Enter a date using the format MM/DD/YYYY	Record the date of diagnosis for the relevant cancer; this is based on the date the tumor was diagnosed, whether through clinical means (such as a physical exam or imaging), biopsy, or other microscopic methods
[Date of first cancer encounter]	Enter a date using the format MM/DD/YYYY	Record the date of the patient's first encounter at the facility where cancer is the primary diagnosis/reason for the encounter, based on the ICD-9-CM or ICD-10-CM code

Question [Data element]	**Response Options**	**What We're Looking For**
[Primary site]	1 Ovary 2 Lung	Code whether the patient is an ovarian cancer case or a lung cancer case
[Cancer stage clinical]	**Ovary** I Stage 1 Not Otherwise Specified (NOS) (localized) IA Stage 1A (localized) IB Stage 1B (localized) IC Stage 1C (localized) II Stage 2 NOS (localized) IIA Stage 2A (localized) IIB Stage 2B (localized) IIC Stage 2C (localized) III Stage 3 NOS(localized) IIIA Stage 3A (localized) IIIB Stage 3B (localized) IIIC Stage 3C (localized) IV Stage 4 (metastasis) **Lung** 0 Stage 0 (in situ) IA Stage 1A (localized) IB Stage 1B (localized) IIA Stage 2A (localized) IIB Stage 2B (localized) IIIA Stage 3A (localized) IIIB Stage 3B (localized) IV Stage 4 (metastasis)	Record patient's clinical cancer stage based on the AJCC TNM* staging schema; this may be documented in a staging form that the physician has completed, in a pathology report, etc.; note: cancer is staged clinically before the patient receives treatment *American Joint Committee on Cancer – T (tumor) N (node) M (metastasis)

Question [Data element]	Response Options	What We're Looking For
[Cancer stage pathologic]	**Ovary** I Stage 1 Not Otherwise Specified (NOS) (localized) IA Stage 1A (localized) IB Stage 1B (localized) IC Stage 1C (localized) II Stage 2 NOS (localized) IIA Stage 2A (localized) IIB Stage 2B (localized) IIC Stage 2C (localized) III Stage 3 NOS(localized) IIIA Stage 3A (localized) IIIB Stage 3B (localized) IIIC Stage 3C (localized) IV Stage 4 (metastasis) **Lung** 0 Stage 0 (in situ) IA Stage 1A (localized) IB Stage 1B (localized) IIA Stage 2A (localized) IIB Stage 2B (localized) IIIA Stage 3A (localized) IIIB Stage 3B (localized) IV Stage 4 (metastasis)	Record patient's pathologic cancer stage based on the AJCC TNM* staging schema; this may be documented in a staging form that the physician has completed, in a pathology report, etc.; note: cancer is staged pathologically after the patient receives treatment (specifically, surgery) *American Joint Committee on Cancer – T (tumor) N (node) M (metastasis)
DISTRESS SCREENING		
Did the patient receive distress screening? [Distress screening received]	0 No 1 Yes	Record whether the patient received distress screening. Some sources in EHR may include: • A note in EHR indicating that screening occurred • EHR field(s) with inputted screening data • Electronic scan of screening instrument appearing in EHR • Documentation in provider note

Question [Data element]	**Response Options**	**What We're Looking For**
If the patient did not receive distress screening, what was the reason why? [Why no distress screening received]	0 Patient declined participation 1 Patient did not have the opportunity to receive screening (e.g., did not return to the hospital, patient expired, other reasons) 2 Other 3 Unknown	Record why a patient did not receive distress screening
How many distress screenings did the patient receive? [Number of screenings]	Enter a number	Count and record the number of times the patient received distinct distress screenings
How many days elapsed between the date of the patient's first cancer encounter and the date of their first distress screening at the facility? [Timing of Distress Screening]	Enter a number	Calculate the difference in days between the date of first distress screening and date of the first cancer encounter; it is possible to enter a value of 0, if they occurred on the same day
What distress tool was used for distress screening? [Distress Tool]	0 Distress Thermometer 1 Hospital Anxiety and Depression Scale (HADS) 2 Brief Symptom Inventory-18 (BSI-18) 3 Other	Record the specific distress tool that was used for distress screening
What score did the patient receive from the distress screening? [Distress Score]	Enter the number; if there is no score indicated, enter "999"	Record what score the patient received from the distress screening
What are some of reasons or problems that the patient identified as being sources of their distress? [Distress Reason]	0 Practical problems 1 Family problems 2 Emotional problems 3 Spiritual/religious concerns 4 Physical symptoms 5 Substance abuse 6 Other	Record what problems the patient identified as being sources of their distress, based on the distress thermometer problem list or similar documents/resources; reference the NCCN distress thermometer problem list for how to categorize specific problems

Question [Data element]	Response Options	What We're Looking For
Was the distress screening that the patient received associated with a "pivotal point" in the patient's cancer care? [Distress screening point]	0 Time of diagnosis 1 First visit with a medical oncologist to discuss treatment 2 Routine visit with a radiation oncologist 3 Post-chemotherapy follow-up visit 4 Post-surgical visit 5 Transitions during treatment 6 Transitions off treatment 7 Referral to palliative care 8 Other	Indicate if the patient was given distress screening as part of a "pivotal point" in their cancer care; review the date distress screening was given and compare it to dates that the patient received cancer care, such as the date of diagnosis and dates of treatment
Where did the patient receive distress screening? [Distress Screening Location]	0 Radiation department 1 Chemotherapy infusion center 2 In-patient Medical Oncology 3 In-patient Surgical Oncology 4 Out-patient Medical Oncology 5 Out-patient Surgical Oncology 6 Other	Indicate where in the hospital the patient received distress screening
ASSESSMENT*		
*It is possible to record information about multiple assessments that the patient receives, based on their first distress screening		
Did the patient actually receive an assessment, following distress screening? [Assessment received]	0 No, reason unknown 1 No, patient refused 2 No, patient did not need/was not referred for assessment 3 Yes	Indicate whether the patient actually received an assessment following distress screening
How many days elapsed between the date of the patient's first cancer encounter and the date of the assessment that they received based on the results of distress screening at the facility? [Timing of assessment [1-5]]	Enter a number	Calculate the difference in days between the date of the assessment that the patient received based on the results of distress screening and date of the first cancer encounter; it is possible to enter a value of 0, if they occurred on the same day

Question [Data element]	Response Options	What We're Looking For
What is the role of the staff person who administered the assessment following distress screening? [Assessment staff]	1 Oncology Social Worker 2 Nurse or Nurse Navigator 3 Physician 4 Behavioral Health (e.g., mental health professional, including Psychiatrist) 5 Spiritual Care Provider/Chaplain 6 Patient Navigator (e.g., lay or volunteer only) 7 Case Manager/Care Coordinator 8 Nutrition/Dietary (e.g., RD, LD) 9 Outpatient Rehab (e.g., PT,OT,SLP,AuD) 10 Other	Indicate what staff person administered the assessment to the patient following distress screening
What mode of contact was used for the assessment between the assessor (social worker or otherwise) and the patient? [Assessment mode]	1 Face to Face 2 Telephone 3 Email 4 Text 5 Patient Portal 6 Letter 7 Other	Indicate how the patient received the assessment following distress screening
INTERVENTION/SERVICES*		
*It is possible to record information about multiple interventions/services that the patient is referred to and receives, based on their first distress screening		
Number of Interventions/Services		
Did the patient receive a referral for intervention/services following distress screening and assessment? [Referral for intervention/services]	1 No – no needs were identified 2 No – patient declined further services 3 No – patient referred for psychosocial assessment only 4 Yes	Indicate whether the patient received a referral for intervention/services following assessment

Question [Data element]	**Response Options**	**What We're Looking For**
How many days elapsed between the date of the patient's first cancer encounter and the date they received a referral based on the results of distress screening at the facility? [Timing of referral for intervention/ services]	Enter a number	Calculate the difference in days between the date the patient received a referral for intervention/services based on the results of distress screening and date of the first cancer encounter; it is possible to enter a value of 0, if they occurred on the same day
If the patient received a referral for intervention/services, who were they referred to for intervention/services? [Referral for intervention/services staff]	1 Oncology Social Worker 2 Nurse or Nurse Navigator 3 Physician 4 Behavioral Health (e.g., mental health professional, including Psychiatrist) 5 Spiritual Care Provider/Chaplain 6 Patient Navigator (e.g., lay or volunteer only) 7 Case Manager/Care Coordinator 8 Nutrition/Dietary (e.g., RD, LD) 9 Outpatient Rehab (e.g., PT,OT,SLP,AuD) 10 Other	Indicate what staff person the patient was referred to for intervention/services
Did the patient actually receive the intervention/services that they were referred for? [Intervention/services given]	0 No 1 Yes	Indicate whether the patient actually received the intervention/services that they received a referral for

Question [Data element]	Response Options	What We're Looking For
How many days elapsed between the date of the patient's first cancer encounter and the date the patient received an intervention/service based on the results of distress screening at the facility? [Timing of intervention/services]	Enter a number	Calculate the difference in days between the date the patient received an intervention/service based on the results of distress screening and date of the first cancer encounter; it is possible to enter a value of 0, if they occurred on the same day

Question [Data element]	Response Options	What We're Looking For
If the patient actually received an intervention/services, what type of intervention/services did they receive? [Intervention/service type]	1 Financial resources (e.g., financial services, SSI, disability/SSDI, employment, household expenses) 2 Facilitate treatment (e.g., transportation, housing, insurance, medication/pharmacy access, FMLA, care coordination) 3 Other in-house/professional services (e.g., dietician or nutrition; psychology or psychiatry; genetic or fertility; navigator; chaplain) 4 External/community services (e.g., support group, hospice/palliative, home health, counseling, complementary, physical appearance, rehab) 5 Counseling related to support/emotional support (e.g., validated, normalized, empathic listening) 6 Counseling related to decision-making support (e.g., treatment, end of life planning, advance directives) 7 Specific counseling intervention (e.g., individual psychotherapy, family/couples, support group, sexual/reproductive health, EOL bereavement) 8 Evaluation for symptoms/disorders related to mental health 9 Other service given by provider that patient was referred to	Indicate what types of intervention/services the patient received as a result of the distress screening and assessment, as documented in EHR

Question [Data element]	Response Options	What We're Looking For
If the patient actually received an intervention/services, did they receive ongoing/repeat visits for intervention/services? [Repeat visits for intervention/services]	0 No 1 Yes	Indicate whether the patient received ongoing/repeat visits for intervention services; ongoing/repeat visits are defined as any visits that occur following the first visit for the intervention/services the patient was referred to
OTHER		
Does the patient have any diagnoses or history related to mental health-related conditions? [Mental health status]	0 No 1 Yes	Indicate whether patient has any diagnoses or a history of conditions such as depression, suicidal ideation, anxiety, and post-traumatic stress
What is the patient's current smoking status? [Smoking status]	0 Non-smoker 1 Ever smoker 2 Current smoker 3 Recent quitter 4 Former smoker	Record patient's smoking status, as indicated in a designated smoking status field or in their physical exam or history notes
Did the provider ask the patient about their smoking status? [Smoking status from provider]	0 No 1 Yes 2 Unknown/Not applicable	Indicate whether the provider asked the patient specifically about their smoking status during their cancer care
If the patient is a smoker, did the provider refer the patient to a cessation program or similar intervention? [Referral for smoking cessation]	0 No 1 Yes 2 Not applicable – patient is not a current smoker 3 Unknown	Indicate whether the provider referred the patient to a cessation program or similar program, or provided any information about quitting smoking to the patient
Did the provider ask the patient if they recently attempted to quit smoking? [Quit attempt from provider]	0 No 1 Yes 2 Patient never smoked 3 Unknown	Indicate whether the provider asked the patient if they made a recent attempt to quit smoking

Question [Data element]	Response Options	What We're Looking For
How many times did the patient visit the emergency department (ED) within a six-month window after they received distress screening (or should have received distress screening according to the protocol)? [ED VISIT]	Enter a number	Review the information provided about the patient's ED visits and count the number of ED visits the patient had within 6 months after they received their first distress screening or should have received distress screening according to protocol; for example, if the protocol indicates patients should receive distress screening at diagnosis, use that date as the start date; count all ED visits, including those outside the institution
How many times was the patient admitted for hospitalization within a six-month window after they received distress screening (or should have received distress screening according to the protocol)? [INPATIENT ADMISSIONS AND/OR DISCHARGES]	Enter a number	Review the information provided about the patient's admissions to the hospital and count the number of admissions the patient had within 6 months after they received their first distress screening or should have received distress screening according to protocol; for example, if the protocol indicates patients should receive distress screening at diagnosis, use that date as the start date; count all inpatient admissions, including those outside the institution