



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

Brief Measure Information

NQF #: 1746

Corresponding Measures:

De.2. Measure Title: [Intrapartum Antibiotic Prophylaxis for Group B Streptococcus \(GBS\)](#)

Co.1.1. Measure Steward: [Massachusetts General Hospital](#)

De.3. Brief Description of Measure: [Percentage of pregnant women who are eligible for and receive appropriate intrapartum antibiotic prophylaxis \(IAP\) for Group B Streptococcus \(GBS\)](#)

1b.1. Developer Rationale: [Administering appropriate antibiotic prophylaxis to this patient population significantly decreases the risk of infection to their newborn further reducing risks of complications, readmissions, morbidity, mortality and the associated costs.](#)

S.4. Numerator Statement: [All eligible patients who receive intrapartum antibiotic prophylaxis for GBS.](#)

S.7. Denominator Statement: [All women delivering live infants, except certain classes \(described in response to 2a1.9 below\) who are specifically deemed not to be at risk of vertical transmission of GBS.](#)

S.10. Denominator Exclusions: [Women not included in the denominator defined above, with specific exclusions as described below.](#)

De.1. Measure Type: [Process](#)

S.23. Data Source: [Claims, Electronic Health Records, Other, Paper Medical Records](#)

S.26. Level of Analysis: [Facility, Integrated Delivery System, Population : Regional and State](#)

IF Endorsement Maintenance – Original Endorsement Date: [Apr 02, 2012](#) **Most Recent Endorsement Date:** [Mar 30, 2012](#)

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? [n/a](#)

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form
[1746_Evidence_MSF5.0_Data.doc](#)

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure) Administering appropriate antibiotic prophylaxis to this patient population significantly decreases the risk of infection to their newborn further reducing risks of complications, readmissions, morbidity, mortality and the associated costs.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Results of the Active Bacterial Core surveillance (ABCs) system of the Centers for Disease Control (CDC), as reported in 2009 in the New England Journal of Medicine, note, "Because chemoprophylaxis guidelines differ according to gestational age, we stratified... according to term or preterm delivery. Mothers who delivered preterm were less likely to receive chemoprophylaxis when indicated than mothers who delivered at term (relative risk, 0.81; 95% CI, 0.75 to 0.87). Among women who delivered preterm and were positive for group B streptococcus, 84.5% received chemoprophylaxis. However, only 63.4% of women who delivered preterm and had unknown colonization status received intrapartum antibiotics... The rate of administration of chemoprophylaxis was high among women who delivered at term: 87.0% of women who were positive for group B streptococcus and 78.5% of women with a risk factor and unknown colonization status received intrapartum antibiotics."

In use of the current measure in Massachusetts, the Medicaid Pay for Performance program found average compliance of 71% in FY 2008, 83% in RY 2009, and 87% in RY 2010. (Data for each rate year are based on the preceding calendar year.)

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

Van Dyke MK, Phares CR, Lynfield R, et al. Evaluation of universal antenatal screening for Group B Streptococcus. N Engl J Med 2009;360:2626-36.

Personal communication from MassHealth Primary Provider Network, Massachusetts EOHHS, citing data reviewed in December 16, 2010

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

The Active Bacterial Core surveillance (ABCs) project reported in 2009, "When stratified by race, incidence [of early-onset GBS] among black infants increased significantly (0.52 to 0.86 cases per 1,000 live births, $p=0.005$, whereas incidence among white infants did not change significantly (0.26 to 0.29 cases per 1,000 live births; $p=0.64$). When EOD incidence was stratified by gestational age, the average incidence among preterm infants during 2003-2006 was 2.8 times higher among black infants (1.79 cases per 1,000 live births) compared with white infants (0.67 cases per 1,000 live births)... Th[e] increase in EOD from 2003 to 2006... was not anticipated and cannot yet be explained fully... I[ntrapartum] A[ntimicrobial] P[rophylaxis] was administered to a similar proportion of black and white mothers of term infants with EOD... evaluation of these factors will be important in determining whether the causes of increasing racial difference in EOD can be directly linked to missed opportunities for prevention."

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

Trends in perinatal Group B Streptococcal disease, United States 2000-2006. MMWR 2009;58:109-112

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Severity of illness

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.

Prevention of Group B streptococcus in newborns is a nationally recognized health priority where every pregnant woman is a potential carrier of GBS, and transmission of it to newborns carries substantial risk of neonatal infection and mortality. Approximately 10%-30% of pregnant women are colonized with GBS. Classic epidemiological studies in the 1980's revealed that women with prenatal GBS colonization were >25 times more likely than women with negative cultures to deliver infants with early-onset GBS disease.

1c.4. Citations for data demonstrating high priority provided in 1a.3

ACOG Committee on Obstetric Practice. Prevention of early-onset Group B Streptococcal disease in newborns. *Obstet Gynecol* 2011;117:1019-27.

CDC. Prevention of perinatal Group B Streptococcal disease: revised guidelines from CDC, 2010. *MMWR* 2010;59:1-32.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

2. Reliability and 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. ***Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Infectious Diseases (ID), Perinatal Health

De.6. Non-Condition Specific (check all the areas that apply):

Disparities Sensitive, Safety : Healthcare Associated Infections

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

URL Attachment:

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

All eligible patients who receive intrapartum antibiotic prophylaxis for GBS.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

At the time of labor or rupture of membranes, in the absence of complicating circumstances (listed as exclusions).

S.6. 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, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

Patients who receive antibiotics as recommended under current CDC guidelines. The 2010 guidelines recommend penicillin as the agent of choice, with ampicillin as an acceptable alternative. Penicillin-allergic women who do not have a history of anaphylaxis, angioedema, respiratory distress or urticaria following administration of a penicillin or a cephalosporin should antimicrobial susceptibility testing. If the culture is susceptible to clindamycin, clindamycin should be given. If the culture is resistant to clindamycin, vancomycin should be given.

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

All women delivering live infants, except certain classes (described in response to 2a1.9 below) who are specifically deemed not to be at risk of vertical transmission of GBS.

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Women

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

The population may be identified in two stages. The first stage identified all women delivering live infants. The second stage further restricts the eligible population on the basis of specific clinical criteria.

Identification of women giving birth to live infants is generally a straightforward task that may be accomplished in various ways. Commonly, it is done using ICD-9 principal and secondary diagnosis codes for live births as defined in the Appendices of the National Hospital Quality Measures, as they may be modified from time to time. In 2011, codes for live births are listed in Appendix A Tables 4.01, 4.02, 4.03, or 4.04 of the Specifications Manual.

This population must be further restricted on the basis of the following criteria.

- Previous infant with invasive GBS disease, or
- GBS bacteriuria during current pregnancy, or
- Positive GBS screening culture during current pregnancy* (unless a planned cesarean delivery, in the absence of labor or amniotic membrane rupture, is performed), or
- Unknown GBS status (culture not done, incomplete or results unknown) and any of the following:
 - o Delivery at < 37 weeks gestation**
 - o Amniotic membrane rupture greater than or equal to 18 hours, or
 - o Intrapartum temperature greater than or equal to 100.4° F (38.0° C)

*Optimal timing for prenatal GBS screening is 35-37 weeks of gestation. In the absence of culture results for this period, other available results from the 5 weeks preceding delivery should be reviewed.

****Recommendations for prophylaxis in the setting of threatened preterm delivery are presented separately by the CDC in Figures 5 and 6 of the most recent guidelines (Centers for Disease Control and Prevention. Prevention of perinatal Group B Streptococcal disease: revised guidelines from CDC, 2010. MMWR 2010;59(RR-10):1-36.) Those interested in detailed criteria and assessment of compliance for the preterm population are referred there for specifics.**

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Women not included in the denominator defined above, with specific exclusions as described below.

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

Excluded populations:

- Patient screened negative for GBS at 35-37 weeks of delivery.
- Patients delivering via planned cesarean sections (in the absence of labor or amniotic membrane rupture).
- Patients already on antibiotics for a pre-natal maternal infection or other prophylaxis.
- Deliveries resulting in stillbirths identified by ICD-9-CM principal and secondary diagnosis codes (in any position) of V.27.1, V27.3, V27.4, V27.6, or V27.7.

*Optimal timing for prenatal GBS screening is 35-37 weeks of gestation. In the absence of culture results for this period, other available results from the 5 weeks preceding delivery should be reviewed.

S.12. Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*

S.15. Detailed risk model specifications *(must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)*

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications *(if not provided in excel or csv file at S.2b)*

S.16. Type of score:

Rate/proportion

If other:

S.17. 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

S.18. 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.)*

The score is calculated by dividing the numerator by the denominator. Where sample or population sizes are limited, the Measure Steward encourages the use of reporting with confidence intervals or graphical displays using standard statistical techniques for description of measurement error. The Measure Steward discourages ranking based on statistically indistinguishable scores.

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1) [URL](#)

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

[IF a PRO-PM](#), identify whether (and how) proxy responses are allowed.

Hospitals that are capable can construct systems of real-time data capture that will enable routine reporting on their complete patient populations.

In situations where resources are limited, the Measure Steward suggests that the sampling methodologies and tables in use for the National Hospital Quality Measures provide one reasonable method of balance between statistically strong sample sizes and resource requirements.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

[IF a PRO-PM](#), specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

[Required for Composites and PRO-PMs.](#)

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

[If other, please describe in S.24.](#)

[Claims, Electronic Health Records, Other, Paper Medical Records](#)

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

[IF a PRO-PM](#), identify the specific PROM(s); and standard methods, modes, and languages of administration.

[Appropriate data sources will vary from one institution to another. Typical sources of relevant information include administrative claims, electronic records, and paper records.](#)

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

[Facility, Integrated Delivery System, Population : Regional and State](#)

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

[Inpatient/Hospital](#)

[If other:](#)

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

[1746_MeasureTesting_MS5.0_Data.doc](#)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

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)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields? (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

Some data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

Data elements will usually be present in hospitals with advanced electronic systems, but others will need to review paper charts.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.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.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

It is of course impossible to isolate the hospital phase entirely from overall perinatal care, but in practice we have found that hospitals usually have very good information about relevant aspects of prenatal care.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (*e.g., value/code set, risk model, programming code, algorithm*).

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are

publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Planned	Current Use (for current use provide URL)
Public Reporting	
Payment Program	
Quality Improvement (Internal to the specific organization)	

4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of

unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

The measure is generally straightforward and unambiguous. As with all guidelines, clinicians should exercise appropriate judgment in unusual cases where standard treatments may not be the most appropriate approach.

5. Comparison to Related or 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.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications completely harmonized?

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

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses 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.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment:

Contact Information
<p>Co.1 Measure Steward (Intellectual Property Owner): Massachusetts General Hospital</p> <p>Co.2 Point of Contact: Paul, Nordberg, pnordberg@partners.org, 617-724-8269-</p> <p>Co.3 Measure Developer if different from Measure Steward: Massachusetts General Hospital</p> <p>Co.4 Point of Contact: Paul, Nordberg, pnordberg@partners.org, 617-724-8269-</p>
Additional Information
<p>Ad.1 Workgroup/Expert Panel involved in measure development Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development. Jeffrey Ecker, M.D., clinical sponsor Vincent Obstetrics Service Massachusetts General Hospital</p> <p>Dr. Ecker oversaw the development of the measure, and has collaborated in related work with colleagues across the hospitals of the Partners Healthcare system.</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.2 Year the measure was first released: Ad.3 Month and Year of most recent revision: Ad.4 What is your frequency for review/update of this measure? As significant guideline and evidence changes emerge Ad.5 When is the next scheduled review/update for this measure? 11, 2012</p>
<p>Ad.6 Copyright statement: Ad.7 Disclaimers:</p>
Ad.8 Additional Information/Comments: