



Health Benchmarks®
Clinical Quality Indicator Specification 2007

Client	HEALTH BENCHMARKS, INC. STANDARD ALGORITHM <i>Implemented for Blue Cross Blue Shield of Texas</i>	
Measure Title	CERVICAL CANCER SCREENING	
Disease State	Cervical Cancer	Indicator Classification¹ Screening
Strength of Recommendation²	A	
Organizations Providing Recommendation	NCQA (HEDIS 2007 Technical Specification), The United States Preventive Services Task Force, The American Cancer Society, The American Academy of Family Physicians, The American College of Obstetricians and Gynecologists, The American College of Preventive Medicine, The American Medical Association, The Canadian Task Force on Preventive Health Care, The American Academy of Pediatrics	
Clinical Intent	To ensure that all eligible women within a designated age group receive a cervical cancer screening test at a clinically appropriate frequency.	
Physician Specialties	Family Practice, Internal Medicine, Obstetrics-Gynecology	
Clinical Rationale	<p>Disease Burden</p> <ul style="list-style-type: none"> • In the United States, an estimated 9,710 new cases of invasive cervical cancer are diagnosed annually, and there are 3,700 deaths from the disease; this represents 1.3 percent of cancer deaths in women.[1] • All sexually active women are at risk of cervical cancer, however, the disease is more prevalent in women who have had multiple sexual partners, women who became sexually active at an early age, and women who smoke.[2-5] <p>Reason for Indicated Intervention or Treatment</p> <ul style="list-style-type: none"> • The United States Preventive Services Task Force (USPSTF) found that screening with cervical cytology (Pap smears) reduces mortality from cervical cancer.[6] <p>Evidence supporting Intervention or Treatment</p> <ul style="list-style-type: none"> • Epidemiological studies from the United States, Europe, and Canada have detected a dramatic reduction in invasive cervical cancer disease and a 20-60% reduction in cervical cancer mortality after the implementation of universal screening for cervical cancer with Pap smears.[7-14] • Case control studies have also shown that screening is protective by demonstrating a strong negative association between screening and invasive disease.[15-19] • Screening programs introduced to populations naïve to screening have been shown to reduce cervical cancer rates by 60 to 90 percent within three years of implementation.[20, 21] • No randomized, controlled trials of screening with Pap smears have been conducted. 	

Clinical Recommendations

- The USPSTF “strongly recommends” cervical cancer screening in all women who are sexually active and who have a cervix.[6]
- The USPSTF recommends against routine screening of women aged 65 and older if they have had “adequate recent screening” and are not at high risk of the disease.[6]
- The USPSTF concluded that the evidence is insufficient to recommend for or against the routine use of technologies other than the conventional Pap smear.[6]
- The American Cancer Society recommends that women be screened for cervical cancer beginning 3 years after the onset of sexual activity but not later than age 21. Screening should be performed either annually with Pap smears or every 2 years if liquid based cytology is used, until age 30. Based on past screening results and risk factors, the screening interval may be extended to 2-3 years.[22]
- Other organizations which recommend screening starting at age 18 or with the onset of sexual activity include: the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), the American College of Preventive Medicine (ACPM), the American Medical Association (AMA), the Canadian Task Force on Preventive Health Care (CTFPHC), and the American Academy of Pediatrics (AAP), among others.[23-27]

Source	Health Plan Employer Data and Information Set (HEDIS®) 2007 Technical Specification
Denominator	Continuously enrolled women ages 24 – 64 years by the end of measurement year.
Denominator Exclusion	Women with a hysterectomy with no residual cervix at any time in the member’s history through the end of the measurement year.
Numerator	Members who had at least one cervical cancer screening test during the measurement year or within the two years prior to the measurement year.
Interpretation of Score	High score implies better performance
Physician Attribution	Score all physicians (in the selected specialties) who saw the member during the measurement year.

References	<ol style="list-style-type: none">1. Jemal, A., et al., <i>Cancer statistics, 2006</i>. CA Cancer J Clin, 2006. 56(2): p. 106-30.2. Schottenfeld, D. and F. Jfe., <i>Cancer Epidemiology and Prevention</i>. Second ed. 1996, New York: Oxford University Press.3. de Vet, H.C., F. Sturmans, and P.G. Knipschild, <i>The role of cigarette smoking in the etiology of cervical dysplasia</i>. Epidemiology, 1994. 5(6): p. 631-3.4. Lyon, J.L., et al., <i>Smoking and carcinoma in situ of the uterine cervix</i>. Am J Public Health, 1983. 73(5): p. 558-62.5. Winkelstein, W., Jr., <i>Smoking and cervical cancer--current status: a review</i>. Am J Epidemiol, 1990. 131(6): p. 945-57; discussion 958-60.6. Berg, A.O., <i>Screening for Cervical Cancer: Recommendations and</i>
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¹ **Indicator Classification** (Adapted from Health Plan Employer Data Information Set (HEDIS®) technical specifications)

Diagnosis	Measures applicable to patients receiving diagnostic workups for a symptom or condition that delineate appropriate laboratory or radiological testing to be performed (e.g. evaluation of thyroid nodule; pregnancy test in patients with vaginal bleeding or abdominal pain)
Effectiveness of Care	
Prevention	Measures applicable to asymptomatic individuals that are designed to prevent the onset of the targeted condition (e.g. immunizations).
Screening	Measures applicable to asymptomatic patients who have risk factors or pre-clinical disease, but in whom the condition has not become clinically apparent (e.g. pap smears; screening for elevated blood pressure).
Disease Management	Measures applicable to individuals diagnosed with a condition that are part of the treatment or management of the condition (e.g. cholesterol reduction in patients with diabetes; radiation therapy following breast conserving surgery; appropriate follow-up after acute event).
Medication Monitoring	Measures applicable to patients taking medications with narrow therapeutic windows and / or potential preventable significant side effects or adverse reactions (e.g. thyroid stimulating hormone (TSH) testing after levothyroxine dose change; hepatic enzyme monitoring for patients using antimycotic pharmacotherapy)
Medication Adherence	Measures applicable to patients taking medications for chronic conditions that are designed to assess patient adherence to medication (e.g. adherence to lipid lowering medication).
Utilization	Measures applicable to patients receiving treatment for a symptom or condition that advocate appropriate utilization of laboratory and pharmaceutical resources (e.g. conservative use of imaging for low back pain; inappropriate use of antibiotics for viral upper respiratory infection).

² Strength of Recommendation

Strength of Recommendation Based on a Body of Evidence

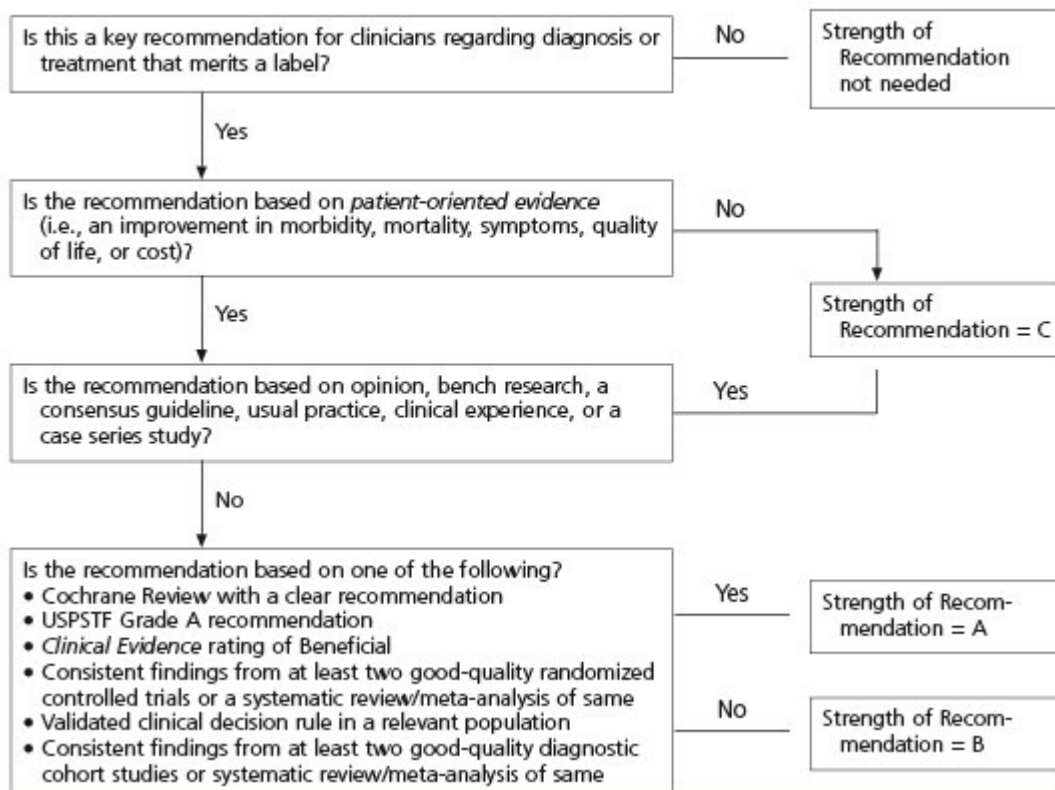


FIGURE 2. Algorithm for determining the strength of a recommendation based on a body of evidence (applies to clinical recommendations regarding diagnosis, treatment, prevention, or screening). While this algorithm provides a general guideline, authors and editors may adjust the strength of recommendation based on the benefits, harms, and costs of the intervention being recommended. (USPSTF = U.S. Preventive Services Task Force)