

APPENDIX B: CROSSWALK TABLE OF ORIGINAL AND FINAL INDICATORS

Chapter 1 - Breast Cancer Screening

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Screening</i>			
1. Women aged 52 to 69 should have had a screening mammography performed in the past 2 years.	1.	Women aged 50 to 70 should have had a screening mammography performed in the past at least every 2 years.	MODIFIED: Age was modified to reflect the earliest required mammography, rather than age at time of record review. Panelists also wanted to emphasize “every” 2 years. ACCEPTED AS MODIFIED
	-- (2)	Women aged 50-70 should have a clinical breast exam of both breasts at least every two years.	PROPOSED BUT DROPPED BY Q2 PANEL due to low validity score. The evidence linking exams to improved outcomes is poor.

Chapter 2 - Breast Cancer Diagnosis And Treatment

Original Indicator Proposed by Staff	Indicator Voted on by Panel	Comments/Disposition
<i>Diagnosis</i>		
1. If a palpable breast mass has been detected, at least one of the following procedures should be completed within 3 months: <ul style="list-style-type: none"> • Fine needle aspiration; • Mammography; • Ultrasound; • Biopsy; • Follow-up visit. 	1. If a palpable breast mass has been detected, at least one of the following procedures should be completed within 3 months: <ul style="list-style-type: none"> • Fine needle aspiration; • Mammography; • Ultrasound; • Biopsy; • Follow-up visit. 	INCLUDED BASED ON Q1 PANEL RATING
2. If a breast mass has been detected on two separate occasions, then either a biopsy, FNA or ultrasound should be performed within 3 months of the second visit.	2. If a breast mass has been detected on two separate occasions, then either a biopsy, FNA or ultrasound should be performed within 3 months of the second visit.	INCLUDED BASED ON Q1 PANEL RATING
3. A biopsy or FNA should be performed within 6 weeks of either of the following circumstances: <ol style="list-style-type: none"> a. mammography suggests malignancy; b. persistent palpable mass is not cystic on ultrasound. 	3. A biopsy or FNA should be performed within 6 weeks of either of the following circumstances: <ol style="list-style-type: none"> a. mammography suggests malignancy; b. persistent palpable mass is not cystic on ultrasound. 	INCLUDED BASED ON Q1 PANEL RATING
4. A biopsy should be performed within 6 weeks if FNA cannot rule out malignancy.	4. A biopsy should be performed within 6 weeks if FNA cannot rule out malignancy.	INCLUDED BASED ON Q1 PANEL RATING
<i>Treatment</i>		
5. Women with stage I or stage II breast cancer should be offered a choice of modified radical mastectomy or breast-conserving surgery, unless contraindications to breast-conserving surgery are present.	5. Women with stage I or stage II breast cancer should be offered a choice of modified radical mastectomy or breast-conserving surgery, unless contraindications to breast-conserving surgery are present.	ACCEPTED
6. Women treated with breast conserving surgery should begin radiation therapy within 6 weeks of completing either of the following (unless wound complications prevent the initiation of treatment): <ul style="list-style-type: none"> • last surgical procedure on the breast (including reconstructive surgery); or • chemotherapy, if patient receives adjuvant chemotherapy. 	6. Women treated with breast conserving surgery should begin radiation therapy within 6 weeks of completing either of the following (unless wound complications prevent the initiation of treatment): <ul style="list-style-type: none"> • last surgical procedure on the breast (including reconstructive surgery that occurs within 6 weeks of primary resection) • chemotherapy, if patient receives adjuvant chemotherapy 	MODIFIED: Panelists felt that radiation therapy should not be delayed until after reconstructive surgery if the surgery occurred more than 6 weeks after the primary resection. ACCEPTED AS MODIFIED

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Treatment</i>			
7. Women with node-positive breast cancer should be treated with adjuvant systemic therapy to include one of the following: <ul style="list-style-type: none"> • Combination chemotherapy (more than one agent, lasting for at least 2 months); • Tamoxifen (20mg/d for at least 2 years). 	7.	Women with node-positive invasive breast cancer that is node-positive, or node-negative and primary tumor >= 1 cm , should be treated with adjuvant systemic therapy to include at least one of the following: <ul style="list-style-type: none"> • Combination chemotherapy (more than one agent, lasting for at least 2 months); • Tamoxifen (20mg/d for at least 2 years). 	MODIFIED: Panelists wanted to exclude carcinoma-in-situ, and felt that node-negative breast cancers >= 1 cm should also receive chemotherapy. ACCEPTED AS MODIFIED
	8. (11)	Women with metastatic breast cancer should be offered one of the following treatments within 6 weeks of the identification of metastases: <ul style="list-style-type: none"> • Hormonal therapy; • Chemotherapy; • Enrollment in a clinical trial with documentation of informed consent. 	PROPOSED AND ACCEPTED BY Q2 PANEL. Panelists felt that it is important to have an indicator on metastatic breast cancer treatment.
<i>Follow-up</i>			
8. Women with a history of breast cancer should have a yearly mammography.	9.	Women with a history of breast cancer should have a yearly mammography.	ACCEPTED
9. Women diagnosed with breast cancer in the past 5 years should have a clinical breast exam in the past 6 months.	10.	Women diagnosed with breast cancer in the past 5 years should have a clinical breast exam at least once a year in the past 6 months.	MODIFIED: Panelists felt that a yearly clinical breast exam is sufficient. ACCEPTED AS MODIFIED
10. Women diagnosed with breast cancer more than 5 years ago should have a clinical breast exam in the past year.	11.	Women diagnosed with breast cancer more than 5 years ago should have a clinical breast exam at least once a year .	MODIFIED: Panelists wanted to clarify that this is a minimum annual requirement. ACCEPTED AS MODIFIED

Chapter 3 - Cervical Cancer Screening

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Screening</i>			
1. The medical record should contain the date and result of the last Pap smear.	1.	The medical record should contain the date and result of the last Pap smear.	INCLUDED BASED ON Q1 PANEL RATING
2. Women who have not had a Pap smear within the last 3 years should have one performed (unless never sexually active with men or have had a hysterectomy for benign indications).	2.	Women who have not had a Pap smear within the last 3 years should have one performed (unless never sexually active with men or have had a hysterectomy for benign indications).	INCLUDED BASED ON Q1 PANEL RATING
3. Women who have not had 3 consecutive normal smears and who have not had a Pap smear within the last year should have one performed.	3.	Women who have not had 3 consecutive normal smears and who have not had a Pap smear within the last year should have one performed.	INCLUDED BASED ON Q1 PANEL RATING
4. Women with a history of cervical dysplasia or carcinoma-in-situ who have not had a Pap smear within the last year should have one performed.	4.	Women with a history of cervical dysplasia, or carcinoma-in-situ or HIV infection who have not had a Pap smear within the last year should have one performed.	MODIFIED: Panelists wanted to include HIV positive women who are at high risk for cervical dysplasia. ACCEPTED AS MODIFIED
5. Women with a severely abnormal Pap smear should have colposcopy performed within 3 months of the Pap smear date.	5.	Women with a severely abnormal Pap smear should have colposcopy performed within 3 months of the Pap smear date.	INCLUDED BASED ON Q1 PANEL RATING
6. If a woman has a Pap smear that shows a low grade lesion (ASCUS or LGSIL), then one of the following should occur within 6 months of the initial Pap: 1) repeat Pap smear; or 2) colposcopy.	6.	If a woman has a Pap smear that shows a low grade lesion (ASCUS or LGSIL), then one of the following should occur within 6 months of the initial Pap: 1) repeat Pap smear; or 2) colposcopy.	INCLUDED BASED ON Q1 PANEL RATING
7. Women with a Pap smear that shows ASCUS or LGSIL, and who have had the abnormality documented on at least 2 Pap smears in a 2 year period should have colposcopy performed.	7.	Women with a Pap smear that shows ASCUS or LGSIL, and who have had the abnormality documented on at least 2 Pap smears in a 2 year period should have colposcopy performed.	INCLUDED BASED ON Q1 PANEL RATING

Chapter 4 - Colorectal Cancer Screening

Original Indicator Proposed by Staff	Indicator Voted on by Panel	Comments/Disposition
<i>Screening</i>		
<p>1. Patients documented in the chart as having one or more first degree relatives with CRC should be offered at least one of the following colon cancer screening tests beginning at age 40:</p> <ul style="list-style-type: none"> • FOBT; • Sigmoidoscopy; • Colonoscopy; • DCBE. 	<p>1. Patients documented in the chart as having one or more first degree relatives with CRC should be offered at least one of the following colon cancer screening tests beginning at age 40:</p> <ul style="list-style-type: none"> • FOBT (if not done in the past 2 years); • Sigmoidoscopy (if not done in the past 5 years); • Colonoscopy (if not done in the past 10 years); • Double contrast barium enema (if not done in the past 5 years). 	<p>MODIFIED: Test frequencies vary and are now specified.</p> <p>ACCEPTED AS MODIFIED</p>
<p>2. The chart should document discussion of the risk of CRC and risks and benefits of surveillance/screening for all patients with elevated risk of CRC due to any of the following indications:</p> <ul style="list-style-type: none"> a. inflammatory bowel disease of at least 10 years duration; b. familial adenomatous polyposis syndromes; c. hereditary nonpolyposis colon cancer (HNPCC). 	<p>-- The chart should document discussion of the risk of CRC and risks and benefits of surveillance/screening for all patients with elevated risk of CRC due to any of the following indications:</p> <ul style="list-style-type: none"> a. inflammatory bowel disease of at least 10 years duration; b. familial adenomatous polyposis syndromes; c. hereditary nonpolyposis colon cancer (HNPCC). 	<p>DROPPED PRIOR TO PANEL due to feasibility concerns.</p>
<p>3. Providers should offer to remove all polyps with either of the following characteristics within 6 weeks of detection:</p> <ul style="list-style-type: none"> a. size greater than 1 cm; b. adenomatous histology. 	<p>2. Providers should offer to remove all polyps with either of the following characteristics within 6 weeks 3 months of detection:</p> <ul style="list-style-type: none"> a. size greater than 1 cm; b. adenomatous histology. 	<p>MODIFIED: Panelists thought 3 months was more consistent with standard of care, especially if the referral is made from primary care.</p> <p>ACCEPTED AS MODIFIED</p>
<p>4. All polyps found on screening sigmoidoscopy should be biopsied at that time.</p>	<p>-- All polyps found on screening sigmoidoscopy should be biopsied at that time.</p>	<p>DROPPED PRIOR TO PANEL. Panelists felt that referral for biopsy was adequate.</p>
<p>5. Surveillance colonoscopy should not be repeated sooner than 3 years following the removal of adenomatous polyps in otherwise average risk patients.</p>	<p>3. Surveillance colonoscopy should not be repeated sooner than 3 years following the removal of adenomatous polyps in otherwise average risk patients.</p>	<p>ACCEPTED</p>

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Screening</i>			
6. Procedure note documentation for endoscopic management of polyps should include: a. whether biopsy only versus complete removal of polyps was performed; b. location of any polyps removed endoscopically; c. polyp type: sessile versus pedunculated.	4.	4. Procedure note documentation for endoscopic management of polyps should include: a. whether biopsy only versus complete removal of polyps was performed; b. location of any polyps removed endoscopically; c. polyp type: sessile versus pedunculated.	ACCEPTED
7. All patients with positive screening sigmoidoscopy tests should be offered a diagnostic colonoscopy.	5.	5. All patients with positive screening sigmoidoscopy tests should be offered a diagnostic colonoscopy within 3 months	MODIFIED: The time frame was specified. ACCEPTED AS MODIFIED
8. If a screening FOBT is positive, a diagnostic evaluation of the colon should be offered within a 6 month period.	6.	6. If a screening FOBT is positive, a diagnostic evaluation of the colon should be offered within a 6 3 month period.	MODIFIED: Panelists felt that 6 months was too long. ACCEPTED AS MODIFIED
9. A FOBT should be offered to those who refuse other screening tests for CRC.	--	A FOBT should be offered to those who refuse other screening tests for CRC.	DROPPED due to low validity score. Panelists felt that the indicator was redundant with other indicators.
10. All adults age 52 to 80 should be offered at least one of the following colon cancer screening tests: • FOBT (if not done in the past 2 years); • Sigmoidoscopy (if not done in the past 5 years); • Colonoscopy (if not done in the past 10 years); • Double contrast barium enema (if not done in the past 5 years).	7.	All average risk adults age 52 to 80 50 to 80 should be offered at least one of the following colon cancer screening tests: • FOBT (if not done in the past 2 years); • Sigmoidoscopy (if not done in the past 5 years); • Colonoscopy (if not done in the past 10 years); • Double contrast barium enema (if not done in the past 5 years).	MODIFIED: Panelists wanted indicator to apply only to "average risk" patients. The age range was changed to reflect intervention age rather than age at the time of record review. ACCEPTED AS MODIFIED
11. Colonoscopy screening should not be done more frequently than every 5 years provided the previous colonoscopy was negative and procedure note specifies adequate exam.	8.	Colonoscopy screening should not be done in average risk patients more frequently than every 5 years provided the previous colonoscopy was negative and procedure note specifies adequate exam.	MODIFIED: Panelists wanted to clarify that indicator does not apply to high-risk patients, and emphasized that this indicator measures inappropriate use. ACCEPTED AS MODIFIED

Chapter 5 - Colorectal Cancer Treatment

Original Indicator Proposed by Staff	Indicator Voted on by Panel	Comments/Disposition
<i>Staging</i>		
1. Patients who have undergone surgical resection for colon or rectal cancer should have documentation in the chart that colonoscopy or barium enema with sigmoidoscopy was offered within the preceding 12 months.	1. Patients who have undergone surgical resection for colon or rectal cancer should have documentation in the chart that colonoscopy or barium enema with sigmoidoscopy was offered within the preceding 12 months.	ACCEPTED
<i>Treatment</i>		
2. Patients diagnosed with a malignant polyp should be offered a wide surgical resection within 6 weeks if any of the following are true: a. the colonoscopy report states that the polyp was not completely excised; b. the margins are positive; c. lymphatic or venous invasion is present; d. histology is grade 3 or poorly differentiated.	2. Patients diagnosed with a malignant polyp should be offered a wide surgical resection within 6 weeks if any of the following are true: a. the colonoscopy report states that the polyp was not completely excised; b. the margins are positive; c. lymphatic or venous invasion is present; d. histology is grade 3 or poorly differentiated.	ACCEPTED
3. Patients with a malignant polyp treated with polypectomy alone should be offered colonoscopy within 6 months of the polypectomy.	3. Patients with a malignant polyp treated with polypectomy alone should be offered colonoscopy within 6 months of the polypectomy.	ACCEPTED
4. Patients who are diagnosed with colon cancer and do not have metastatic disease should be offered a wide resection with anastomosis within 6 weeks of diagnosis.	4. Patients who are diagnosed with colon cancer and do not have metastatic disease should be offered a wide resection with anastomosis within 6 weeks of diagnosis.	ACCEPTED
5. Patients who undergo a wide surgical resection should have “negative margins” noted on the most recent final pathology report or have documentation that they were offered a repeat resection if they meet either of the following criteria: a. Stage I colon cancer; b. Stage II or III colon cancer that is not invading into other organs (not a T4 lesion).	5. Patients who undergo a wide surgical resection should have “negative margins” noted on the most recent final pathology report or have documentation that they were offered a repeat resection if they meet either of the following criteria: a. Stage I colon cancer; b. Stage II or III colon cancer that is not invading into other organs (not a T4 lesion).	ACCEPTED

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<p>6. Patients with Stage III colon cancer who have undergone a surgical resection should be offered adjuvant chemotherapy within 6 weeks of surgery and not before 21 days after surgery with a published 5-FU-containing regimen.</p>	<p>6. Patients with Stage III colon cancer who have undergone a surgical resection should be offered adjuvant chemotherapy to start within 6 weeks of surgery and not before 21 days after surgery with a published 5-FU-containing regimen (or be enrolled in a clinical trial with documentation of informed consent).</p>	<p>MODIFIED: Panelists added an explicit clinical trial option and also felt that the minimum of 21 days after surgery was unnecessary.</p> <p>ACCEPTED AS MODIFIED</p>	
<p>7. Patients who are diagnosed with rectal cancer that appears clinically to be Stage I, should be offered one of the following surgical resections within 6 weeks of diagnosis:</p> <ul style="list-style-type: none"> • low anterior resection; • abdominal perineal resection; • full-thickness local excision. 	<p>7. Patients who are diagnosed preoperatively with Stage I rectal cancer that appears clinically to be Stage I, should be offered one of the following surgical resections within 6 weeks of diagnosis (or be enrolled in a clinical trial with documentation of informed consent):</p> <ul style="list-style-type: none"> • low anterior resection; • abdominal perineal resection; • full-thickness local excision. 	<p>MODIFIED: Panelists added an explicit clinical trial option and clarified other wording.</p> <p>ACCEPTED AS MODIFIED</p>	
<p>8. Patients who are diagnosed with rectal cancer that appears clinically to be Stage II or III, should be offered one of the following surgical resections within 6 weeks of diagnosis:</p> <ul style="list-style-type: none"> • low anterior resection; • abdominal perineal resection. 	<p>8. Patients who are diagnosed with rectal cancer that appears clinically to be Stage II or III, should be offered one of the following surgical resections within 6 weeks of diagnosis or completion of preoperative therapy (or be enrolled in a clinical trial with documentation of informed consent):</p> <ul style="list-style-type: none"> • low anterior resection; • abdominal perineal resection. 	<p>MODIFIED: Panelists added an explicit clinical trial option and also wanted to allow time for preoperative therapy.</p> <p>ACCEPTED AS MODIFIED</p>	
<p>9. Patients who undergo a wide surgical resection should have “negative margins” noted on the most recent final pathology report or have documentation that they were offered a repeat resection if they meet either of the following criteria:</p> <ol style="list-style-type: none"> a. Stage I rectal cancer; b. Stage II or III rectal cancer that is not invading into other organs (not a T4 lesion). 	<p>9. Patients who undergo a wide surgical resection should have “negative margins” noted on the most recent final pathology report or have documentation that they were offered a repeat resection if they meet either of the following criteria:</p> <ol style="list-style-type: none"> a. Stage I rectal cancer; b. Stage II or III rectal cancer that is not invading into other organs (not a T4 lesion). 	<p>ACCEPTED</p>	

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<p>10. Patients with Stage II and III rectal cancer (defined pathologically) who undergo surgical resection should be offered one of the following treatments (<i>this indicator only applies to patients who have had a surgical resection</i>):</p> <ul style="list-style-type: none"> • postoperative radiation therapy of 45-55 Gy to the pelvis with chemotherapy containing 5-FU to begin not sooner than 4 weeks after surgery and not more than 12 weeks after surgery; • preoperative radiation therapy to the pelvis to begin not more than 6 weeks after diagnosis; • preoperative radiation therapy with chemotherapy containing 5-FU to begin not more than 6 weeks after diagnosis. 	10.	<p>10. Patients with Stage II and III rectal cancer (defined pathologically) who undergo surgical resection should be offered one of the following treatments (or be enrolled in a clinical trial with documentation of informed consent) (this indicator only applies to patients who have had a surgical resection):</p> <ul style="list-style-type: none"> • postoperative radiation therapy of 45-55 Gy to the pelvis with chemotherapy containing 5-FU to begin not sooner than 4 weeks after surgery and not more than 12 weeks after surgery; • preoperative radiation therapy to the pelvis to begin not more than 6 weeks after diagnosis and discussion of postoperative therapy; • preoperative radiation therapy with chemotherapy containing 5-FU to begin not more than 6 weeks after diagnosis and discussion of postoperative therapy. 	<p>MODIFIED: Panelists added an explicit clinical trial option and thought that post-operative chemotherapy should always be discussed.</p> <p>ACCEPTED AS MODIFIED</p>
<p>11. Patients receiving 5-FU chemotherapy should have a CBC checked not more than 48 hours prior to the first dose in each cycle.</p>	--	<p>Patients receiving 5-FU chemotherapy should have a CBC checked not more than 48 hours prior to the first dose in each cycle.</p>	DROPPED due to low validity score.
<p>12. Patients should not receive 5-FU chemotherapy if any of the following are documented in the two days prior to initiation of therapy:</p> <ol style="list-style-type: none"> a. WBC < 2,000 or ANC < 1,500; b. stomatitis that prevents them from eating; c. severe diarrhea (seven or more stools a day). 	--	<p>Patients should not receive 5-FU chemotherapy if any of the following are documented in the two days prior to initiation of therapy:</p> <ol style="list-style-type: none"> a. WBC < 2,000 or ANC < 1,500; b. stomatitis that prevents them from eating; c. severe diarrhea (seven or more stools a day). 	DROPPED due to low validity score.
<p>13. Patients with Stages I, II, and III colorectal cancer should receive a visit with a physician for a history and physical where colorectal cancer is addressed in the assessment and plan at least every 6 months for 3 years after initial treatment.</p>	--	<p>Patients with Stages I, II, and III colorectal cancer should receive a visit with a physician for a history and physical where colorectal cancer is addressed in the assessment and plan at least every 6 months for 3 years after initial initiation of treatment.</p>	DROPPED due to low validity score.

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
	11. (16)	Patients with Stage IV metastatic colon cancer should have chemotherapeutic options discussed within three weeks of staging (or be enrolled in a clinical trial with documentation of informed consent) .	PROPOSED AND ACCEPTED BY Q2 PANEL. Explicit clinical trial option added.
<i>Follow-up</i>			
14. Patients with Stages I, II, and III colorectal cancer should receive colonoscopy or double contrast barium enema within a year of curative surgery if it did not occur within 12 months preoperatively.	12.	Patients with Stages I, II, and III colorectal cancer should receive colonoscopy or double contrast barium enema within a year of curative surgery if it did not occur within 12 months preoperatively.	ACCEPTED
15. Patients with Stages I, II, and III colorectal cancer should receive colonoscopy or double contrast barium enema three years after surgery and every five years thereafter.	13.	Patients with Stages I, II, and III colorectal cancer should receive colonoscopy or double contrast barium enema three years within one year after surgery and, if normal, at least every five years thereafter.	MODIFIED: Panelists shortened time frame and clarified that follow-up time frame is for normal results. ACCEPTED AS MODIFIED

Chapter 6 - HIV Disease

Original Indicator Proposed by Staff	Indicator Voted on by Panel	Comments/Disposition
<i>Screening and Prevention</i>		
<p>1. HIV+ patients should be offered PCP prophylaxis within one month of meeting any of the following conditions:</p> <ul style="list-style-type: none"> a. CD4 count dropping below 200; b. thrush; c. completion of active treatment of PCP. 	<p>1. HIV+ patients should be offered PCP prophylaxis within one month of meeting any of the following conditions:</p> <ul style="list-style-type: none"> a. a. CD4 count dropping below 200; -- b. thrush; b. c. completion of active treatment of PCP; c. d. CD4 below 15%. 	<p>“a, c” ACCEPTED “b” DROPPED due to low validity score. Thrush was only considered to be associated with, and not a predictor of, PCP. Panelists noted that the more recent recommendations for prophylaxis do not include thrush. “d” PROPOSED AND ACCEPTED BY Q2 PANEL. CD4 percentage is also used in practice.</p>
<p>2. HIV+ patients who do not have active TB and who have not previously received TB prophylaxis should be offered TB prophylaxis within one month of meeting any of following conditions:</p> <ul style="list-style-type: none"> a. current PPD > 5 mm; b. provider noting that patient has had PPD > 5 mm administered at anytime since HIV diagnosis; c. contact with person with active TB. 	<p>2. HIV+ patients who do not have active TB and who have not ever previously received TB prophylaxis should be offered TB prophylaxis within one month of meeting any of the following conditions:</p> <ul style="list-style-type: none"> a. a. current PPD > 5 mm; b. b. provider noting that patient has had PPD > 5 mm administered at anytime since HIV diagnosis; -- c. contact with person with active TB. 	<p>MODIFIED: Clarified wording.</p> <p>“a, b” ACCEPTED AS MODIFIED “c” DROPPED due to disagreement in validity. Panelists felt that contact information may not be readily available except from the health department.</p>
<p>3. HIV+ patients who do not have active toxoplasmosis should be offered toxoplasmosis prophylaxis within one month of meeting all of the following conditions:</p> <ul style="list-style-type: none"> • Toxo IgG positive; • CD4 count dropping below 100 • Completion of therapy for active toxoplasmosis. 	<p>3. HIV+ patients who do not have active toxoplasmosis should be offered toxoplasmosis prophylaxis within one month of meeting either of the following conditions:</p> <ul style="list-style-type: none"> • Toxo IgG positive and CD4 count dropping below 100; • CD4 count dropping below 100 • Completion of therapy for active toxoplasmosis. 	<p>MODIFIED: Typographical error corrected.</p> <p>ACCEPTED AS MODIFIED</p>
<p>4. Toxoplasmosis serology should be offered within one month of initial diagnosis of HIV.</p>	<p>4. HIV+ patients should have toxoplasmosis serology documented should be offered within one month of initial diagnosis of HIV.</p>	<p>MODIFIED: Panelists simplified the indicator to broaden the eligible population to all people with HIV and improve the feasibility in finding information on toxoplasmosis.</p> <p>ACCEPTED AS MODIFIED</p>
<p>5. HIV+ patients should be offered MAC prophylaxis within one month of a CD4 count dropping below 50.</p>	<p>5. HIV+ patients should be offered MAC prophylaxis within one month of a CD4 count dropping below 50.</p>	<p>ACCEPTED</p>

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Screening and Prevention</i>			
6. HIV+ patients should have a documented pneumovax.	6.	HIV+ patients with a lowest recorded CD4 count > 200 should have a documented pneumovax.	MODIFIED: Panelists felt that pneumovax should not be offered to those with a CD4 count below 200 because of impaired vaccine response. ACCEPTED AS MODIFIED
7. HIV+ patients with a lowest recorded CD4 count of less than 100 should have had a fundoscopic exam in the past year.	7.	HIV+ patients with a lowest recorded CD4 count of less than 100 should have had a yearly dilated fundoscopic exam in the past year.	MODIFIED: Panelists added "dilated" to ensure an adequate exam. ACCEPTED AS MODIFIED
8. VDRL or RPR should be offered within one month of initial diagnosis of HIV infection unless done in past year.	8.	HIV+ patients should have a VDRL or RPR documented in the chart. should be offered within one month of initial diagnosis of HIV infection unless done in past year.	MODIFIED: Panelists simplified the indicator to broaden the eligible population to all people with HIV and improve the feasibility of finding information on VDRL or RPR. ACCEPTED AS MODIFIED
9. Sexually active HIV+ patients should be offered a VDRL/RPR annually.	--	Sexually active HIV+ patients should be offered a VDRL/RPR annually.	DROPPED due to low validity score. Panelists felt this indicator was redundant with the modified indicator 8. They also questioned whether there would be information on sexual activity in the charts.
<i>Diagnosis</i>			
10. The following tests should be obtained within one month of initial diagnosis of HIV infection: a. CBC; b. HIV RNA (viral load); c. CD4.	9.	The following tests should be obtained within one month of initial diagnosis of HIV infection: a. CBC; b. HIV RNA (viral load); c. CD4.	ACCEPTED
11. HIV+ patients with CD4 counts > 500 should be offered the following tests within 6 months: a. CD4; b. viral loads.	10.	HIV+ patients with CD4 counts > 500 300 should be offered the following tests every 6 months: a. CD4 count or percentage; b. viral loads HIV RNA (viral load).	MODIFIED: Panelists lowered the CD4 threshold because patients with more impaired immune function need closer follow-up. They also clarified test terminology. ACCEPTED AS MODIFIED

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
12. HIV+ patients with CD4 counts < 500 should be offered the following tests within 3 months: a. CD4; b. viral loads.	11. -- a.	HIV+ patients with CD4 counts < 500 detectable viral loads should be offered the following tests within 4-3 months: a. CD4 count or percentage ; b. viral loads HIV RNA (viral load) .	MODIFIED: Panelists felt that 3 months was too short and clarified test terminology. Panelists indicated that patients with any detectable viral load should be monitored. “a” DROPPED due to low validity score. ACCEPTED AS MODIFIED
13. HIV+ patients on antiretroviral therapy should have been offered the following tests within the past 3 months: a. CD4; b. viral load; c. CBC.	12. a. b. c.	HIV+ patients on antiretroviral therapy should have been offered the following tests within the past 3 4 months: a. CD4 count or percentage ; b. HIV RNA (viral load) ; c. CBC.	MODIFIED: Panelists compromised on a 4-month time period and clarified test terminology. ACCEPTED AS MODIFIED
<i>Treatment</i>			
14. HIV+ patients should receive adequate antiretroviral treatment within one month of any of the following conditions being met: a. CD4 > 500 and viral load >30k; b. CD4 350-500 and viral load >10k; c. CD4 <350; d. any AIDS-defining condition; e. thrush.	13. a. b. c. d. e.	HIV+ patients should receive adequate antiretroviral treatment within one month of any of the following conditions being met (or be enrolled in a clinical trial with documentation of informed consent): a. CD4 >= 500 and viral load >30k; b. CD4 350- 500 499 and viral load >10k; c. CD4 <350; d. any AIDS-defining condition; e. thrush.	MODIFIED: Panelists added an explicit clinical trial option and clarified the CD4 cutoffs. ACCEPTED AS MODIFIED
15. Protease inhibitors should not be prescribed concurrently with astemizole, terfenadine, rifampin or cisapride.	14.	Protease inhibitors should not be prescribed concurrently with astemizole, terfenadine, rifampin or cisapride.	ACCEPTED
	15. (18) a. b.	HIV+ patients should be counseled regarding high risk behavior: a. at the time of HIV diagnosis ; b. within one month of presentation with an initial infection of STD.	PROPOSED AND ACCEPTED BY Q2 PANEL- Panelists felt that education is critical to prevent HIV/STD transmission.

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Follow-up</i>			
16. HIV+ patients should be offered viral load measurement within one month of initiation or change in antiretroviral treatment.	16.	HIV+ patients should be offered viral load measurement within one month two months of initiation or change in antiretroviral treatment.	MODIFIED: Panelists felt one month was too short. ACCEPTED AS MODIFIED
	17. (17)	HIV+ patients started on protease inhibitors should have documented counseling regarding compliance with therapy within 1 month of the start of therapy.	PROPOSED AND ACCEPTED BY Q2 PANEL. Compliance is critical to effective treatment and to prevent resistant strains of HIV.

Chapter 7 - Lung Cancer

Original Indicator Proposed by Staff	Indicator Voted on by Panel	Comments/Disposition
<i>Diagnosis</i>		
<p>1. Patients without a prior diagnosis of cancer (except non-melanoma skin cancer) with a mass (≥ 3 cm) on chest x-ray or CT scan of the chest should have one of the following diagnostic endpoints documented in the chart within 2 months of the radiological study:</p> <ul style="list-style-type: none"> • Chest CT with multiple nodules; • Sputum cytology diagnostic of cancer (expectorated or bronchoscopic washing); • Cytology report from a fine needle aspiration of the mass; • Pathology report from lymph node biopsy that is diagnostic of cancer; • Pathology report from lung biopsy; • Operative report indicating surgical resection of the mass. 	<p>1. Patients without a prior diagnosis of metastatic cancer (except non-melanoma skin cancer) with a solitary mass (≥ 3 cm) on chest x-ray or CT scan of the chest should have one of the following diagnostic endpoints a tissue or cytologic diagnosis of pathologic process documented in the chart within 2 months of the radiological study unless contraindicated.</p> <ul style="list-style-type: none"> • Chest CT with multiple nodules; • Sputum cytology diagnostic of cancer (expectorated or bronchoscopic washing); • Cytology report from a fine needle aspiration of the mass; • Pathology report from lymph node biopsy that is diagnostic of cancer; • Pathology report from lung biopsy; • Operative report indicating surgical resection of the mass. 	<p>MODIFIED: Panelists wanted to consolidate the description of a histological diagnosis and simplify the wording for operationalization.</p> <p>ACCEPTED AS MODIFIED</p>

Original Indicator Proposed by Staff	Indicator Voted on by Panel	Comments/Disposition
<i>Diagnosis</i>		
<p>2. Patients without a prior diagnosis of cancer (except non-melanoma skin cancer) with a solitary nodule (< 3 cm) on chest x-ray or CT scan of the chest should have one of the following diagnostic endpoints documented in the chart within 2 months of the radiological study:</p> <ul style="list-style-type: none"> • Report of chest x-ray or CT scan of the chest from at least 2 years prior to the index study which shows a nodule of the same size in the same location; • Chest x-ray or CT scan report describes the nodule has having central, diffuse, speckled, or laminar calcifications; • Chest CT scan report states that the density of the nodule is > 160 Hounsfield units; • Chest CT with multiple nodules; • Sputum cytology, bronchoscopic washing, or bronchoscopic brushing diagnostic of cancer • Cytology report from a fine needle aspiration of the mass; • Pathology report from lymph node biopsy that is diagnostic of cancer; • Pathology report from biopsy of nodule; • Operative report indicating surgical resection of the mass. 	<p>2. Patients without a prior diagnosis of cancer (except non-melanoma skin cancer) with a solitary nodule (< 3 cm) on chest x-ray or CT scan of the chest should have one of the following diagnostic endpoints documented in the chart within 2 months of the radiological study:</p> <ul style="list-style-type: none"> • Report of chest x-ray or CT scan of the chest from at least 2 years prior to the index study which shows a nodule of the same size in the same location; • Chest x-ray or CT scan report describes the nodule has having central, diffuse, speckled, or laminar calcifications; • Chest CT scan report states that the density of the nodule is > 160 Hounsfield units; • Chest CT with multiple nodules; • Sputum cytology, bronchoscopic washing, or bronchoscopic brushing diagnostic of cancer; • Cytology report from a fine needle aspiration of the mass; • Pathology report from lymph node biopsy that is diagnostic of cancer; • Pathology report from biopsy of nodule; • Operative report indicating surgical resection of the mass. 	<p>MODIFIED: Wording clarified.</p> <p>ACCEPTED AS MODIFIED</p>

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Treatment</i>			
<p>3. Patients with non-small cell lung cancer should have both of the following not more than 3 months prior to lung resection:</p> <p>a. pulmonary function assessment with either pulmonary function tests (FEV1, maximum ventilatory volume) or a quantitative ventilation scan or a quantitative perfusion scan;</p> <p>b. EKG.</p>	<p>3. Patients with non-small cell lung cancer should have both of the following not more than 3 months prior to lung resection:</p> <p>a. pulmonary function assessment with either pulmonary function tests (FEV1, maximum ventilatory volume) or a quantitative ventilation scan or a quantitative perfusion scan;</p> <p>b. EKG.</p>	<p>ACCEPTED</p>	
<p>4. Patients with Stage I and II non-small cell lung cancer should be offered a lung resection (pneumonectomy, lobectomy, or wedge resection) within 6 weeks of diagnosis unless any of the following are documented:</p> <p>a. another metastatic cancer;</p> <p>b. FEV1 < 40% on pulmonary function tests;</p> <p>c. maximum ventilatory volume < 50% on pulmonary function tests;</p> <p>d. pCO₂> 45 mm Hg on an arterial blood gas;</p> <p>e. <=0.8 liter perfusion to contralateral lung by quantitative perfusion scan;</p> <p>f. documentation in chart that patient is medically "unacceptable risk" for surgery.</p>	<p>4. Patients with Stage I and II non-small cell lung cancer should be offered a lung resection (pneumonectomy, lobectomy, or wedge resection) within 6 weeks of diagnosis unless contraindicated. any of the following are documented:</p> <p>-- a. another metastatic cancer;</p> <p>-- b. FEV1<40% on pulmonary function tests;</p> <p>-- c. maximum ventilatory volume <50% on pulmonary function tests;</p> <p>-- d. pCO₂> 45 mm Hg on an arterial blood gas;</p> <p>-- e. <=0.8 liter perfusion to contralateral lung by quantitative perfusion scan;</p> <p>-- f. documentation in chart that patient is medically "unacceptable risk" for surgery.</p>	<p>MODIFIED: The term "contraindicated" will be defined during operationalization rather than listing all of the contraindication as part of the indicator.</p> <p>ACCEPTED AS MODIFIED</p>	
<p>5. Patients with Stage I or II non-small cell lung cancer who do not undergo a lung resection should be offered radiation therapy to the chest (>= 5000 cGy) within 6 weeks of diagnosis.</p>	<p>5. Patients with Stage I or II non-small cell lung cancer who do not undergo a lung resection should be offered radiation therapy to the chest (>= 5000 cGy) within 6 weeks of diagnosis.</p>	<p>ACCEPTED</p>	

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Treatment</i>			
<p>6. Patients with Stage III non-small cell lung cancer with good performance status should be offered at least one of the following within 6 weeks of diagnosis:</p> <ul style="list-style-type: none"> • thoracotomy with surgical resection of the tumor; • radiation therapy to the thorax; • chemotherapy. 	6.	<p>Patients with Stage III non-small cell lung cancer with good performance status should be offered at least one of the following within 6 weeks of diagnosis (unless contraindicated or enrolled in a clinical trial with documentation of informed consent):</p> <ul style="list-style-type: none"> • thoracotomy with surgical resection of the tumor; • radiation therapy to the thorax with chemotherapy. • chemotherapy. 	<p>MODIFIED: An explicit clinical trial option was added. Panelists felt that there was no consensus on the effectiveness of chemotherapy alone.</p> <p>ACCEPTED AS MODIFIED</p>
<p>7. Patients with Stage IV non-small cell lung cancer and good performance status should be offered chemotherapy within 6 weeks of diagnosis.</p>	7.	<p>Patients with Stage IV non-small cell lung cancer and good performance status should have be offered chemotherapy discussed within 6 weeks of diagnosis (or be enrolled in a clinical trial with documentation of informed consent).</p>	<p>MODIFIED: An explicit clinical trial option was added. Panelists preferred the term “discussed” as both chemotherapy and its contraindications should be considered.</p> <p>ACCEPTED AS MODIFIED</p>
<p>8. Patients with non-small cell lung cancer who have metastases on MRI or CT of the brain should be offered one of the following treatments within 2 weeks of the MRI or CT:</p> <ul style="list-style-type: none"> • radiation therapy to the brain; • surgical resection of the metastasis; • stereotactic radiosurgery. 	8.	<p>Patients with non-small cell lung cancer who have first metastases on MRI or CT of the brain should be offered one of the following treatments within 2 1 week of the MRI or CT (or be enrolled in a clinical trial with documentation of informed consent):</p> <ul style="list-style-type: none"> • radiation therapy to the brain; • surgical resection of the metastasis; • stereotactic radiosurgery. 	<p>MODIFIED: An explicit clinical trial option was added. Panelists also clarified criteria (“first” added) and felt that the 2 week time frame was too long.</p> <p>ACCEPTED AS MODIFIED</p>
<p>9. Patients with limited small cell lung cancer should be offered combined modality therapy with radiation therapy ($\geq 5,000$ cGy) and chemotherapy within 6 weeks of diagnosis.</p>	9.	<p>Patients with limited small cell lung cancer should be offered combined modality therapy with radiation therapy ($\geq 5,000$ cGy) and chemotherapy within 6 2 weeks of diagnosis (or be enrolled in a clinical trial with documentation of informed consent).</p>	<p>MODIFIED: An explicit clinical trial option was added. Panelists felt that 6 weeks was too long.</p> <p>ACCEPTED AS MODIFIED</p>
<p>10. Patients with extensive small cell lung cancer should be offered chemotherapy within 6 weeks of diagnosis.</p>	10.	<p>Patients with extensive small cell lung cancer should be offered chemotherapy within 6 2 weeks of diagnosis.</p>	<p>MODIFIED: Panelists felt that 6 weeks was too long.</p> <p>ACCEPTED AS MODIFIED</p>

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Treatment</i>			
11. Patients with small cell lung cancer who have metastases on MRI or CT of the brain should be offered either of the following within 2 weeks of diagnosis of brain metastases (unless they have received both previously): <ul style="list-style-type: none"> • chemotherapy; • radiation therapy to the brain. 	11.	Patients with small cell lung cancer who have first metastases on MRI or CT of the brain should be offered either of the following within 2 1 week of diagnosis of brain metastases (unless they have received both previously): <ul style="list-style-type: none"> • chemotherapy; • radiation therapy to the brain. 	MODIFIED: Panelists felt that 2 weeks was too long and clarified criteria (“first” added). ACCEPTED AS MODIFIED
12. Patients with small cell lung cancer who have bone pain and a corresponding positive radiographic study should be offered either of the following within 3 weeks of presenting with the complaint of pain (unless they have received both previously): <ul style="list-style-type: none"> • chemotherapy; • radiation therapy to the region. 	--	Patients with small cell lung cancer who have bone pain and a corresponding positive radiographic study should be offered either of the following within 3 weeks 1 week of presenting with the complaint of pain (unless they have received both previously): <ul style="list-style-type: none"> • chemotherapy; • radiation therapy to the region. 	DROPPED due to low validity score. Panelists felt that pain was an important indication for treatment, but had concerns about clinical heterogeneity of the eligible population.

Chapter 9 - Prostate Cancer Treatment

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Diagnosis</i>			
<p>1. A patient <i>without</i> any previously known diagnosis of cancer who has an x-ray or radionuclide bone scan with blastic or lytic lesions, or with a notation that the findings are consistent with metastases, should be offered all of the following within the 12 months prior or the 3 weeks following the date of the x-ray or bone scan:</p> <ul style="list-style-type: none"> a. digital rectal exam; b. PSA. 	--	<p>A patient Men <i>without</i> any previously known diagnosis of cancer who has have an x-ray or radionuclide bone scan with blastic or lytic lesions, or with a notation that the findings are consistent with metastases, should be offered all both of the following within the 12 months prior to or the 3 weeks following the date of the x-ray or bone scan:</p> <ul style="list-style-type: none"> a. digital rectal exam; b. PSA. 	DROPPED due to low validity score.
<p>2. Patients with a new diagnosis of prostate cancer, who have not had a serum PSA in the prior three months, should have serum PSA checked within one month after diagnosis or prior to any treatment, whichever comes first.</p>	1.	<p>Patients Men with a new diagnosis of prostate cancer, who have not had a serum PSA in the prior three months, should have serum PSA checked within one month after diagnosis or prior to any treatment, whichever comes first.</p>	<p>MODIFIED: Wording clarified. ACCEPTED AS MODIFIED</p>
<p>3. Patients with a new diagnosis of prostate cancer who have a PSA > 10mg/ml should be offered a radionuclide bone scan within 1 month or prior to initiation of any treatment, whichever is first.</p>	2.	<p>Patients Men with a new diagnosis of prostate cancer who have a PSA > 10mg/ml should be offered a radionuclide bone scan within 1 month or prior to initiation of any treatment, whichever is comes first.</p>	<p>MODIFIED: Wording clarified. ACCEPTED AS MODIFIED</p>
<i>Treatment</i>			
<p>4. Men over 60 with minimal prostate cancer (Stage 0/A1) should not be offered any of the following treatments:</p> <ul style="list-style-type: none"> a. bilateral orchiectomy; b. LHRH analogue ; c. antiandrogen; d. radical prostatectomy; e. radiation therapy. 	3.	<p>Men over 60 with minimal prostate cancer (Stage 0/A1) should not be offered any of the following treatments:</p> <ul style="list-style-type: none"> a. a. bilateral orchiectomy; b. b. LHRH analogue; c. c. antiandrogen; -- d. radical prostatectomy; -- e. radiation therapy. 	<p>“a”, “b”. “c” ACCEPTED</p> <p>“d, e” DROPPED due to disagreement on validity.</p>

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
	<p>4. (4)</p> <p>a. a. bilateral orchiectomy; b. LHRH analogue; c. antiandrogen.</p>	<p>Men over 60 with minimal prostate cancer (Stage T1C with Gleason <= 4 and PSA <= 10) should not be offered any of the following treatments:</p>	<p>Panelists considered and ACCEPTED indicator with modified stage and grade (for “a, b, c” only). Panelists indicated that T1C diagnoses are made more often now.</p>
<p>5. Men under 65, who do not have coronary artery disease or a second cancer should be offered radical prostatectomy or radiation therapy for localized prostate cancer (Stage I & II/A2 & B) within 3 months of staging.</p>	<p>5.</p> <p>Men under age 65 with localized prostate cancer (Stage I or II/A2 or B) and a Gleason score <= 6 should have all of the following treatment options discussed within 3 months of diagnosis (unless contraindicated or enrolled in a clinical trial with documentation of informed consent):</p> <ul style="list-style-type: none"> • Radiation therapy; • Prostatectomy; • Watchful waiting. 	<p>Men under age 65 with localized prostate cancer (Stage I or II/A2 or B) and a Gleason score <= 6 should have all of the following treatment options discussed within 3 months of diagnosis (unless contraindicated or enrolled in a clinical trial with documentation of informed consent):</p>	<p>MODIFIED: Panelists reworded the indicator to include a Gleason score and an explicit clinical trial option. Panelists also felt that watchful waiting was appropriate care, and that “offered” should be changed to “discussed” in order to account for patients who may have a limited life expectancy.</p> <p>ACCEPTED AS MODIFIED</p>
<p>6. Men with metastatic prostate cancer (Stage IV/D) should be offered at least one of the following androgen blockade treatments within three months of staging:</p> <ul style="list-style-type: none"> • bilateral orchiectomy; • LHRH analogue; • Antiandrogen. 	<p>6.</p> <p>Men with metastatic prostate cancer (Stage IV/D) should be offered at least one of the following androgen blockade treatments within three months of staging:</p> <ul style="list-style-type: none"> • bilateral orchiectomy; • LHRH analogue with or without antiandrogen. • antiandrogen 	<p>Men with metastatic prostate cancer (Stage IV/D) should be offered at least one of the following androgen blockade treatments within three months of staging:</p>	<p>MODIFIED: Panelists felt that antiandrogen alone is not adequate therapy.</p> <p>ACCEPTED AS MODIFIED</p>
<p>7. Men who undergo orchiectomy for the treatment of prostate cancer should have documented that they were offered treatment with an LHRH analogue or antiandrogen within 12 months prior to surgery.</p>	<p>7.</p> <p>Men who undergo orchiectomy for the treatment of prostate cancer should have documented that they were offered treatment with an LHRH analogue (with or without antiandrogen) or antiandrogen within 12 months prior to surgery.</p>	<p>Men who undergo orchiectomy for the treatment of prostate cancer should have documented that they were offered treatment with an LHRH analogue (with or without antiandrogen) or antiandrogen within 12 months prior to surgery.</p>	<p>MODIFIED: Panelists felt that antiandrogen alone is not adequate therapy.</p> <p>ACCEPTED AS MODIFIED</p>

Original Indicator Proposed by Staff	Indicator Voted on by Panel	Comments/Disposition
<p>8. Prostate cancer patients who present with acute low back pain should have documentation within 24 hours of the complaint or in the preceding 3 months of one of the following:</p> <ul style="list-style-type: none"> • a CT scan of the spine <i>without</i> blastic or lytic lesions or compression fractures; • a CT myelogram; • an MRI of the spine. 	<p>8. Metastatic prostate cancer patients who present with acute low back pain with radiculopathy should have documentation within 24 hours of the complaint or in the preceding 3 months of presentation of one of the following:</p> <ul style="list-style-type: none"> • a CT scan of the spine <i>without</i> blastic or lytic lesions or compression fractures; • a CT myelogram; • an MRI of the spine. 	<p>MODIFIED: Panelists wanted to restrict back pain more to that which may be due to spinal cord compression. They also narrowed the time frame and clarified that the indicator only applies to metastatic cases.</p> <p>ACCEPTED AS MODIFIED</p>
<p>9. Prostate cancer patients with evidence of cord compression on MRI scan of the spine or CT myelogram should be offered one of the following within 24 hours of the radiologic study:</p> <ul style="list-style-type: none"> • radiation therapy to the spine at a total dose between 3000 cGy and 4500 cGy over 2-4 weeks; • decompressive laminectomy. 	<p>9. Prostate cancer patients with evidence of cord compression from tumor on MRI scan of the spine or CT myelogram should be offered one of the following within 24 hours of the radiologic study:</p> <ul style="list-style-type: none"> • radiation therapy to the spine at a total dose between 3000 cGy and 4500 cGy over 2-4 weeks; • decompressive laminectomy. 	<p>MODIFIED: Wording clarified.</p> <p>ACCEPTED AS MODIFIED</p>
<p>10. Prostate cancer patients with evidence of cord compression on MRI scan of the spine or CT myelogram should be offered at least 4 mg dexamethazone IV prior to the radiologic study or within 1 hour of its completion, followed by dexamethasone 4 mg IV or PO q six hours for at least 72 hours.</p>	<p>10. Prostate cancer patients with evidence of cord compression from tumor on MRI scan of the spine or CT myelogram should be offered at least 4 mg dexamethazone IV prior to the radiologic study or within 1 4 hours of its completion, followed by dexamethasone 4 mg IV or PO q six hours for at least 72 hours.</p>	<p>MODIFIED: Panelists felt that dexamethazone within one hour of completion of study was too narrow a time frame.</p> <p>ACCEPTED AS MODIFIED</p>
	<p>11. (11) Men under age 75 with localized prostate cancer (Stage I or II/A2 or B) and a Gleason score \geq 7 should be offered both of the following treatment options within 3 months of diagnosis (unless contraindicated or enrolled in a clinical trial with documentation of informed consent):</p> <ul style="list-style-type: none"> • radiation therapy; • radical prostatectomy. 	<p>PROPOSED AND ACCEPTED BY Q2 PANEL</p>
	<p>12. (12) Men with prostate cancer who present with acute back pain should have the presence or absence of all the following elicited on the day of presentation:</p> <ol style="list-style-type: none"> a. bladder dysfunction; b. bowel dysfunction; c. weakness or radicular symptoms; d. sensory loss. 	<p>PROPOSED AND ACCEPTED BY Q2 PANEL</p>

Chapter 10 - Skin Cancer Screening

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Primary Prevention</i>			
1. When a patient is noted to have a sunburn, the chart should document counseling regarding avoidance of midday sun, use of protective clothing, and/or use of sunscreens.	--	When a patient is noted to have a sunburn, the chart should document counseling regarding avoidance of midday sun, use of protective clothing, and/or use of sunscreens.	DROPPED due to low feasibility score.
2. Patients who have evidence of aktinic keratosis or solar keratosis (AK), should be counseled regarding avoidance of midday sun, use of protective clothing, and/or use of sunscreens within 1 year before or after diagnosis.	1.	Patients who have evidence of aktinic keratosis or solar keratosis (AK), should be counseled regarding avoidance of midday sun, use of protective clothing, and/or use of sunscreens within 1 year before or after diagnosis.	ACCEPTED
3. All patients noted to have strong skin cancer risk factors should be instructed in midday sun avoidance, use of protective clothing, and/or use of sunscreens within 1 year before or after note of high risk.	--	All patients noted to have strong skin cancer risk factors should be instructed in midday sun avoidance, use of protective clothing, and/or use of sunscreens within 1 year before or after note of high risk.	DROPPED due to low feasibility score. Panelists felt that risk factors may not be documented and that that would not necessarily reflect poor quality.
<i>Secondary Prevention/Skin Self-exam</i>			
4. All patients noted to have strong skin cancer risk factors should be instructed in skin self-examination within 1 year before or after note of high risk.	--	All patients noted to have strong skin cancer risk factors should be instructed in skin self-examination within 1 year before or after note of high risk.	DROPPED due to low validity score. Evidence linking examination with improved outcomes is lacking.
5. All patients with a personal history of melanoma or non-melanoma skin cancer (NMSC) should be counseled to do skin self-examination within 1 year before or after the history is documented.	2.	All patients with a personal history of melanoma or non-melanoma skin cancer (NMSC) should be counseled to do skin self-examination within 1 year before or after the history is documented.	MODIFIED: Panelists felt that this was not critical for those with NMSC because NMSC causes less morbidity/mortality. ACCEPTED AS MODIFIED
<i>Secondary Prevention/ Clinician Screening</i>			
6. Patients diagnosed with NMSC or multiple AKs in the past 5 years should have a skin exam documented in the past 12 months.	3.	Patients with a history of diagnosed with NMSC or multiple AKs in the past 5 years should have a skin exam documented in the past 12 months.	MODIFIED ACCEPTED AS MODIFIED
7. Referral to a dermatologist for surveillance/screening should be documented if a patient has either of the following: a. personal history of cutaneous melanoma (CM); b. multiple common or atypical moles plus a family history of CM (possible FAM-M phenotype).	--	Referral to a dermatologist for surveillance/screening should be documented if a patient has either of the following: a. personal history of cutaneous melanoma (CM); b. multiple common or atypical moles plus a family history of CM (possible FAM-M phenotype).	DROPPED PRIOR TO PANEL. Panelists indicated that it was difficult to identify dermatologists from the medical record alone.

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
8. All patients newly diagnosed with melanoma should be advised to have family members undergo a screening skin exam.	--	All patients newly diagnosed with melanoma should be advised to have family members undergo a screening skin exam.	DROPPED due to low validity score. Evidence linking screening to improved outcomes is poor.
9. All patients with a documented family history of melanoma in a first degree relative should have a screening skin exam at least once in the year preceding or subsequent to documentation.	--	All patients with a documented family history of melanoma in a first degree relative should have a screening skin exam at least once in the year preceding or subsequent to documentation.	DROPPED due to low validity score. Panelists did not feel that a family history of melanoma was a sufficient reason to require a skin exam.
	4. (9)	All patients with a documented personal history of melanoma should have a screening skin exam at least once in the year preceding or subsequent to documentation.	Panelists considered and ACCEPTED an indicator for personal history. Panelists felt that a personal history of melanoma was a sufficient reason to require a skin exam.

Chapter 11 - Cancer Pain and Palliation

Original Indicator Proposed by Staff		Indicator Voted on by Panel	Comments/Disposition
<i>Diagnosis</i>			
	1. (1)	Patients with metastatic cancer to bone should have the presence or absence of pain noted at least every 6 months.	PROPOSED AND ACCEPTED BY Q2 PANEL
<i>Treatment</i>			
	2. (2)	Cancer patients whose pain is uncontrolled should be offered a change in pain management within 24 hours of the pain complaint.	PROPOSED AND ACCEPTED BY Q2 PANEL
	-- (3)	Patients with painful bony metastases, who are noted to be unresponsive to or intolerant of narcotic analgesia, should be offered one of the following within one week of the notation of pain: <ul style="list-style-type: none"> • radiation therapy to the sites of pain; • radioactive strontium therapy. 	PROPOSED BUT DROPPED BY Q2 PANEL due to low validity score.
	3. (4)	Patients receiving emetogenic chemotherapy should be offered concurrent potent antiemetic therapy (e.g. 5HT blockade).	PROPOSED AND ACCEPTED BY Q2 PANEL