

Measures: Availability of Outpatient Maternal Fetal Medicine and Specialty Care for Women With High-Risk Pregnancies and Availability of Multidisciplinary Outpatient Care for Women With High-Risk Pregnancies

Measure Developer: Collaboration for Advancing Pediatric Quality Measures (CAPQuaM)

Numerator	Denominator	Exclusions	Data Source(s)
Availability of Outpatient Maternal Fetal Medicine and Specialty Care for Women High-Risk Pregnancies (HROB V)			
The number of eligible high-risk pregnant women who have the specified number of maternal fetal medicine or indicated subspecialty visits during their pregnancy (includes eight sub-measures).	Overall number of eligible qualifying high-risk pregnancies using the indicated look back period. Described further in technical specifications.	Numerator – None. Denominator – Identified using maternal ICD-9 codes specified in technical specifications.	Administrative claims data, supplemented by medical records (paper or electronic) for mother's race/ ethnicity if needed.
Availability of Multidisciplinary Outpatient Care for Women with High-Risk Pregnancies (HROB VI)			
The number of eligible high-risk pregnant women seen as an outpatient by at least three different specified types of clinicians during their pregnancy.	Overall number of eligible qualifying high-risk pregnancies using the indicated look back period. Described further in technical specifications.	Numerator – None. Denominator – Identified using maternal ICD-9 codes specified in technical specifications.	Administrative claims data, supplemented by medical records (paper or electronic) for mother's race/ ethnicity if needed.

Measure Importance

Maternal morbidity resulting from certain diseases and chronic conditions (such as hypertension, cardiac disease, HIV, diabetes, mental disorders, epilepsy, infectious diseases, and placenta previa) is on the rise and affects approximately 52,000 women annually.[1,2] Maternal morbidity places women at greater risk of experiencing complications during pregnancy. These complications can also be harmful to the newborn.

Appropriate availability of specialized services beyond maternal-fetal medical (MFM) specialists (e.g., cardiologists, infection disease specialists, neurologists, psychologists/psychiatrist/licensed therapists), including the availability of multidisciplinary outpatient care for pregnant women with chronic diseases (focus of HROB VI) can also be important for healthy pregnancies and births. Professional societies such as the American Congress of Obstetricians and Gynecologists recommend that specialty and multidisciplinary care be provided for high-risk pregnant women in order to improve outcomes for mothers and their babies.

The purpose of these two measures is to assess the availability of specialty services for high-risk pregnant women. The first measure (HROB V) assesses population access to MFM specialists and other specialty physicians. The second measure (HROB VI) follows a line of research that suggests that multidisciplinary care is associated with better outcomes in high-risk pregnancies.

Evidence Base for the Focus of these Measures

MFM specialists are instrumental in managing high-risk pregnancies.[3, 4, 5] In settings where other specialists are not available, MFMs play a crucial role in developing structures and protocols to enhance quality and safety for patients.[6] Studies have demonstrated that the density of MFMs is significantly and inversely associated with maternal mortality ratios.[7]

Advantages of the Measures

- These two measures address gaps in availability of quality care/services and safety for women who have chronic illness or pregnancy related problems.
- The two measures are feasible to implement, as the data elements required are available and easy to abstract from administrative claims databases/systems and medical records (whether in paper or electronic formats).

Issues to Consider

- These measures are designed to detect whether or not basic levels of outpatient specialty care are available to the specified populations of pregnant women. They do not assess whether or not the level of availability that is present meets the need of any individual woman.

Levels of Aggregation Applicable to the Measures[8]

- These measures are intended to be reported at the level of health plan or geographical entity, such as county, State, region, etc. They are not appropriate for measuring at the level of the individual clinical provider.

Reliability and Validity of the Measures

- The measure developers assessed the feasibility of identifying the specific provider type and/or specialty visits by identifying these visits in outpatient claims/encounter data.
- Both measures exhibit face and construct validity as demonstrated by a formal RAND/UCLA Delphi process, which helped to define both availability of services and which women should be considered to have high-risk pregnancies.

Measure Testing

- The measure developer tested the reliability of administrative claims data by identifying high-risk deliveries in the Medicaid Analytic eXtract files for 16 States.
- The measure developer conducted a more detailed analysis with the New York Department of Health using New York State Medicaid data to identify claims for Reporting Year, July 2011–June 2012.

Selected Results from Tests of these Measures

- Administrative Medicaid data in New York State found almost the same number of high-risk pregnancies/deliveries as found in an analysis of maternal codes contained in internal databases for the same population.
- Women who live in more medically dense communities experience greater availability of care and services than those who live in less medically dense communities and/or more isolated communities.
- Specialty and/or multidisciplinary care and services become less available with increasing rurality.
- Certain subspecialists are more available than others.
- Our testing suggests that the overall availability of high-risk obstetrical services is low compared to the identified need.

Related Measures

For other measures related to the availability of services and care for women with high-risk pregnancies, see the list of submitted CHIPRA COE measures at http://www.ahrq.gov/policymakers/chipra/factsheets/index.html.

More Information

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References

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[5]Russo M, Krenz E, Hart S, et al. Multidisciplinary Approach to the Management of Placenta Accreta. The Ochsner Journal. 2011;11(1):84-88.

[6]Antony K, Dildy III GA. Postpartum hemorrhage: The role of the Maternal–Fetal Medicine specialist in enhancing quality and patient safety. Seminars in Perinatology. 2013;37(4):246-256.

[7]Sullivan S, Hill EG, Newman NB, et al. Maternal-fetal medicine specialist density is inversely associated with maternal mortality ratios. American Journal of Obstetrics and Gynecology. 2005;193(3, Supplement):1083-1088.

[8]The Children's Health Insurance Program Reauthorization Act required measures developed under this program to "permit comparison of quality and data at a State, plan, and provider level." The measure developer identified the intended levels of aggregation and comparison reported here.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) called for establishment of a Pediatric Quality Measures Program (PQMP) as a followup to identifying the initial core set of children's health care quality measures. This fact sheet was produced by the Agency for Healthcare Research and Quality (AHRQ), based on information provided by the AHRQ-CMS Collaboration for Advancing Pediatric Quality Measures (CAPQM). A listing of all submitted CHIPRA Centers of Excellence measures can be found at http://www.ahrq.gov/policymakers/chipra/factsheets/index.html. All measures are publicly available for noncommercial use.

AHRQ Pub. No. 14(15)-P009-1-EF
March 2015