

Proposed Minimum and Aspirational Quality Measures for the Colposcopic Exam

Recommendation	Context/background	Calculation for individual provider or group of providers	Minimum Target	Aspirational Target	References and notes
#1 Document that squamo-columnar junction visualized (fully/partial/not)	Adequate visualization at the time of colposcopy is important in management of abnormal screening tests. Lack of such visualization can alter management	Numerator: N colposcopy notes with documentation of visualized (fully/partial/not) Denominator: N total colposcopies performed by individual provider or group	90	100	Massad et al. ASCCP management guidelines (J Low Genit Tract Dis. 2013 Apr;17(5 Suppl 1):S1-S27) WHO: IARC 2003, European Federation of Colposcopy 2013, New Zealand 2013, ECF 2013
#2 Document if any acetowhite lesion is present (yes/no)	Documentation of presence of a lesion is important in correlating histopathologic data and appropriate management. Lack of such documentation can alter management and lead to less optimal outcomes	Numerator: N colposcopy notes with documentation of lesion present Denominator: N total colposcopies performed by individual provider or group	90%	100%	Massad et al. ASCCP management guidelines (J Low Genit Tract Dis. 2013 Apr;17(5 Suppl 1):S1-S27) British 2016, New Zealand 2013, Italian 2006
#3 Document of colposcopic impression (normal/benign; low grade; high grade; cancer)	Documentation of colposcopic impression is helpful in quality assurance and precision metrics for colposcopy	Numerator: N colposcopy notes with documentation of colposcopic impression Denominator: N total colposcopies performed by individual provider or group	80%	100	Australia 2016 draft, British 2016, WHO: IARC 2003, New Zealand 2013
#4 Documentation of cervix visibility (fully/partial/not)	Adequate visualization of the cervix at the time of colposcopy is important in management of abnormal screening tests. Lack of or partial visualization can alter management	Numerator: N colposcopy notes with documentation of adequate visualization of the cervix at the time of colposcopy Denominator: N total colposcopies performed by individual provider or group	70%	100	British 2016, WHO: IARC 2003, New Zealand 2013
#5 Documentation of Extent of Lesion Visualized (fully/partial)	Adequate visualization of the extent of the lesion(s) at the time of colposcopy is important in management of abnormal screening tests. Partial visualization of the	Numerator: N colposcopy notes with documentation of visualization of extent of any/all lesion(s) or no lesion Denominator: N total colposcopies performed by individual provider or group	70%	100	British 2016, WHO: IARC 2003, New Zealand 2013

	lesion(s) can alter management				
#6 Documentation of Location of Lesion(s)	Documentation of number of cervical quadrants and extent of lesion involved in any abnormality. Larger lesions tend to 1) be less likely to regress spontaneously, 2) be correlated with inadequate colposcopy, 3) margin positivity with LEEP more common	Numerator: N colposcopy notes with documentation of location of the lesion(s) or no lesion Denominator: N total colposcopies performed by individual provider or group	70%	100	Australia 2016 draft, New Zealand 2013
#7 Provider should take multiple biopsies targeting all areas with acetowhitening, metaplasia or higher abnormalities (at least two and up to four biopsies)	Many studies have shown that taking a single biopsy targeting the worst appearing lesion may miss up to a third of prevalent precancers (Gage, Pretorius, Stoler, Wentzensen, others). In the NCI Biopsy Study, which used a very low threshold of colposcopic abnormality (any acetowhitening), the yield of precancer increased substantially from the first to second and second to third biopsies. A fourth targeted biopsy, or an additional non-targeted biopsy (random biopsy) only provided a minimal increase in disease yield.	Numerator: N colposcopy notes with documentation of any acetowhite lesion and 2 to 4 biopsies taken OR a biopsy and endocervical sampling taken. Denominator: N colposcopy notes with documentation of any acetowhite lesion	85	100	British 2016, Canadian 2012, Australia 2016 draft (in more than 95% of women with HG abnormalities), Gage JC Obstet Gynecol 108:264-72, 2006; Stoler MH Int J Cancer 128:1354-62, 2011; Pretorius RG Am J Obstet Gynecol 191:430-34; 2004; Pretorius RG JLGTD 16:333-8, 2012; Wentzensen N JCO 33:83-9, 2015
#8 An attempt should be made to contact a patient with suspected invasive disease * within 2 weeks of receipt of report or referral.	Multiple factors for contacting a patient with a high acuity abnormality identified in screening including 1) screening environment, 2) insurance	Numerator: N of patients with suspected invasive disease with attempted contact within 2 weeks Denominator: N of patients with suspected invasive disease	60%	90%	New Zealand 2013 (call within 10 days). Expert/committee opinion.

	status, 3) patient communication abilities, 4) social/cultural barriers. In a system-based approach, the layers and logistics of a system should be able to prioritize this communication, which includes availability of contact information by phone or mail or emergency contact				
#9 Patients with suspected invasive disease should be seen within 2 weeks of contact.	Multiple factors for a patient to be seen in a short interval if identified with a high acuity abnormality including 1) screening environment, 2) insurance status, 3) patient communication abilities, 4) social/cultural barriers, 5) provider availability. In a system-based approach, the layers and logistics of a system should be able to prioritize this communication and ability to extend access to a patient, which might include logistical assistance	Numerator: N of patients with suspected invasive disease seen within 2 weeks of contact Denominator: N of patients with suspected invasive disease	60%	90%	New Zealand 2013 (call within 10 days). Expert/committee opinion.
#10 An attempt should be made to contact a patient with high grade Pap results** within 4 weeks of receipt of report or referral.	Multiple factors for contacting a patient with a high acuity abnormality identified in screening including 1) screening environment, 2) insurance status, 3) patient communication abilities, 4) social/cultural barriers. In a system-based approach, the layers and logistics of a	Numerator: N of patients with high-grade Pap results** with attempted contact within 4 weeks Denominator: N of Pap tests with high grade disease	60%	90%	New Zealand 2013 (call within 10 days). Expert/committee opinion.

	system should be able to prioritize this communication, which includes availability of contact information by phone or mail or emergency contact				
#11 Patients with high grade Pap results** should be seen within 4 weeks of contact.	Multiple factors for a patient to be seen in a short interval if identified with a high acuity abnormality including 1) screening environment, 2) insurance status, 3) patient communication abilities, 4) social/cultural barriers, 5) provider availability. In a system-based approach, the layers and logistics of a system should be able to prioritize this communication and ability to extend access to a patient, which might include logistical assistance	Numerator: N of patients with high-grade Pap results** seen within 4 weeks of contact Denominator: N of Pap tests with high grade disease	60%	90%	New Zealand 2013 (call within 10 days). Expert/committee opinion.

*Suspected invasive disease includes Pap tests with neoplasia or suspected neoplasia or with clinical suspicion for invasive disease.

**A high grade Pap result includes any of the following cytology results: High-grade Squamous Intraepithelial Lesion (HSIL), Atypical Squamous Cells: Cannot Exclude High-grade SIL (ASC-H), Atypical Glandular Cells (AGC)