

NATIONAL QUALITY FORUM

Measure Evaluation 4.1 December 2009

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The subcriteria and most of the footnotes from the evaluation criteria are provided in Word comments within the form and will appear if your cursor is over the highlighted area. Hyperlinks to the evaluation criteria and ratings are provided in each section.

TAP/Workgroup (if utilized): Complete all **yellow highlighted** areas of the form. Evaluate the extent to which each subcriterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

Note: *If there is no TAP or workgroup, the SC also evaluates the subcriteria (yellow highlighted areas).*

Steering Committee: Complete all **pink** highlighted areas of the form. Review the workgroup/TAP assessment of the subcriteria, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

Evaluation ratings of the extent to which the criteria are met

C = Completely (unquestionably demonstrated to meet the criterion)

P = Partially (demonstrated to partially meet the criterion)

M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)

N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)

NA = Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) NQF Review #: PSM-039-10 NQF Project: Patient Safety Measures
MEASURE DESCRIPTIVE INFORMATION
De.1 Measure Title: Third or fourth degree laceration of the perineum
De.2 Brief description of measure: Number of women who suffer a 3rd or 4th degree laceration of the perineum during vaginal delivery.
1.1-2 Type of Measure: Outcome De.3 If included in a composite or paired with another measure, please identify composite or paired measure Adverse Outcome Index, Weighted Adverse Outcome Score and Severity Index
De.4 National Priority Partners Priority Area: Safety De.5 IOM Quality Domain: Safety De.6 Consumer Care Need: Staying healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	NQF Staff
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. <i>Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.</i> A.1 Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes A.2 Indicate if Proprietary Measure (as defined in measure steward agreement): A.3 Measure Steward Agreement: Agreement will be signed and submitted prior to or at the time of measure submission A.4 Measure Steward Agreement attached:	A Y <input type="checkbox"/> N <input type="checkbox"/>
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and	B

update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. Yes, information provided in contact section	Y <input type="checkbox"/> N <input type="checkbox"/>
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ► Purpose: Public reporting, Internal quality improvement	C Y <input type="checkbox"/> N <input type="checkbox"/>
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement. D.1 Testing: Yes, fully developed and tested D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures? Yes	D Y <input type="checkbox"/> N <input type="checkbox"/>
(for NQF staff use) Have all conditions for consideration been met? Staff Notes to Steward (if submission returned):	Met Y <input type="checkbox"/> N <input type="checkbox"/>
Staff Notes to Reviewers (issues or questions regarding any criteria):	
Staff Reviewer Name(s):	

TAP/Workgroup Reviewer Name:	
Steering Committee Reviewer Name:	
1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. <i>Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.</i> (evaluation criteria) 1a. High Impact	Eval Rati ng
(for NQF staff use) Specific NPP goal:	
1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, Other 1a.2 Addresses NPP Goal: Safety 1a.3 Summary of Evidence of High Impact: Delivery hospitalization is one of the highest volume reasons for admission to a hospital. 3rd or 4th degree laceration is a serious OB injury with potential long term impact on the woman. 1a.4 Citations for Evidence of High Impact:	1a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
1b. Opportunity for Improvement 1b.1 Benefits (improvements in quality) envisioned by use of this measure: Third or fourth degree perineal tear is a commonly tracked adverse event in obstetric care (AHRQ, Joint Commission). Obstetric management, especially use of episiotomy and forceps delivery, strongly influences the rate of perineal tear. In addition, vaginal delivery of a large baby and prolonged second stage of labor, both influenced by obstetric decision making, are also associated with increased rates of perineal tears. Thus, this complication is frequently preventable. 1) http://www.qualitymeasures.ahrq.gov/summary/summary.aspx?doc_id=12735 . 2) http://www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement/Pregnancy+and+Re	1b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>

lated+Conditions+Core+Measure+Set.htm

3) Ogunyemi D, Manigat B, Marquis J, Bazargan M. Demographic variations and clinical associations of episiotomy and severe perineal lacerations in vaginal delivery. J Natl Med Assoc. 2006 Nov;98(11):1874-8.

4) Dandolu V, Chatwani A, Harmanli O, et al. Risk factors for obstetrical anal sphincter lacerations. Int Urogynecol J Pelvic Floor Dysfunct. 2005;16:304-7.

5) Mikolajczyk RT, Zhang J, Troendle J, Chan L. Risk factors for birth canal lacerations in primiparous women. Am J Perinatol. 2008 May;25(5):259-64.

6) Kudish B, Blackwell S, Mcneeley SG, et al. Operative vaginal delivery and midline episiotomy: a bad combination for the perineum. Am J Obstet Gynecol. 2006 Sep;195(3):749-54.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:

This measure is part of the AOI composite measure with a weight of 5 points. Please see AOI composite submission for details on variation in performance.

1b.3 Citations for data on performance gap:

1b.4 Summary of Data on disparities by population group:

Some data suggest that African American race is an independent risk factor for perineal tear.

1b.5 Citations for data on Disparities:

Ogunyemi D, Manigat B, Marquis J, Bazargan M. Demographic variations and clinical associations of episiotomy and severe perineal lacerations in vaginal delivery. J Natl Med Assoc. 2006 Nov;98(11):1874-81.

1c. Outcome or Evidence to Support Measure Focus

1c.1 Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population*): The rate of 3rd or 4th degree perineal tear may exceed 40% in some populations. This complication is associated with perineal pain and anal incontinence.

1c.2-3. Type of Evidence:

1c.4 Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*):

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom*):

1c.6 Method for rating evidence:

1c.7 Summary of Controversy/Contradictory Evidence:

1c.8 Citations for Evidence (*other than guidelines*):

1c.9 Quote the Specific guideline recommendation (*including guideline number and/or page number*):

1c.10 Clinical Practice Guideline Citation:

1c.11 National Guideline Clearinghouse or other URL:

1c
C
P
M
N

<p>1c.12 Rating of strength of recommendation (<i>also provide narrative description of the rating and by whom</i>):</p> <p>1c.13 Method for rating strength of recommendation (<i>If different from USPSTF system, also describe rating and how it relates to USPSTF</i>):</p> <p>1c.14 Rationale for using this guideline over others:</p>	
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Importance to Measure and Report</i>?</p>	1
<p>Steering Committee: Was the threshold criterion, <i>Importance to Measure and Report</i>, met? Rationale:</p>	<p>1 Y <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES</p>	
<p>Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria)</p>	Eval Rati ng
<p>2a. MEASURE SPECIFICATIONS</p>	
<p>S.1 Do you have a web page where current detailed measure specifications can be obtained? S.2 If yes, provide web page URL:</p> <p>2a. Precisely Specified</p>	
<p>2a.1 Numerator Statement (<i>Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome</i>): All women who meet above criteria</p> <p>2a.2 Numerator Time Window (<i>The time period in which cases are eligible for inclusion in the numerator</i>): Occurring during delivery hospitalization only. Can be run for any period of time to determine rate</p> <p>2a.3 Numerator Details (<i>All information required to collect/calculate the numerator, including all codes, logic, and definitions</i>): DRG 370 - 375 or MS DRG 765-768 or 774-775 with diagnosis codes 664.2 - 3rd degree perineal laceration or 664.3 4th degree perineal laceration</p>	
<p>2a.4 Denominator Statement (<i>Brief, text description of the denominator - target population being measured</i>): All women with vaginal delivery.</p> <p>2a.5 Target population gender: Female</p> <p>2a.6 Target population age range:</p> <p>2a.7 Denominator Time Window (<i>The time period in which cases are eligible for inclusion in the denominator</i>): Same as numerator</p> <p>2a.8 Denominator Details (<i>All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions</i>): DRGs 370-375 or MS DRGs 765-768 and 774-775</p>	<p>2a- spec s C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2a.9 Denominator Exclusions (<i>Brief text description of exclusions from the target population</i>): None</p>	

<p>2a.10 Denominator Exclusion Details (<i>All information required to collect exclusions to the denominator, including all codes, logic, and definitions</i>):</p>	
<p>2a.11 Stratification Details/Variables (<i>All information required to stratify the measure including the stratification variables, all codes, logic, and definitions</i>): None</p>	
<p>2a.12-13 Risk Adjustment Type: No risk adjustment necessary</p>	
<p>2a.14 Risk Adjustment Methodology/Variables (<i>List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method</i>):</p>	
<p>2a.15-17 Detailed risk model available Web page URL or attachment:</p>	
<p>2a.18-19 Type of Score: Rate/proportion</p>	
<p>2a.20 Interpretation of Score: Better quality = Lower score</p>	
<p>2a.21 Calculation Algorithm (<i>Describe the calculation of the measure as a flowchart or series of steps</i>): 1) identify all delivered women for the time period under review 2) scan dx code string for all codes of 664.2 - 3rd degree perineal laceration or 664.3 4th degree perineal laceration 3) establish count of cases for the time period. This measure is part of the Adverse Outcome Index composite measure; please see AOI composite submission.</p>	
<p>2a.22 Describe the method for discriminating performance (<i>e.g., significance testing</i>): This measure is part of the Adverse Outcome Index composite measure; please see AOI composite submission.</p>	
<p>2a.23 Sampling (Survey) Methodology <i>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):</i></p>	
<p>2a.24 Data Source (<i>Check the source(s) for which the measure is specified and tested</i>) Electronic administrative data/claims, Electronic clinical data, Public health data/vital statistics, Electronic Health/Medical Record</p>	
<p>2a.25 Data source/data collection instrument (<i>Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.</i>): Administrative data UB04</p>	
<p>2a.26-28 Data source/data collection instrument reference web page URL or attachment:</p>	
<p>2a.29-31 Data dictionary/code table web page URL or attachment: URL www.npic.org Sample AOI report</p>	
<p>2a.32-35 Level of Measurement/Analysis (<i>Check the level(s) for which the measure is specified and tested</i>) Can be measured at all levels</p>	
<p>2a.36-37 Care Settings (<i>Check the setting(s) for which the measure is specified and tested</i>) Hospital</p>	
<p>2a.38-41 Clinical Services (<i>Healthcare services being measured, check all that apply</i>) Clinicians: Nurses, Clinicians: Physicians (MD/DO), Clinicians: Other non-clinical L&D staff</p>	
<p>TESTING/ANALYSIS</p>	
<p>2b. Reliability testing</p> <p>2b.1 Data/sample (<i>description of data/sample and size</i>): Administrative data for Beth Israel Deaconess</p>	<p>2b C <input type="checkbox"/> P <input type="checkbox"/></p>

<p>Medical Center for the period Q 3, 2005- Q2 2006 was reconciled with abstracted data for the same period.</p> <p>2b.2 Analytic Method (<i>type of reliability & rationale, method for testing</i>): Case by case review</p> <p>2b.3 Testing Results (<i>reliability statistics, assessment of adequacy in the context of norms for the test conducted</i>): Administrative and audited data had a strong match.</p>	<p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>2c. Validity testing</p> <p>2c.1 Data/sample (<i>description of data/sample and size</i>): Beth Israel Deconess Medical Center has been tracking this adverse event as part of their Adverse Outcome Index since early 2001.</p> <p>2c.2 Analytic Method (<i>type of validity & rationale, method for testing</i>): Chart review and analysis of the administrative data set for all deliveries during the period.</p> <p>2c.3 Testing Results (<i>statistical results, assessment of adequacy in the context of norms for the test conducted</i>): Tracking and monitoring perineal tears has decreased this adverse event during this period.</p>	<p>2c</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>2d. Exclusions Justified</p> <p>2d.1 Summary of Evidence supporting exclusion(s):</p> <p>2d.2 Citations for Evidence:</p> <p>2d.3 Data/sample (<i>description of data/sample and size</i>):</p> <p>2d.4 Analytic Method (<i>type analysis & rationale</i>):</p> <p>2d.5 Testing Results (<i>e.g., frequency, variability, sensitivity analyses</i>):</p>	<p>2d</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>2e. Risk Adjustment for Outcomes/ Resource Use Measures</p> <p>2e.1 Data/sample (<i>description of data/sample and size</i>):</p> <p>2e.2 Analytic Method (<i>type of risk adjustment, analysis, & rationale</i>):</p> <p>2e.3 Testing Results (<i>risk model performance metrics</i>):</p> <p>2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:</p>	<p>2e</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>2f. Identification of Meaningful Differences in Performance</p> <p>2f.1 Data/sample from Testing or Current Use (<i>description of data/sample and size</i>): This measure has been individually tracked as part of a composite measure. It has been used in three published reports (see references), totalling more than 50,000 deliveries. In addition, the National Perinatal Information center has tracked this across a wide range of clinical settings, totally nearly 500,000 deliveries.</p> <p>1) Nielsen PE, Goldman MB, Mann S, Shapiro DE, Marcus RG, Pratt SD, et al. Effects of teamwork training on adverse outcomes and process of care in labor and delivery: a randomized controlled trial. <i>Obstet Gynecol</i> 2007; 109:48-55.</p>	<p>2f</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>

<p>2) Pratt SD, Mann S, Salisbury M, et al. Impact of CRM-based team training on obstetric outcomes and clinicians' patient safety attitude. <i>Joint Commission Journal on Quality and Patient Safety</i> 2007; 33:720-5.</p> <p>3) Nicholson JM, Parry S, Caughey AB, et al. The impact of the active management of risk in pregnancy at term on birth outcomes: a randomized clinical trial. <i>Am J Obstet Gynecol.</i> 2008; 198:511.e1-15.</p> <p>2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance (type of analysis & rationale):</p> <p>2f.3 Provide Measure Scores from Testing or Current Use (description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance):</p>	
<p>2g. Comparability of Multiple Data Sources/Methods</p> <p>2g.1 Data/sample (description of data/sample and size): All Beth Israel cases between Q 3-2005 and Q2 2006 were reconciled using abstracted data.</p> <p>2g.2 Analytic Method (type of analysis & rationale): chart review</p> <p>2g.3 Testing Results (e.g., correlation statistics, comparison of rankings): Administrative and audited data had a strong match.</p>	<p>2g C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>2h. Disparities in Care</p> <p>2h.1 If measure is stratified, provide stratified results (scores by stratified categories/cohorts):</p> <p>2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:</p>	<p>2h C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Scientific Acceptability of Measure Properties</i>?</p>	<p>2</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Scientific Acceptability of Measure Properties</i>, met? Rationale:</p>	<p>2 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
3. USABILITY	
<p>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)</p>	<p>Eval Rati ng</p>
<p>3a. Meaningful, Understandable, and Useful Information</p> <p>3a.1 Current Use: In use</p> <p>3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large) (If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years): Used in a public reporting initiative- The Joint Commission</p> <p>3a.3 If used in other programs/initiatives (If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years):</p>	<p>3a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

<p>As part of the AOI composite measure it has been used to report to numerous NPIC members, hospitals involved in the Maryland Patient Safety Initiative and the Permier Perinatal Patient Safety Initiative and Navy Military Treatment Facilities reporting.</p> <p>Testing of Interpretability (<i>Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement</i>)</p> <p>3a.4 Data/sample (<i>description of data/sample and size</i>): The measure is part of the AOI composite measure. Please see AOI composite submission for interpretability discussion.</p> <p>3a.5 Methods (<i>e.g., focus group, survey, QI project</i>): The measure is part of the AOI composite measure. Please see AOI composite submission for interpretability discussion.</p> <p>3a.6 Results (<i>qualitative and/or quantitative results and conclusions</i>): The measure is part of the AOI composite measure. Please see AOI composite submission for interpretability discussion.</p>	
<p>3b/3c. Relation to other NQF-endorsed measures</p> <p>3b.1 NQF # and Title of similar or related measures:</p>	
<p>(for NQF staff use) Notes on similar/related endorsed or submitted measures:</p>	
<p>3b. Harmonization If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source <u>or</u> different topic but same target population):</p> <p>3b.2 Are the measure specifications harmonized? If not, why?</p>	<p>3b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>3c. Distinctive or Additive Value</p> <p>3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:</p> <p>5.1 If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), Describe why it is a more valid or efficient way to measure quality:</p>	<p>3c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Usability</i>?</p>	<p>3</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Usability</i>, met? Rationale:</p>	<p>3 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
4. FEASIBILITY	
<p>Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)</p>	<p>Eval Rati ng</p>
<p>4a. Data Generated as a Byproduct of Care Processes</p> <p>4a.1-2 How are the data elements that are needed to compute measure scores generated? Data generated as byproduct of care processes during care delivery (Data are generated and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition), Coding/abstraction performed by someone other than person obtaining original information (E.g., DRG, ICD-9 codes on claims, chart abstraction for quality measure or registry)</p>	<p>4a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

<p>4b. Electronic Sources</p> <p>4b.1 Are all the data elements available electronically? (<i>elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims</i>) Yes</p> <p>4b.2 If not, specify the near-term path to achieve electronic capture by most providers.</p>	<p>4b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>4c. Exclusions</p> <p>4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? No</p> <p>4c.2 If yes, provide justification.</p>	<p>4c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences</p> <p>4d.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results. Correct documentation and coding are key to the accuracy of this measure. Coders will code a second degree tear with an extension as a third degree. If providers are not aware of this, the rate can be overstated.</p> <p>Potential problems could be audited by: Providing case counts and MRNs for numerator cases can help hospitals audit their data for incompleting documentation or incorrect coding.</p> <p>These potential problems were audited during testing. Problems at test sites were minimal but provided opportunity for provider and coder education.</p>	<p>4d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>4e. Data Collection Strategy/Implementation</p> <p>4e.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/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: Administrative data has improved greatly over the years such that it is a very liable source for calculating quality measure/indicator rates. It is a standard data set across all health care facilities, maintains patient confidentiality, is cost effective to collect and analyze, and can be collected at reasonable intervals (monthly, quarterly etc) so as to identify improvements or deterioration in patient safety. As with any measuring system, facilities being measured should have the opportunity to review and validate their data prior to their final rate calculations. Numerator case lists can be generated using medical record numbers present on most administrative data sets. Chart review to confirm or correct numerator cases has proven very effective in validating measure rates.</p> <p>4e.2 Costs to implement the measure (<i>costs of data collection, fees associated with proprietary measures</i>): The administrative data set is a secondary data source so the cost to collect and analyze the data is very reasonable.</p> <p>4e.3 Evidence for costs: NPIC 's years of data collection and submission of data to the Joint Commission and reporting laceration rates to member hospitals.</p> <p>4e.4 Business case documentation: See AOI composite submission.</p>	<p>4e C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the subcriteria for <i>Feasibility</i>?</p>	<p>4</p>
<p>Steering Committee: Overall, to what extent was the criterion, <i>Feasibility</i>, met? Rationale:</p>	<p>4 C <input type="checkbox"/></p>

	P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
RECOMMENDATION	
(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.	Time-limited <input type="checkbox"/>
Steering Committee: Do you recommend for endorsement? Comments:	Y <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/>
CONTACT INFORMATION	
Co.1 Measure Steward (Intellectual Property Owner) Co.1 Organization Department of OB/Gyn. Beth Israel Deaconess Medical Center, 330 Brookline Ave, Boston, Massachusetts, 02215 Co.2 Point of Contact Janet, Muri, MBA, jmuri@npic.org, 401-274-0650-105	
Measure Developer If different from Measure Steward Co.3 Organization Department of OB/Gyn. Beth Israel Deaconess Medical Center, 330 Brookline Ave, Boston, Massachusetts, 02215 Co.4 Point of Contact Susan, Mann, MD, smann@bidmc.harvard.edu, 617-504-0728-	
Co.5 Submitter If different from Measure Steward POC Stephen, Pratt, MD, spratt@bidmc.harvard.edu, 617-667-3353-, Dept Of Anesthesia, Beth Israel Deaconess Medical Center	
Co.6 Additional organizations that sponsored/participated in measure development	
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. Peter E. Nielsen, MD; Marlene B. Goldman, ScD; Susan Mann, MD; David E. Shapiro, PhD; Ronald G. Marcus, MB, BCh; Stephen D. Pratt, MD; Penny Greenberg, RN; Patricia McNamee, RN, MS; Mary Salisbury, RN, MSN; David J. Birnbach, MD; Paul A. Gluck, MD; Mark D. Pearlman, MD; Heidi King, MS; David N. Tornberg, MD MPH; Benjamin P. Sachs, MB, BS; Lauren Bales, MD, Naval Medical Center Camp Pendleton; Ronald Burkman, MD, Baystate Medical Center; Cynthia Brumfield, MD, University of Alabama at Birmingham Hospital; Peter Cherouny, MD, University of Vermont-Fletcher Allen Health Care; Jack Cooley, MD, National Naval Medical Center; Harold Fox, MD, Johns Hopkins Medical Center; Elizabeth Golladay, MD, Tripler Army Medical Center; Lynn Leventis, MD, Naval Medical Center of San Diego; Robert Lorenz, MD, William Beaumont Hospital; William Lucky, MD, Baptist Hospital of Miami; Patrick Nugent, MD, South Shore Hospital; Spike Lipschitz, MD, South Shore Hospital; Chris Stolle, MD, Naval Medical Center of Portsmouth; Cosmas van DeVen, MD, University of Michigan Medical Center; Frank Witter, MD, Johns Hopkins Medical Center. In addition, representatives from the American College of Obstetrics and Gynecology, the American Society of Anesthesiologists, Association of Women's Health Obstetric and Neonatal Nurses; the Society for Obstetric Anesthesia and Perinatology; the Armed Forces Institute of Pathology; the U.S. Navy Bureau of Medicine and Surgery; the Office of the Surgeon General, U.S. Army; and TRICARE Management Activity were present. Consensus panels were developed for the identification of measure to be included in the composite measure (AOI). This included vetting each of the individual measures. See reference for full description of panel process	

<p>1) Mann S, Pratt SD et al. Assessing Quality in Obstetrical Care: Development of Standardized Measures. Jt Comm J Qual Pt Safety. 2006; 32 (9):497-505.</p>
<p>Ad.2 If adapted, provide name of original measure: Ad.3-5 If adapted, provide original specifications URL or attachment</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.6 Year the measure was first released: 2007 Ad.7 Month and Year of most recent revision: 04, 2008 Ad.8 What is your frequency for review/update of this measure? On-going Ad.9 When is the next scheduled review/update for this measure?</p>
<p>Ad.10 Copyright statement/disclaimers:</p>
<p>Ad.11 -13 Additional Information web page URL or attachment:</p>
<p>Date of Submission (MM/DD/YY): 08/01/2010</p>