



Perinatal and Women's Health, Fall 2020 Cycle: CDP Report

**TECHNICAL REPORT
SEPTEMBER 13, 2021**

This report is funded by the Centers for Medicare & Medicaid Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

<https://www.qualityforum.org>

Contents

Executive Summary	3
Introduction	4
NQF Portfolio of Performance Measures for Perinatal and Women’s Health Conditions	4
Table 1. NQF Perinatal and Women’s Health Portfolio of Measures.....	4
Perinatal and Women’s Health Measure Evaluation	5
Table 2. Perinatal and Women’s Health Measure Evaluation Summary	5
Comments Received Prior to Standing Committee Evaluation.....	5
Comments Received After Standing Committee Evaluation	5
Summary of Measure Evaluation.....	5
References	8
Appendix A: Details of Measure Evaluation	9
Measure Endorsed.....	9
NQF #0470 Incidence of Episiotomy.....	9
Appendix B: Perinatal and Women’s Health Portfolio—Use in Federal Programs	12
Appendix C: Perinatal and Women’s Health Standing Committee and NQF Staff.....	13
Appendix D: Measure Specifications.....	16
NQF #0470 Incidence of Episiotomy: Specifications.....	16
Appendix E: Related and Competing Measures	17
Appendix F: Pre-Evaluation Comments	18

Executive Summary

Maternal and infant health is a public health priority, and high quality care can lead to improved outcomes (i.e., clinical, patient-centric, and cost). The Perinatal and Women's Health Standing Committee oversees the measurement portfolio used to advance accountability and quality in the delivery of perinatal and women's health services. The National Quality Forum's (NQF) portfolio of measures for this topic includes measures for reproductive health; pregnancy and labor and delivery; high-risk pregnancy; newborn, premature, or low-birth-weight newborns; and postpartum patients. Measures related to other aspects of women's health are reviewed by other Standing Committees (e.g., an osteoporosis management measure for women is in the Prevention and Population Health Standing Committee portfolio). The background and description of NQF's most recent Perinatal and Women's Health Standing Committee meeting, as well as previous meetings, are available on NQF's project [webpage](#).

For the fall 2020 cycle, the Perinatal and Women's Health Standing Committee evaluated one measure undergoing maintenance review against NQF's standard evaluation criteria. The Standing Committee recommended the measure for endorsement. The Consensus Standards Approval Committee (CSAC) upheld the Standing Committee's recommendation. The recommended measure is listed below:

- **NQF #0470** Incidence of Episiotomy (Christiana Care Health System/National Perinatal Information Center [NPIC])

A brief summary of the measure's review is included in the body of the report; detailed summaries of the Standing Committee's discussion and ratings of the criteria for the measure are in [Appendix A](#).

Introduction

According to the Centers for Disease Control and Prevention's (CDC) National Vital Statistics System (NVSS), the 2018 maternal mortality rate was 17.4 maternal deaths per 100,000 live births, and it increases with age; women ages 40 and older die at a rate of 81.9 per 100,000 live births.¹ Women of this age group are 7.7 times more likely to die compared with women under the age of 25. Additionally, the maternal death rate for African American women was more than double that of White women and three times the rate for Hispanic women.² Compared with other countries in the World Health Organization's (WHO) latest maternal mortality ranking, the United States (U.S.) ranked 55th, just behind Russia (17 per 100,000) and just ahead of Ukraine (19 per 100,000).¹ Moreover, birth-related events are considered to be among the best measures for assessing healthcare quality.³ For women of reproductive age in the U.S., access to high quality care, before and between pregnancies, can reduce the risk of pregnancy-related complications, including maternal and infant morbidity and mortality.⁴ The 2018 infant mortality rate was 5.7 deaths per 1,000 live births, and the low-birth-weight rate (i.e., infants born at less than 2,500 grams) was 8.28 percent.⁵ Moreover, the top six leading causes of death for infants were birth defects, maternal pregnancy complications, sudden infant death syndrome (SIDS), injuries, preterm birth, and low birth weight.^{6,7}

For the fall 2020 cycle, NQF's Perinatal and Women's Health project focused on a measure related to episiotomy. Outdated guidance previously encouraged episiotomy during routine vaginal deliveries due to the belief that episiotomy could ease the birth process for both the parent and child. As of 2016, the American College of Obstetricians and Gynecologists' (ACOG) evidence links the restricted use of episiotomy to lower rates of perineal injury. Thus, decreasing routine episiotomies will influence perineal injury rates in vaginal deliveries, the targeted measure population.⁸

NQF Portfolio of Performance Measures for Perinatal and Women's Health Conditions

The Perinatal and Women's Health Standing Committee ([Appendix C](#)) oversees NQF's portfolio of Perinatal and Women's Health measures, which includes measures for reproductive health; pregnancy and labor and delivery; high-risk pregnancy; newborn, premature, or low-birth-weight newborns; and postpartum patients. The Perinatal and Women's Health portfolio measures that are currently in use in federal programs can be found in [Appendix B](#). This portfolio contains 15 measures: seven process measures and eight outcome and resource use measures (see Table 1 below). There are no composite measures in the portfolio. This portfolio also contains two electronic clinical quality measures (eQCMs).

Table 1. NQF Perinatal and Women's Health Portfolio of Measures

Type	Process	Outcome/Resource Use	Composite
Preconception	1	4	0
Birth	5	1	0
Newborns	1	3	0
Total	7	8	0

Additional measures for related topics have been assigned to other project portfolios. These include various complications and outcomes measures (Surgery), management and screening of osteoporosis in women (Primary Care and Chronic Illness), and routine breast cancer screening (Prevention and Population Health).

Perinatal and Women’s Health Measure Evaluation

On February 12, 2021, the Perinatal and Women’s Health Standing Committee evaluated one measure undergoing maintenance review against NQF’s [standard measure evaluation criteria](#).

Table 2. Perinatal and Women’s Health Measure Evaluation Summary

Status	Maintenance	New	Total
Measure under review	1	0	1
Measure endorsed	1	0	1

Comments Received Prior to Standing Committee Evaluation

NQF accepts comments on endorsed measures on an ongoing basis through the [Quality Positioning System \(QPS\)](#). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on December 23, 2020, and closed on January 21, 2021. No comments were received during the pre-evaluation commenting period.

Comments Received After Standing Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on April 28, 2021. Following the Standing Committee’s evaluation of the measures under review, NQF received four comments from four nonmember organizations and zero member organizations pertaining to the draft report and the measure under review. One comment came from the measure developer, and it clarified the submission. The remaining comments were generally supportive of the measure, with one also outlining several concerns.

Throughout the 16-week continuous public commenting period, NQF members had the opportunity to express their support (“support” or “do not support”) for the measure submitted for endorsement consideration to inform the Standing Committee’s recommendations. This expression of support (or not) during the commenting period replaces the member voting opportunity that was previously held subsequent to the Standing Committee’s deliberations. No NQF members shared their expressions. This information can be found in [Appendix A](#) of the post-comment memo.

Summary of Measure Evaluation

The following comprehensive summary of the measure evaluation highlights the major issues that the Standing Committee considered. Details of the Standing Committee’s discussion and ratings of the criteria for each measure are included in [Appendix A](#).

NQF #0470 Incidence of Episiotomy (Christiana Care Health System/National Perinatal Information Center [NPIC]): Endorsed

Description: This measure reports the percentage of vaginal deliveries (excluding those coded with shoulder dystocia) during which an episiotomy is performed. **Measure Type:** Process; **Level of Analysis:** Facility; **Setting of Care:** Inpatient/Hospital; **Data Source:** Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records

The Standing Committee recommended the measure for continued endorsement. Most recently endorsed in 2016, the focus of the measure is patients who undergo routine vaginal deliveries during which an episiotomy is performed (excluding those coded with shoulder dystocia). In July 2016, ACOG published the *Prevention and Management of Obstetric Lacerations at Vaginal Delivery Practice Bulletin* (no. 165), which called for the restricted use of episiotomy as a best practice due to increased complications to the mother, including perineal tears, blood loss, pain, and urinary and anal morbidities.⁹ During the measure evaluation meeting, Standing Committee members agreed that although episiotomy rates have steadily declined since measure implementation, further reduction in episiotomies during routine vaginal deliveries is warranted. Standing Committee members also reported increasing episiotomy trends when the measure was inconsistently monitored in practice, reinforcing that continued use is beneficial. For the evidence criterion, the Standing Committee determined that disparities by race and age remain even though the rates have steadily decreased over time. The Standing Committee also agreed that this is an important focus area of measurement, given the positive impacts that the use of the measure has made, and they passed the measure on the evidence and performance gap criteria. Standing Committee members also recommended that the developers provide performance rates based on social risks (e.g., race, ethnicity, geography, payer, and hospital characteristics) to differentiate outcomes in varied populations.

They also suggested that future measure advances could show performance stratification by episiotomy type (i.e., midline [vertical] versus mediolateral [angled] incision), given the potential for different outcomes, although available outcomes research on differences based on episiotomy type is unclear. Other Standing Committee members viewed stratification by episiotomy type as unnecessary because episiotomy rates continue to decrease, and providers no longer learn episiotomy as a standard practice during vaginal delivery. Regarding scientific acceptability, the Standing Committee agreed that the developer presented acceptable results for both reliability and validity testing for facility-level measurement and expressed no concerns. The Standing Committee regarded the measure as highly feasible because it is calculated with administrative data, and they expressed no concerns. During the discussions related to use and usability, the Standing Committee noted that the measure is used by the National Perinatal Information Center (NPIC) and The Leapfrog Group with no recognized harms from unintended consequences. The Standing Committee observed that there are no related or competing measures. All 17 Standing Committee members present voted to recommend the measure for overall suitability of endorsement.

During the post-comment meeting, four comments were received: one from the measure developer and three from the public (summarized in [Appendix A](#)). The developer submitted a comment clarifying that a code was mistakenly left out of the text in the denominator details: Medicare Severity-Diagnosis Related Group (MS-DRG) 806 (Vaginal Delivery Without Sterilization/D&C With CC). The developer noted that “all data and statistical analyses in the document correctly included MS-DRG 806 and it has been

included in the publicly available [measure-specific web page](#) since the MS-DRG was added for discharges starting in 10/1/2018.” The Standing Committee discussed one particular comment during the post-comment meeting. The commenter noted that by avoiding the use of episiotomy, the measure may introduce the unintended consequence of providers being incentivized to perform more cesarean sections, which are also discouraged unless clinically appropriate. The commenter also noted that the denominator of the measure combines three different procedures, and the numerator combines two different procedures, all of which impart different risks of the Outcome and Assessment Information Set (OASIS). Additionally, the commenter noted that midline and mediolateral episiotomies are not distinguished in the International Statistical Classification of Diseases and Related Health Problems (ICD) Version 10 or Current Procedural Terminology® (CPT) coding. The commenter also pointed out that the United Kingdom’s Royal College of Obstetricians and Gynaecologists (RCOG) recommends the consideration of a routine mediolateral episiotomy for both forceps-assisted and vacuum-assisted deliveries. Lastly, the commenter added that they remain “reluctantly” in favor of continued endorsement of NQF #0470 while noting the need for improvements to the measure to allow for the nuances described above. The Standing Committee members did not object to the developer’s responses or any requests to reconsider or re-vote on any of the measure evaluation criteria. Public comments and developer responses can be found in [Appendix A](#) of the post-comment memo.

The CSAC upheld the Standing Committee’s recommendation and endorsed the measure.

Measures Withdrawn From Consideration

One measure previously endorsed by NQF has either not been resubmitted for maintenance of endorsement or has been withdrawn during the endorsement evaluation process. Endorsement for this measure has been removed.

Table 3. Measures Withdrawn From Consideration

Measure	Reason for Withdrawal
NQF #0304 Late Sepsis or Meningitis in Very Low-Birth-Weight (VLBW) Neonates (Risk-Adjusted)	The developer is no longer able to support measure.

References

- 1 National Vital Statistics Reports Volume 69, Number 2 January, 2020 Maternal Mortality in the United States: 69(2):18.
- 2 Hoyert DL. Maternal Mortality Rates in the United States, 2019. *NCHS Health E-Stats*. 2021. <https://doi.org/10.15620/cdc:103855>. Last accessed September 2021.
- 3 Pileggi C, Squillace L, Giordano M, et al. Quality in perinatal care: applying performance measurement using joint commission on accreditation of healthcare organizations indicators in Italy. *BMC Med Res Methodol*. 2019;19(83). <https://doi.org/10.1186/s12874-019-0722-z>. Last accessed March 2021.
- 4 Recommendations to Improve Preconception Health and Health Care - United States: A Report of the CDC/ATSDR Preconception Care Work Group and the Select Panel on Preconception Care. <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm>. Last accessed February 2020.
- 5 Xu J, Murphy S, Kochanek K, et al. *NCHS Data Brief, No. 355*. Hyattsville, Maryland: National Center for Health Statistics; 2020. <https://www.cdc.gov/nchs/products/databriefs/db355.htm>. Last accessed September 2021.
- 6 Infant Mortality | Maternal and Infant Health | Reproductive Health | CDC. <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>. Published September 10, 2020. Last accessed October 2020.
- 7 National Vital Statistics Reports Volume 68, Number 13, November 30, 2019, Births: Final Data for 2018. :47.
- 8 An Interview with Texas Children's Hospital. Leapfrog. <https://www.leapfroggroup.org/news-events/interview-texas-childrens-hospital>. Published January 18, 2019. Last accessed March 2021.
- 9 American College of Obstetricians and Gynecologists (ACOG). Practice Bulletin No. 165: Prevention and Management of Obstetric Lacerations at Vaginal Delivery. *Obstet Gynecol*. 2016;128(1):e1-e15.

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

Vote totals may differ between measure criteria and between measures as Standing Committee members often have to join calls late or leave calls early. NQF ensures that quorum is maintained for all live voting. All voting outcomes are calculated using the number of Standing Committee members present during the meeting for that vote as the denominator. Quorum (17 Standing Committee members) was met and maintained for the entirety of the meeting. The vote totals reflect members present and eligible to vote at the time of the vote.

Measure Endorsed

NQF #0470 Incidence of Episiotomy

[Measure Worksheet](#) | [Specifications](#)

Description: This measure reports the percentage of vaginal deliveries (excluding those coded with shoulder dystocia) during which an episiotomy is performed.

Numerator Statement: The number of episiotomy procedures (ICD-9 code 72.1, 72.21, 72.31, 72.71, 73.6; ICD-10 PCS:0W8NXZZ) performed on women undergoing a vaginal delivery (excluding those with shoulder dystocia ICD-10; O66.0) during the analytic period—monthly, quarterly, yearly, etc.

Denominator Statement: All vaginal deliveries during the analytic period—monthly, quarterly, yearly, etc.—excluding those coded with a shoulder dystocia ICD-10: O66.0.

Exclusions: Women who have a coded complication of shoulder dystocia. In the case of shoulder dystocia, an episiotomy is performed to free the shoulder and prevent/mitigate birth injury to the infant.

Adjustment/Stratification: None

Level of Analysis: Facility

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records

Measure Steward/Developer: Christiana Care Health System/National Perinatal Information Center (NPIC)

STANDING COMMITTEE MEETING: February 12, 2021

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. Evidence, 1b. Performance Gap)

1a. Evidence **Total Votes-17; H-12; M-5; L-0; I-0**; 1b. Performance Gap: **Total Votes-17; H-16; M-1; L-0; I-0**

Rationale:

- This process measure was last reviewed in 2016. The developer reported that this measure is intended to reduce the incidence of episiotomy during vaginal delivery, thereby reducing rates of perineal injury.
- The developer cited a new July 2016 American College of Obstetricians and Gynecologists (ACOG) practice bulletin (no. 165), which provides further evidence that the routine use of episiotomy is unbeneficial and potentially detrimental to the mother. This update was given an “A” grade.

- The evidence cited by the developer does not describe an optimal episiotomy level. However, the developer reported data from 2014 from within their facilities: “6-7% of women continue to undergo this procedure.”
- By 2014, the developer reported that overall incidence dropped from 11.5% to 7.2%. By 2020, the average rate across hospitals dropped to 4.7% with a range of 0.0% to 13.9%.
- Standing Committee members agreed that although episiotomy rates have steadily declined since measure implementation, further reduction in episiotomies during routine vaginal deliveries is warranted.
- The Standing Committee agreed that this is an important focus area of measurement, given the positive impacts that the use of the measure has made.
- The Standing Committee noted that disparities by race and age remain and recommended that the developer provide performance based on social risks (e.g., race, ethnicity, geography, payer, and hospital characteristics) to differentiate outcomes in varied populations.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Total Votes-17; H-14; M-3; L-0; I-0**; 2b. Validity: **Total Votes-17; H-0; M-17; L-0; I-0**

Rationale:

- The developer provided signal-to-noise reliability statistics to test the measure score (Mean: 4.8%; Standard Deviation: 3.1%; Standard Error: 0.32%; Interquartile Range [IQR] of 4.4%).
- The developer provided a Cohen’s Kappa statistic and inter-rater (IRR) agreement to determine percent agreement between the encounters in each documentation method and to test data element reliability (Kappa: 0.958; IRR: 97.7%).
- The developer provided several tests of validity (Sensitivity = 0.9725; Specificity = 0.9858; Positive Predicted Value [PPV] = 97.21%; Negative Predicted Value [NPV] = 98.60%).
- The Standing Committee agreed that the reliability of the measure was considered high.
- The Standing committee agreed that the validity of the measure was considered high.
- No specific concerns with the scientific acceptability of the measure were noted.

3. Feasibility: Total Votes-17; H-15; M-2; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The developer reported that data generated and used by healthcare personnel during the provision of care are coded by someone other than the person obtaining the original information (e.g., DRG, ICD-10 data) and that all data elements are in defined fields in electronic sources.
- The developer reported that the measure is calculated using MS-DRG and ICD-10 code criteria.
- The Standing Committee regarded the measure as highly feasible with no concerns.

4. Usability and Use: The maintenance measure meets the Use sub-criterion.

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use: **Total Votes-17; Pass-17; No Pass-0**; 4b. Usability: **Total Votes-17; H-16; M-1; L-0; I-0**

Rationale:

- The developer reported that the measure is publicly reported and used for accountability as part of The Leapfrog Group and the NPIC Metric.
- The developer offers quarterly webinars to hospitals to disseminate performance results and reported that measure users also receive data, performance interpretation assistance, and measure performance improvement assistance upon request. The developers reported that users are satisfied with the measure and have not reported feedback warranting significant change to the measure.
- The performance trend for this measure is as follows: Calendar Year (CY) 2010: 11.5%, CY 2014: 7.2%, and CY 2019: 4.7%.
- The Standing Committee noted that the measure is in use with no recognized harms from unintended consequences.
- No specific concerns with the use and usability of the measure were noted.

5. Related and Competing Measures

- No related or competing measures were noted.

Standing Committee Recommendation for Endorsement: **Total Votes-17; Yes-17; No-0**

6. Public and Member Comment

- No measure-specific comments were submitted for this measure during the pre-evaluation commenting period.
- Four comments were received during the public commenting period. One comment from the developer clarified that a code, MS-DRG 806, was mistakenly left out of the text in the denominator details, but all data and statistical analysis in the submission correctly included this code. Three other commenters supported the measure and urged for the restricted use of episiotomies unless clinically warranted. One commenter made recommendations to update the measure, suggesting stratification by episiotomy indication and episiotomy and vaginal delivery types. They also noted mediolateral versus midline episiotomy coding gaps.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-12; No-0 (June 29, 2021: Endorsed

The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

Decision: Approved for continued endorsement

8. Appeals

- No appeals were received.

Appendix B: Perinatal and Women's Health Portfolio—Use in Federal Programs^a

NQF #	Title	Federal Programs: Finalized or Implemented as of February 8, 2021
0033	Chlamydia Screening in Women (CHL)	Medicaid (Implemented); Marketplace Quality Rating System (QRS) (Implemented)
0469	PC-01 Elective Delivery	Hospital Inpatient Quality Reporting (Implemented); Medicaid (Implemented)
0469e	PC-01 Elective Delivery	None
0470	Incidence of Episiotomy	None
0471	PC-02 Cesarean Birth	Medicaid (Implemented)
0478	Neonatal Blood Stream Infection Rate (NQI 03)	None
0480	PC-05 Exclusive Breast Milk Feeding	None
0480e	PC-05 Exclusive Breast Milk Feeding	Hospital Inpatient Quality Reporting (Implemented); Medicare and Medicaid Promoting Interoperability Program for Eligible Hospitals and Critical Access Hospitals (Implemented)
0483	Proportion of Infants 22 to 29 Weeks Gestation Screened for Retinopathy of Prematurity	None
0716	Unexpected Newborn Complications in Term Infants	None
1382	Percentage of Low-Birth-Weight Births	Medicaid (Implemented)
2902	Contraceptive Care – Postpartum	Medicaid (Implemented)
2903	Contraceptive Care – Most & Moderately Effective Methods	Medicaid (Implemented)
2904	Contraceptive Care – Access to LARC	Medicaid (Implemented)
3543	Person-Centered Contraceptive Counseling (PCCC)	None

^a Per CMS Measures Inventory Tool as of February 8, 2021

Appendix C: Perinatal and Women's Health Standing Committee and NQF Staff

STANDING COMMITTEE

Martha Carter, DHSc, MBA, APRN, CNM, FACNM (Co-Chair)

Health Resources and Services Administration
Scott Depot, West Virginia

Kimberly Gregory, MD, MPH (Co-Chair)

Helping Hand of Los Angeles
Department of Obstetrics and Gynecology, Cedars Sinai Medical Center
Los Angeles, California

Jill Arnold

Maternal Safety Foundation
Bentonville, Arkansas

J. Matthew Austin, PhD

Johns Hopkins School of Medicine
Baltimore, Maryland

Jennifer Bailit, MD, MPH

MetroHealth Medical Center
Cleveland, Ohio

Amy Bell, DNP, RNC-OB, NEA-BC, CPHQ

Women's and Children's Services and Levine Cancer Institute, Atrium Health
Charlotte, North Carolina

Tasha Cooper, RN

CIGNA HealthCare
Minot, Maine

Christina Davidson, MD

Baylor College of Medicine
Texas Children's Hospital
Houston, Texas

Ashley Hirai, PhD

Maternal and Child Health Bureau, Health Resources and Services Administration
Rockville, Maryland

Lisa Holtzclaw, RN, BS, MHA, MSN

HCA Healthcare
Brentwood, Tennessee

Mambarambath Jaleel, MD

Parkland NICU, University of Texas, Southwestern Medical Center
Dallas, Texas

Diana Jolles, CNM, MS, PhD

American College of Nurse-Midwives
Tucson, Arizona

Elizabeth Jones, MPA

National Family Planning and Reproductive Health Association
Washington, District of Columbia

Sue Kendig JD, WHNP-BC, FAANP

National Association of Nurse Practitioners in Women's Health
Washington, District of Columbia

Deborah Kilday, MSN

Premier, Inc.
Woodstock, Georgia

Sarah McNeil, MD

Contra Costa Medical Center
Martinez, California

Jennifer Moore, PhD, RN, FAAN

Institute for Medicaid Innovation
Washington, DC

Sarah Nathan, MSN, RN, FNP

La Clinica
Department of Family Health Care Nursing, UCSF
San Francisco, California

Kristi Nelson, MBA, BSN

Intermountain Healthcare
Salt Lake City, Utah

Sheila Owens-Collins, MD, MPH, MBA

Johns Hopkins Healthcare, LLC
Glen Burnie, Maryland

Diana E. Ramos, MD, MPH, FACOG

Los Angeles County Public Health Department
Laguna Beach, California

Sindhu Srinivas, MD, MSCE

University of Pennsylvania Health System and Perelman School of Medicine
Women's Health Service Line, Penn Medicine
Philadelphia, Pennsylvania

Nan Strauss, JD

Managing Director of Policy, Advocacy and Grantmaking, Every Mother Counts
New York, New York

Angeline Ti, MD, MPH

Emory University School of Medicine
Grady Memorial Hospital
Division of Reproductive Health at the Centers for Disease Control and Prevention
Atlanta, Georgia

Rajan Wadhawan, MD, MMM, CPE, FAAP

Florida Hospital for Children
Orlando, Florida

NQF STAFF

Kathleen Giblin

Interim Senior Vice President, Quality Measurement

Tricia Elliott, MBA, CPHQ, FNAHQ

Senior Managing Director, Quality Measurement

Sheri Winsper

Former Vice President, Quality Measurement

Michael Haynie

Former Senior Managing Director

Chelsea Lynch, MPH, MSN, RN, CIC

Director, Quality Innovation

Erin Buchanan, MPH

Manager, Quality Measurement

Yemsrach Kidane, PMP

Project Manager, Quality Measurement

Hannah Ingber, MPH

Senior Analyst, Quality Measurement

Sharon Hibay, DNP, BS, RN

Consultant

Appendix D: Measure Specifications

NQF #0470 Incidence of Episiotomy: Specifications

Steward: Christiana Care Health System

Description: Percentage of vaginal deliveries (excluding those coded with shoulder dystocia) during which an episiotomy is performed.

Type: Process

Data Source: Claims, Electronic Health Data, Electronic Health Records, Paper Medical Records, UB04 claims data.

Level: Facility

Setting: Inpatient/Hospital

Numerator Statement: Number of episiotomy procedures [(ICD-9 code 72.1, 72.21, 72.31, 72.71, 73.6; ICD-10 PCS:0W8NXZZ) performed on women undergoing a vaginal delivery (excluding those with shoulder dystocia ICD-10; O66.0)] during the analytic period - monthly, quarterly, yearly, etc.

Numerator Details: Any vaginal delivery with one of the ICD-9 codes for episiotomy - 72.1, 72.21, 72.31, 72.71, 73.6 (ICD-10 PCS:0W8NXZZ)

Denominator Statement: All vaginal deliveries during the analytic period- monthly, quarterly, yearly, etc. excluding those coded with a shoulder dystocia ICD-10: O66.0.

Denominator Details: Any woman with a vaginal delivery calculated by either MS DRG 774,775,767,768: MS DRGs starting with 10/1/2018 discharges: 768, 796, 797, 798, 805, and 807

Exclusions: Women who have a coded complication of shoulder dystocia. In the case of shoulder dystocia, an episiotomy is performed to free the shoulder and prevent/mitigate birth injury to the infant.

Exclusion details: Vaginal deliveries coded with shoulder dystocia, ICD-9 code 660.41, 660.42(ICD-10 CM: O66.0)

Risk Adjustment: No risk adjustment or risk stratification

Stratification: NA

Type Score: Rate/proportion, better quality = lower score

Algorithm:

- A. Identify all vaginal deliveries for time period in question
- B. Exclude those coded with shoulder dystocia to obtain denominator cases
- C. Of the denominator cases, identify those coded with an episiotomy
- D. Divide numerator by denominator and calculate the rate or convert a percent

Copyright / Disclaimer: Not applicable

Appendix E: Related and Competing Measures

No related or competing measures were identified.

Appendix F: Pre-Evaluation Comments

No comments were received during the pre-evaluation commenting period.

National Quality Forum
1099 14th Street NW, Suite 500
Washington, DC 20005
<http://www.qualityforum.org>