

NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the [submitting standards web page](#).

NQF #: 0032 NQF Project: Population Health: Prevention Project
(for Endorsement Maintenance Review) Original Endorsement Date: Aug 10, 2009 Most Recent Endorsement Date: Aug 10, 2009
BRIEF MEASURE INFORMATION
De.1 Measure Title: Cervical Cancer Screening
Co.1.1 Measure Steward: National Committee for Quality Assurance
De.2 Brief Description of Measure: Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.
2a1.1 Numerator Statement: One or more Pap tests during the measurement year (one calendar year) or the two years prior to the measurement year.
2a1.4 Denominator Statement: Women 24-64 years of age. For commercial plans, this includes the measurement year and the two years prior to the measurement year. For Medicaid plans, this includes the measurement year.
2a1.8 Denominator Exclusions: Optional Exclusion: Women who had a hysterectomy with no residual cervix.
1.1 Measure Type: Process 2a1. 25-26 Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records 2a1.33 Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Health Plan
1.2-1.4 Is this measure paired with another measure? No
De.3 If included in a composite, please identify the composite measure (title and NQF number if endorsed):

STAFF NOTES <i>(issues or questions regarding any criteria)</i>
Comments on Conditions for Consideration:
Is the measure untested? Yes <input type="checkbox"/> No <input type="checkbox"/> If untested, explain how it meets criteria for consideration for time-limited endorsement:
1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (check De.5): 5. Similar/related endorsed or submitted measures (check 5.1): Other Criteria:
Staff Reviewer Name(s):

1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT
Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence . <i>Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)</i>

1a. High Impact: H M L I

(The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.)

De.4 Subject/Topic Areas (Check all the areas that apply): Cancer, Cancer : Gynecologic, Prevention, Prevention : Screening

De.5 Cross Cutting Areas (Check all the areas that apply): Population Health

1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, Patient/societal consequences of poor quality, Severity of illness

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact (Provide epidemiologic or resource use data):

Cervical cancer is nearly 100 percent preventable, yet it is the second most common cancer among women worldwide.^{1,2} In the United States, about 12,000 women are diagnosed with cervical cancer each year, resulting in more than 4,000 deaths.^{3,4} For women in whom pre-cancerous lesions have been detected through Pap tests, the likelihood of survival is nearly 100 percent with appropriate evaluation, treatment and follow up.^{1,3} For women under 50 years old, cervical cancer is diagnosed in the early stage 62 percent of the time. ⁵ In 2008, the prevalence of recent Pap test use was lowest among older women, women with no health insurance and recent immigrants.¹

There are large differences in the rates of new cases of and deaths from cervical cancer among women from different racial and ethnic groups in the U.S. Rates of cervical cancer are 45% higher among Black women and 65% higher among Hispanic women than White women. Death rates from cervical cancer are twice as high for Black women and 42% higher among Hispanic women than White women. Further, older women of color are at higher risk for developing and dying from cervical cancer. Death rates of cervical cancer for older Black women are nearly three times greater than those for White women of the same age group. Older Hispanic women, Asian women and American Indian/Alaska Native women also have much higher death rates from cervical cancer than do White women. Cervical cancer mortality is higher than average among Hispanic/Latina women living on the Texas-Mexico border, and among White women in Appalachia, rural New York State, and northern New England. Cervical cancer incidence rates are five times higher among Vietnamese American women than White women.

1a.4 Citations for Evidence of High Impact cited in 1a.3: 1. American Cancer Society. 2011. Cancer Prevention & Early Detection Facts & Figures 2011.

<http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-029459.pdf> (May 29, 2011).

2. Myers, Ecan. 2008. The current and future role of screening in the era of HPV vaccination. *Gynecologic Oncology* 109.2.S31.

3. National Cervical Cancer Collation. Early Detection. http://www.nccc-online.org/health_news/early_detection.html (June 10, 2011).

4. Centers for Disease Control and Prevention. 2010. Cervical Cancer.

http://www.cdc.gov/cancer/cervical/pdf/Cervical_FS_0510.pdf (June 10, 2011).

5. American Cancer Society. Cancer Facts & Figures 2009. Available here: <http://www.cancer.org/downloads/STT/500809web.pdf>

6. Cervical Cancer Health Disparities Fact Sheet. Retrieved from <http://www.say-something.org/disparities.pdf> on June 29, 2011.

7. American Cancer Society. Cancer Facts and Figures 2006. Atlanta: American Cancer Society; 2006.

8. Freeman HP, Wingrove BK. Excess Cervical Cancer Mortality: A Marker for Low Access to Health Care in Poor Communities. Rockville, MD: National Cancer Institute, Center to

9. Reduce Cancer Health Disparities, May 2005. NIH Pub. No. 05-5282.

1b. Opportunity for Improvement: H M L I

(There is a demonstrated performance gap - variability or overall less than optimal performance)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:

Cervical cancer is a resource intensive disease with the total cost of treatment ranging between \$300 to \$400 million annually.² Between 60 and 80 percent of women with advanced cervical cancer have not had a Pap test in the past five years.¹All women are at risk for cervical cancer and women with the lowest levels of education tend to have fewer screenings in their lifetime.⁴A woman who does not have regular Pap tests significantly increases her chances of developing cervical cancer.³

1. American Cancer Society. 2011. Cancer Prevention & Early Detection Facts & Figures 2011.

<http://www.cancer.org/acs/groups/content/@epidemiologysurveillance/documents/document/acspc-029459.pdf> (May 29, 2011).

2. Myers, Ecan. 2008. The current and future role of screening in the era of HPV vaccination. *Gynecologic Oncology* 109.2.S31.
3. National Cervical Cancer Collation. Early Detection. http://www.nccc-online.org/health_news/early_detection.html (June 10, 2011).
4. Centers for Disease Control and Prevention. 2010. Cervical Cancer. http://www.cdc.gov/cancer/cervical/pdf/Cervical_FS_0510.pdf (June 10, 2011).

1b.2 Summary of Data Demonstrating Performance Gap (*Variation or overall less than optimal performance across providers*):
[For Maintenance – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.]

CCS - Reported Rate; Commercial

2009

N 243

MEAN 77.3

STDEV 4.97

STDERR 0.32

MIN 60.6

MAX 90.5

P10 71.2

P25 74.7

P50 77.7

P75 80.1

P90 82.5

Medicaid

CCS - Reported Rate	2009	2008	2007
N	136	165	136
MEAN	64.3	66.9	63.3
STDEV	12.4	10.7	11.9
STDERR	1.06	0.83	1.02
MIN	19.2	23.3	15.2
MAX	83.7	84.3	88.8
P10	49.4	54.1	49.1
P25	59.3	62	54.6
P50	67.4	68.1	66.5
P75	71.8	73.9	70.8
P90	77.1	79.6	76.4

1b.3 Citations for Data on Performance Gap: [For Maintenance – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included]

The data are performance rates from all health plans participating in the HEDIS measure set. There were 755 plan submissions for this measure. NCQA collects data directly from Health Plan Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). NCQA assigns a sub-ID by an accreditable identity based on the legal entity and management structure that supports the product lines/products that NCQA accredits. Each accreditation is legally accountable entity provides to members and representation of an organization and delivery structure that is meaningful to members.

1b.4 Summary of Data on Disparities by Population Group: [For Maintenance –Descriptive statistics for performance results for this measure by population group]

Rates of cervical cancer are 45% higher among Black women and 65% higher among Hispanic women than White women. Death rates from cervical cancer are twice as high for Black women and 42% higher among Hispanic women than White women. Older women of color are at higher risk for developing and dying from cervical cancer. Death rates of cervical cancer for older Black

women are nearly three times greater than those for White women of the same age group. Older Hispanic women, Asian women and American Indian/Alaska Native women also have much higher death rates from cervical cancer than do White women.

Whites are more likely than African Americans to have cancers diagnosed at early stages. Invasive cervical cancers are diagnosed at an early stage in 56% of White women and 48% of African American women. Overall 5-year survival rates from cervical cancer for White women are 75% (1995-2001). Overall 5-year survival rates from cervical cancer for African American women are 66% (1995-2001).

Women have varying rates of cervical cancer screening based on their racial or ethnic background or age. Hispanic women (74%) are screened much less often than either White (88%) or Black women (84%). Older women, who are at particularly high risk of developing cervical cancer, have very low screening rates (74%).

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]

1. American Cancer Society. Cancer Facts and Figures 2006. Atlanta: American Cancer Society; 2006.
2. Freeman HP, Wingrove BK. Excess Cervical Cancer Mortality: A Marker for Low Access to Health Care in Poor Communities. Rockville, MD: National Cancer Institute, Center to Reduce Cancer Health Disparities, May 2005. NIH Pub. No. 05-5282

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
Is the measure focus a health outcome? Yes No **If not a health outcome, rate the body of evidence.**

Quantity: H M L I **Quality:** H M L I **Consistency:** H M L I

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	Yes <input type="checkbox"/>
L	M-H	M	Yes <input type="checkbox"/> IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No <input type="checkbox"/>
M-H	L	M-H	Yes <input type="checkbox"/> IF potential benefits to patients clearly outweigh potential harms: otherwise No <input type="checkbox"/>
L-M-H	L-M-H	L	No <input type="checkbox"/>

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service

Does the measure pass subcriterion1c?
 Yes IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship (*Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome*):

The measure focuses on a process (cervical cancer screening). The process, a secondary prevention measure, has been shown to improve outcomes by catching cervical cancer in its earlier, more treatable stages.

1c.2-3 Type of Evidence (*Check all that apply*):

Clinical Practice Guideline

1c.4 Directness of Evidence to the Specified Measure (*State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population*):

The measure is aligned directly with a U.S. Preventive Services Task Force guideline, which is based on published studies on this topic.

1c.5 Quantity of Studies in the Body of Evidence (*Total number of studies, not articles*): The measure is based on a USPSTF guideline that is based on a comprehensive meta-analysis (see USPSTF report for full number of studies)

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b)*

directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events): **Good**

1c.7 Consistency of Results across Studies (Summarize the consistency of the magnitude and direction of the effect): **Consistent**

1c.8 Net Benefit (Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms):

The USPSTF determined there was a positive net benefit

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? **Yes**

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: **U.S. Preventive Services Task Force.**

1c.11 System Used for Grading the Body of Evidence: **USPSTF**

1c.12 If other, identify and describe the grading scale with definitions:

1c.13 Grade Assigned to the Body of Evidence: **Grade: A Recommendation.** The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix. **Grade: D Recommendation.** The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer. **Grade: D Recommendation.** The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease. **Grade: I Statement.** The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of new technologies to screen for cervical cancer. **Grade: I recommendation.** The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of human papillomavirus (HPV) testing as a primary screening test for cervical cancer.

1c.14 Summary of Controversy/Contradictory Evidence: **Guidelines are generally aligned**

1c.15 Citations for Evidence other than Guidelines(Guidelines addressed below):

Agency for Healthcare Research and Quality (AHRQ). 2011. Screening for Cervical Cancer: A Systematic Evidence Review for the U.S. Preventive Services Task Force. <http://www.uspreventiveservicestaskforce.org/uspstf11/cervcancer/cervcanceres.pdf> (July 15, 2011).

1c.16 Quote verbatim, the specific guideline recommendation (Including guideline # and/or page #):

U.S. Preventive Services Task Force (USPSTF) (2003)

Grade: A Recommendation. The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Grade: D Recommendation. The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Grade: D Recommendation. The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

Grade: I Statement. The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of new technologies to screen for cervical cancer.

Grade: I recommendation. The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of human papillomavirus (HPV) testing as a primary screening test for cervical cancer.

Kaiser Permanente National Cervical Cancer Screening Guideline Development Team

Recommendations 1A-D: Effectiveness of Cervical Cancer Primary Screening Tests in Asymptomatic, Average-Risk Women

- Routine cervical cancer screening is recommended for all asymptomatic, average-risk women. (Evidence-based: B)
- Either of the following tests are options for cervical cancer screening in asymptomatic, average-risk women under age 30.
- Conventional cytology (Evidence-based: B)
- Liquid-based cytology (Consensus-based)

- All of the following tests are acceptable options for cervical cancer screening in asymptomatic, average-risk women age 30 and older.
 - Conventional cytology (Evidence-based: B)
 - Conventional cytology and human papillomavirus (HPV) testing*‡** cytology (Consensus-based)
 - Liquid-based cytology (Consensus-based)
 - Liquid-based cytology and HPV testing*‡** cytology (Consensus-based)
- *HPV testing has not been Food and Drug Administration (FDA) approved as a standalone test for primary screening.
 ‡ Combined cytology and HPV testing provides useful risk-stratification
 ** Hybrid Capture 2 (HC2) Testing Device.
- No recommendation for or against routine use of computer-assisted slide evaluation or automated rescreening of cytology slides. (Evidence-based: I)
- Recommendations 2A-B: Cervical Cancer Screening Intervals in Asymptomatic, Average-risk Women
- The following screening intervals are recommended:
 - Cytology alone: every 3 years* (Consensus-based)
 - Cytology + HPV (age 30 and older): every 3 years*‡ (Consensus-based)
- *Screen if more than 30 months has elapsed.
 ‡ Hybrid Capture 2 (HC2) Testing Device.
- No recommendation for or against routinely providing annual screening tests prior to beginning a triennial screening program. (Evidence-based: I)
- Recommendations 3A-B: Optimal Age to Begin and End Screening in Asymptomatic, Average-risk Women
- Initiation of cervical cancer screening is recommended approximately 3 years after first sexual intercourse or by the age of 21, whichever comes first.*‡(Consensus-based)
 - Routine screening for cervical cancer for women older than age 65 is not recommended if they have had adequate recent screening** with normal results on their last cytology (and HPV test if applicable). (Evidence-based: D)
- *The Guideline Development Team (GDT) recognizes that the age to begin screening may not adequately reflect the current The Health Plan Employer Data and Information Set (HEDIS) measures. Some regions may choose to offer screening at a younger age. The HEDIS® cervical cancer screening rate estimates the percentage of women aged 21 to 64 that were enrolled in the health plan and who had one cytology test during measurement year or the two years prior.
 ‡Routine cervical cancer screening continues to be recommended for women who have received the HPV vaccine.
 **The Guideline Development Team defined adequate recent screening as older women who have had three or more documented, consecutive, technically satisfactory normal/negative cervical cytology tests, and who have had no abnormal/positive cytology tests within the last 10 years.
- Recommendations 4A-B: Triage for Atypical Squamous Cells of Undetermined Significance (ASC-US) Results Using HPV Testing in Asymptomatic, Average-risk Women
- HPV testing is recommended in women of all ages for triage of cytology results indicating atypical squamous cells of undetermined significance.(Evidence-based: B)
 - No recommendation for or against the use of HPV testing to triage women with cytologic results higher than ASC-US. (Evidence-based: I)
- Recommendations 5A-5B: Optimal Cervical Cancer Screening Strategy for Women Who Have Had a Total Hysterectomy for a Benign Condition
- Routine cytology screening is not recommended for women who have had a total hysterectomy for a benign condition unless there was a history of cervical intraepithelial neoplasia grade 2/3 (CIN2/3). (Evidence-based: D)
 - Three consecutive negative cytology results with or without HPV testing are recommended prior to discontinuation of screening in women who have a history of cervical intraepithelial neoplasia grade 2/3 and a subsequent hysterectomy for a benign condition. (Consensus-based)
- Recommendations 6A-C: Screening in Women at Increased Risk of Cervical Cancer
- Cytology and HPV testing are recommended at 6 months following treatment for CIN2/3, and again at 24 months, with colposcopy for any positive result. Routine screening every 3 years can then be resumed indefinitely. (Consensus-based)
 - If HPV testing is not done, two cytology tests at 6 and 12 months after treatment are recommended, with colposcopy for a positive result, then annual cytologic screening indefinitely. (Consensus-based)
 - At least annual cytology with or without HPV testing is recommended for women who are immunosuppressed or human immunodeficiency virus (HIV)-positive. (Consensus-based)
- Recommendation 7A: Optimal Initial Management of Concurrent HPV-Positive and Cytology-Negative Cervical Screening Results
- HPV and cytology retesting is recommended in 12 months, rather than immediate colposcopy, for management of women

with initial concurrent HPV-positive and cytology-negative screening results. (Consensus-based)

The American Congress of Obstetricians and Gynecologists (2009)

The following recommendations are based on good and consistent scientific evidence (Level A):

- Cervical cancer screening should begin at age 21 years. Screening before age 21 should be avoided because it may lead to unnecessary and harmful evaluation and treatment in women at very low risk of cancer.

The following recommendations are based on limited and inconsistent scientific evidence (Level B):

- Sexually active adolescents (i.e., females younger than age 21 years) should be counseled and tested for sexually transmitted infections, and should be counseled regarding safe sex and contraception. These measures may be carried out without cervical cytology and, in the asymptomatic patient, without the introduction of a speculum.
- Because cervical cancer develops slowly and risk factors decrease with age, it is reasonable to discontinue cervical cancer screening between 65 years and 70 years of age in women who have three or more negative cytology test results in a row and no abnormal test results in the past 10 years.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Women who have been immunized against HPV-16 and HPV-18 should be screened by the same regimen as nonimmunized women.

The following recommendations are based on good and consistent scientific evidence (Level A):

- Cervical cytology screening is recommended every 2 years for women between the ages of 21 years and 29 years.
- Women aged 30 years and older who have had three consecutive negative cervical cytology screening test results and who have no history of CIN 2 or CIN 3, are not HIV infected, are not immunocompromised, and were not exposed to diethylstilbestrol in utero may extend the interval between cervical cytology examinations to every 3 years.
- Both liquid-based and conventional methods of cervical cytology are acceptable for screening.
- Co-testing using the combination of cytology plus HPV DNA testing is an appropriate screening test for women older than 30 years. Any low-risk woman aged 30 years or older who receives negative test results on both cervical cytology screening and HPV DNA testing should be rescreened no sooner than 3 years subsequently.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Regardless of the frequency of cervical cytology screening, physicians also should inform their patients that annual gynecologic examinations may still be appropriate even if cervical cytology is not performed at each visit.

The following recommendations are based on good and consistent scientific evidence (Level A):

- In women who have had a total hysterectomy for benign indications and have no prior history of highgrade CIN, routine cytology testing should be discontinued.

The following recommendations are based on limited and inconsistent scientific evidence (Level B):

- Women who have had a hysterectomy with removal of the cervix and have a history of CIN 2 or CIN 3—or in whom a negative history cannot be documented—should continue to be screened even after their period of posttreatment surveillance. Whereas the screening interval may then be extended, there are no good data to support or refute discontinuing screening in this population.

1c.17 Clinical Practice Guideline Citation: U.S. Preventive Services Task Force. Screening for Cervical Cancer:

Recommendations and Rationale. <http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm>

Kaiser Permanente National Cervical Cancer Screening Guideline Development Team. Cervical cancer screening guideline.

Oakland (CA): Kaiser Permanente Care Management Institute; 2006 Oct. 124 p. [199 references]

1c.18 National Guideline Clearinghouse or other URL: <http://www.guideline.gov/content.aspx?id=10713>

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? **Yes**

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: USPSTF

1c.21 System Used for Grading the Strength of Guideline Recommendation: USPSTF

1c.22 If other, identify and describe the grading scale with definitions:

1c.23 Grade Assigned to the Recommendation: Grade: A Recommendation. The USPSTF strongly recommends screening for

cervical cancer in women who have been sexually active and have a cervix. Grade: D Recommendation. The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer. Grade: D Recommendation. The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease. Grade: I Statement. The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of new technologies to screen for cervical cancer. Grade: I recommendation. The USPSTF concludes that the evidence is insufficient to recommend for or against the routine use of human papillomavirus (HPV) testing as a primary screening test for cervical cancer.

1c.24 Rationale for Using this Guideline Over Others: It is NCQA policy to use guidelines that are evidence-based, applicable to physicians and other healthcare providers, and developed by a national specialty organization or government agency.

NCQA convened an expert panel of diverse stakeholders to review the guidelines and evidence for this measure. The panel determined the measure was scientifically sound using the full body of evidence and guidelines for this measure concept.

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?

1c.25 Quantity: [High](#) 1c.26 Quality: [High](#) 1c.27 Consistency: [High](#)

Was the threshold criterion, *Importance to Measure and Report*, met?

(1a & 1b must be rated moderate or high and 1c yes) Yes No

Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.

For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & VALIDITY - SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **(evaluation criteria)**

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See [guidance on measure testing](#).

S.1 Measure Web Page *(In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained).* Do you have a web page where current detailed specifications for this measure can be obtained? [No](#)

S.2 If yes, provide web page URL:

2a. RELIABILITY. Precise Specifications and Reliability Testing: H M L I

2a1. Precise Measure Specifications. *(The measure specifications precise and unambiguous.)*

2a1.1 Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome):*

[One or more Pap tests during the measurement year \(one calendar year\) or the two years prior to the measurement year.](#)

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion):*
[December 31 of the measurement year.](#)

2a1.3 Numerator Details *(All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, codes with descriptors, and/or specific data collection items/responses:*

ADMINISTRATIVE SPECIFICATION:

[Evidence of a Pap test is a submitted claim/encounter containing any of the following codes.](#)

[Codes to Identify Cervical Cancer Screening](#)

[CPT: 88141-88143, 88147, 88148, 88150, 88152-88155, 88164-88167, 88174, 88175](#)

NQF #0032 Cervical Cancer Screening

HCPCS: G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091
ICD-9-CM Diagnosis: V72.32, V76.2
ICD-9-CM Procedure: 91.46
UB Revenue: 0923
LOINC: 10524-7, 18500-9, 19762-4, 19764-0, 19765-7, 19766-5, 19774-9, 33717-0, 47527-7, 47528-5

MEDICAL RECORD SPECIFICATION:

One or more Pap tests during the measurement year or the two years prior to the measurement year. Documentation in the medical record must include:

- A note indicating the date when the test was performed, AND
- The result or finding.

Count any cervical cancer screening method that includes collection and microscopic analysis of cervical cells. Do not count lab results that explicitly state the sample was inadequate or that "no cervical cells were present"; this is not considered appropriate screening.

Do not count biopsies because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.

NOTE: Lab results that indicate the sample contained "no endocervical cells" may be used if a valid result was reported for the test.

2a1.4 Denominator Statement (Brief, narrative description of the target population being measured):

Women 24-64 years of age. For commercial plans, this includes the measurement year and the two years prior to the measurement year. For Medicaid plans, this includes the measurement year.

2a1.5 Target Population Category (Check all the populations for which the measure is specified and tested if any): **Adult/Elderly Care**

2a1.6 Denominator Time Window (The time period in which cases are eligible for inclusion):

December 31 of the measurement year.

2a1.7 Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):

Product lines - Commercial, Medicaid (report each product line separately).

Ages - Women 24-64 years as of December 31 of the measurement year.

Continuous enrollment Commercial: The measurement year and the two years prior to the measurement year.

Medicaid: The measurement year.

Allowable gap No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).

Anchor date December 31 of the measurement year.

Benefit Medical.

Event/diagnosis None.

Medical Record Specification

A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the General Guidelines.

- The Medical Record Method
- The Hybrid Method
- Sampling Methods

2a1.8 Denominator Exclusions (Brief narrative description of exclusions from the target population):

Optional Exclusion: Women who had a hysterectomy with no residual cervix.

2a1.9 Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):

ADMINISTRATIVE SPECIFICATION:

Women who had a hysterectomy with no residual cervix. Look as far back as possible in the member's history for evidence of hysterectomy through December 31 of the measurement year. Refer to the following codes to identify a hysterectomy.

Codes to Identify Exclusions

CPT: 51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135

ICD-9-CM Diagnosis: 618.5, V67.01, V76.47, V88.01, V88.03

ICD-9-CM Procedure: 68.4-68.8

MEDICAL RECORD SPECIFICATION:

Exclusionary evidence in the medical record must include a note indicating a hysterectomy with no residual cervix. The hysterectomy must have occurred by December 31 of the measurement year. Documentation of "complete," "total" or "radical" abdominal or vaginal hysterectomy meets the criteria for hysterectomy with no residual cervix.

Documentation of a "vaginal pap smear" in conjunction with documentation of "hysterectomy" meets exclusion criteria, but documentation of hysterectomy alone does not meet the criteria because it does not indicate that the cervix was removed.

2a1.10 Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses):

None

2a1.11 Risk Adjustment Type (Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13): No risk adjustment or risk stratification **2a1.12 If "Other," please describe:**

2a1.13 Statistical Risk Model and Variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.):

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. Type of Score: Rate/proportion

2a1.19 Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score): Better quality = Higher score

2a1.20 Calculation Algorithm/Measure Logic(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.):

Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, enrollment, benefit, event, or anchor date enrollment requirement.

Step 2. Search administrative systems to identify numerator events for all members in the eligible population.

Step 3. If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured.

NOTE: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.

Step 4. Exclude from the eligible population members from step 3 for whom administrative system data identified an exclusion to the service/procedure being measured.

Step 5. Calculate the rate.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):

Medical Record Specification

A systematic sample drawn from the eligible population. Use the Medical Record Method or the Hybrid Method to identify the eligible population. Refer to the following sections in the General Guidelines.

- The Medical Record Method
- The Hybrid Method
- Sampling Methods

2a1.25 Data Source (Check all the sources for which the measure is specified and tested). If other, please describe:

Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records

2a1.26 Data Source/Data Collection Instrument (Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.): Healthcare Effectiveness Data and Information Set (HEDIS)

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment:

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:

2a1.33 Level of Analysis (Check the levels of analysis for which the measure is specified and tested): Clinician : Group/Practice, Clinician : Individual, Health Plan

2a1.34-35 Care Setting (Check all the settings for which the measure is specified and tested): Ambulatory Care : Clinician Office

2a2. Reliability Testing. (Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability.)

2a2.1 Data/Sample (Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

HEDIS Health Plan performance data from 2010

2a2.2 Analytic Method (Describe method of reliability testing & rationale):

Reliability was estimated by using the beta-binomial model. Beta-binomial is a better fit when estimating the reliability of simple pass/fail rate measures as is the case with most HEDIS® health plan measures. The beta-binomial model assumes the plan score is a binomial random variable conditional on the plan's true value that comes from the beta distribution. The beta distribution is usually defined by two parameters, alpha and beta. Alpha and beta can be thought of as intermediate calculations to get to the needed variance estimates. The beta distribution can be symmetric, skewed or even U-shaped.

Reliability used here is the ratio of signal to noise. The signal in this case is the proportion of the variability in measured performance that can be explained by real differences in performance. A reliability of zero implies that all the variability in a measure is attributable to measurement error. A reliability of one implies that all the variability is attributable to real differences in performance. The higher the reliability score, the greater is the confidence with which one can distinguish the performance of one plan from another. A reliability score greater than or equal to 0.7 is considered very good.

2a2.3 Testing Results (Reliability statistics, assessment of adequacy in the context of norms for the test conducted):

The reliability statistic for Cervical Cancer Screening is 0.99

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H M L I

2b1.1 Describe how the measure specifications (measure focus, target population, and exclusions) are consistent with the evidence cited in support of the measure focus (criterion 1c) and identify any differences from the evidence:

The measure is aligned with current guidelines

2b2. Validity Testing. (Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.)

2b2.1 Data/Sample (Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

Field test data and first-year data

2b2.2 Analytic Method (Describe method of validity testing and rationale; if face validity, describe systematic assessment):

NCQA tested the measure for face validity using a panel of stakeholders with specific expertise in measurement. This panel included representatives from key stakeholder groups, including specialists' in women's health, oncologists, family practitioners, health plans, state Medicaid agencies and researchers. Experts reviewed the results of the field test and assessed whether the results were consistent with expectations, whether the measure represented quality care, and whether we were measuring the most important aspect of care in this area.

2b2.3 Testing Results (Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment):

This measure was deemed valid by the expert panel.

POTENTIAL THREATS TO VALIDITY. (All potential threats to validity were appropriately tested with adequate results.)

2b3. Measure Exclusions. (Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.)

2b3.1 Data/Sample for analysis of exclusions (Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

NCQA currently allows health plans for optional exclusion to their results. NCQA does not conduct the annual analysis applied to a sample. In measure development, field testing and any re-analysis for update, we investigate and validate the effect reliability exclusion applied to the eligible denominator.

2b3.2 Analytic Method (Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference):

2b3.3 Results (Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):

2b4. Risk Adjustment Strategy. (For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.)

2b4.1 Data/Sample (Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

2b4.2 Analytic Method (Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables):

2b4.3 Testing Results (Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata):

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: The measure assesses rate of cervical cancer screening in a general population; risk adjustment is not indicated.

2b5. Identification of Meaningful Differences in Performance. (The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.)

2b5.1 Data/Sample (Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

Data analysis demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful differences in performance.

2b5.2 Analytic Method (Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance):

Comparison of means and percentiles; analysis of variance against established benchmarks; if sample size is >400, we would use an analysis of variance

2b5.3 Results (Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance):

CCS - Reported Rate; Commercial

2009

N 243

MEAN 77.3

STDEV 4.97

STDERR 0.32

MIN 60.6

MAX 90.5

P10 71.2

P25 74.7

P50 77.7

P75 80.1

P90 82.5

Medicaid

CCS - Reported Rate	2009	2008	2007
N	136	165	136
MEAN	64.3	66.9	63.3
STDEV	12.4	10.7	11.9
STDERR	1.06	0.83	1.02
MIN	19.2	23.3	15.2
MAX	83.7	84.3	88.8
P10	49.4	54.1	49.1
P25	59.3	62	54.6
P50	67.4	68.1	66.5
P75	71.8	73.9	70.8
P90	77.1	79.6	76.4

2b6. Comparability of Multiple Data Sources/Methods. (If specified for more than one data source, the various approaches result in comparable scores.)

2b6.1 Data/Sample (Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):

2b6.2 Analytic Method (Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure):

During field testing, performance rates are calculated from administrative claims and compared to rates calculated from medical

record review.

2b6.3 Testing Results (Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted):

For all product lines, the rates for the measure have held relatively steady from 2003 through 2005 for commercial plans and for Medicaid plans. However, in 2006 commercial plans saw a small decrease in screening rates from 2005 (0.08 points); Medicaid saw a similar decrease in screening from 2006 to 2007 with a decrease in 1.0 points. The national rate for commercial plans in 2007 was 81.7%; Medicaid plans had a national rate of 64.7%.

2c. Disparities in Care: H M L I NA (If applicable, the measure specifications allow identification of disparities.)

2c.1 If measure is stratified for disparities, provide stratified results (Scores by stratified categories/cohorts): The measure is not stratified to detect disparities.

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?

(Reliability and Validity must be rated moderate or high) Yes No

Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (**evaluation criteria**)

C.1 Intended Purpose/ Use (Check all the purposes and/or uses for which the measure is intended): Public Reporting, Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

3.1 Current Use (Check all that apply; for any that are checked, provide the specific program information in the following questions): Public Reporting, Regulatory and Accreditation Programs, Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

3a. Usefulness for Public Reporting: H M L I

(The measure is meaningful, understandable and useful for public reporting.)

3a.1. Use in Public Reporting - disclosure of performance results to the public at large (If used in a public reporting program, provide name of program(s), locations, Web page URL(s)). If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: **[For Maintenance – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.]**

This measure is used in public reporting for plans only through Healthcare Effectiveness Data and Information Set (HEDIS) and is reported through venues such as the annual State of Healthcare Quality report, Quality Compass, America's Best Health Plans.

3a.2. Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: HEDIS measures adhere to the desirable attributes of scientific acceptability, feasibility and usability. The measures provide performance rates that are audited for consistency and accuracy.

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s): [The measure is part of federal reporting initiative, including Meaningful Use.](#)

3b. Usefulness for Quality Improvement: H M L I

(The measure is meaningful, understandable and useful for quality improvement.)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s): **[For Maintenance – If not used for QI, indicate the reasons and describe progress toward using performance results for improvement].**

[This is a measure in the HEDIS measurement set and is used in NCQA's Health Plan Accreditation program.](#)

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated (e.g., QI initiative), describe the data, method and results:

Overall, to what extent was the criterion, Usability, met? H M L I

Provide rationale based on specific subcriteria:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. **(evaluation criteria)**

4a. Data Generated as a Byproduct of Care Processes: H M L I

4a.1-2 How are the data elements needed to compute measure scores generated? *(Check all that apply).*

Data used in the measure are:

[generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, Coded by someone other than person obtaining original information \(e.g., DRG, ICD-9 codes on claims\), Abstracted from a record by someone other than person obtaining original information \(e.g., chart abstraction for quality measure or registry\)](#)

4b. Electronic Sources: H M L I

4b.1 Are the data elements needed for the measure as specified available electronically *(Elements that are needed to compute measure scores are in defined, computer-readable fields):* [ALL data elements are in a combination of electronic sources](#)

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources:

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H M L I

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:

[All measures that are used in NCQA programs are audited.](#)

4d. Data Collection Strategy/Implementation: H M L I

A.2 Please check if either of the following apply *(regarding proprietary measures):* [Proprietary measure](#)

4d.1 Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues *(e.g., fees for use of proprietary measures):*

[NCQA's multi-stakeholder advisory panels examined an analysis of the measure after its first year of reporting. The measure was deemed appropriate for public reporting. NCQA has processes to ensure coding and specifications are clear and updated when needed.](#)

Overall, to what extent was the criterion, Feasibility, met? H M L I

Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes No

Rationale:

If the Committee votes No, STOP.

If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND COMPETING MEASURES

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure before a final recommendation is made.

5.1 If there are related measures (either same measure focus or target population) or competing measures (both the same measure focus and same target population), list the NQF # and title of all related and/or competing measures:

0579 : Annual cervical cancer screening or follow-up in high-risk women

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized? No

5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:

#0579 focuses on high-risk patients and is a surveillance strategy. The NCQA measure is for routine preventive screening. These measures cover different patient populations and are well served by 2 measures. Where possible #0579 uses HEDIS criteria.

5b. Competing Measure(s)

5b.1 If this measure has both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible):

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005

Co.2 Point of Contact: Bob, Rehm, Assistant Vice President, Performance Measurement, Rehm@ncqa.org, 202-955-1728-

Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance, 1100 13th Street NW, Suite 1000, Washington, District Of Columbia, 20005

Co.4 Point of Contact: Bob, Rehm, Assistant Vice President, Performance Measurement, Rehm@ncqa.org, 202-955-1728-

Co.5 Submitter: Dawn, Alayon, MPH, CPH, Senior Health Care Analyst, alayon@ncqa.org, 202-955-3533-, National Committee for Quality Assurance

Co.6 Additional organizations that sponsored/participated in measure development:

Co.7 Public Contact: Bob, Rehm, Assistant Vice President, Performance Measurement, Rehm@ncqa.org, 202-955-3500-, National Committee for Quality Assurance

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development

Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

The NCQA Women & Child MAP advised NCQA during measure development. They evaluated the way staff specified measures, assessed the content validity of measures, and reviewed field test results. As you can see from the list, the MAP consisted of a balanced group of experts. Note that, in addition to the MAP, we also vetted these measures with a host of other stakeholders, as is our process. Thus, our measures are the result of consensus from a broad and diverse group of stakeholders, in addition to the MAP.

Women & Child Measurement Advisory Panel (WCMAP)

Member List

Bill Hueston, MD (chair)

Thomas J. Benedetti, MD (JCAHO)

Robin S. Richman, MD, FACOG

Robert H. Pantell, MD

Shirley Girouard

Grant P. Bagley, MD, JD

Maureen Shannon, CNM, FNP, MS

Milton Kotelchuck, PhD, MPH

David Archer, MD

Mark Pearlman MD

Christopher B. Forrest, MD, PhD

Dorothy Mann PhD, MPH

Jeff Susman, MD

Denise Dougherty

Charles Homer MD, MPH

Lynne S. Wilcox, MD, MPH

Mary Kay Holleran

Marilyn C. Jones, MD (AMA)

Michael G. Ross, MD, MPH (JCAHO)

Mark Mandell, M.D.

Lee Partridge

Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward: NA

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.3 Year the measure was first released: 1994

Ad.4 Month and Year of most recent revision: 2009

Ad.5 What is your frequency for review/update of this measure? Approximately every three years

Ad.6 When is the next scheduled review/update for this measure? 2012

Ad.7 Copyright statement: © June 29, 2011 by the National Committee for Quality Assurance

1100 13th Street, NW, Suite 1000

Washington, DC 20005

Ad.8 Disclaimers:

Ad.9 Additional Information/Comments:

Date of Submission (MM/DD/YY): 07/12/2011