HHSC: Maternal Mortality and Morbidity Review Committee, September 18th, 2020

The Maternal Mortality and Morbidity Review Committee studies maternal mortality and morbidity by studying and reviewing cases of pregnancy-related deaths and trends in severe maternal morbidity, determining the feasibility of the task force studying cases of severe maternal morbidity, and recommending ways to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas.

The Maternal Mortality and Morbidity Task Force was created by Senate Bill 495, 83rd Legislature, Regular Session, 2013, which added Texas Health and Safety Code Chapter 34. Maternal Mortality and Morbidity Task Force. The name of the Task Force was changed to the Texas Maternal Mortality and Morbidity Review Committee by Senate Bill 750, 86th Legislature, Regular Session, 2019 in alignment with the federal Preventing Maternal Deaths Act of 2018. Later in 2019, the review committee was awarded Center for Disease Control and Prevention funding for the for the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program.

The multidisciplinary review committee within the Department of State Health Services (DSHS) will study maternal mortality and morbidity. The review committee:

- studies and reviews cases of pregnancy-related deaths and trends in severe maternal morbidity;
- determines the feasibility of the review committee studying cases of severe maternal morbidity; and
- makes recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas.

The review committee and DSHS must submit a joint report on the findings of the review committee and make recommendations to the Governor, Lieutenant governor, Speaker of the House of Representatives, and appropriate committees of the Texas Legislature by September 1 of each even-numbered year, beginning September 1, 2016.

Members of the review committee are appointed by the DSHS commissioner and serve six-year staggered terms.

Current Members

Dr. Lisa Hollier, Chair, Physician specializing in Obstetrics, maternal fetal medicine specialist, Houston
Dr. Carla Ortique, Vice Chair, Physician specializing in Obstetrics, Houston
Dr. Manda Hall, DSHS representative - Associate Commissioner Community Health Improvement Division, Austin
Dr. Meitra Doty, Physician specializing in Psychiatry, Dallas
Dr. Kelly Fegan-Bohm, DSHS representative - State Epidemiologist Interim Designee, Austin
Ms. Kimberly Williams, Community Advocate, Pearland
Dr. Pamala Gessling, Registered Nurse, Dallas

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Dr. James Maher, Physician specializing in Obstetrics, Maternal-Fetal Medicine specialist, Odessa
Dr. D. Kimberley Molina, Medical Examiner, San Antonio
Dr. Sherri Onyiego, Physician specializing in Family Practice, Houston
Dr. Amy Raines-Milenkov, Researcher of pregnancy-related deaths, Fort Worth
Dr. Patrick Ramsey, Physician specializing in Maternal-Fetal Medicine, San Antonio
Ms. Nancy Jo Reedy, Certified Nurse-Midwife, Arlington
Ms. Nancy Alderman, Social Worker, Austin
Dr. Eumenia Castro, Pathologist, Houston
Dr. Lavannya Pandit, Physician specializing in Critical Care, Houston
Dr. Christina Murphey, Nurse specializing in Labor and Delivery, Corpus Christi

Maternal Mortality and Morbidity Review Committee Legislative Reports

- Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report, September 2018
- Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report, July 2016
- Maternal Mortality and Morbidity Task Force Report, September 2014

Call to Order and Determination of Quorum; Welcome and Introductions. The meeting was convened by Dr. Hollier, Chair.

Approval of March 6, 2020 Meeting Minutes. The minutes were approved as written.

Subcommittee on Maternal Health Disparities Update. Dr. Ortique provided the update. Inequality of access is not just based on low socioeconomic status or lack of insurance, but often on race. The Center for Disease Control (CDC) has stated that discrimination and bias of racism is a major factor in health care. This has spilled over into the COVID-19 inequality and associated maternal deaths. There has been active review of case materials with the goals of identifying best practices. At the March 6th meeting, a tool was identified to look at case records to look at disparities. Social determinants of health and impact on death was the goal of the new tool. They will be collaborating with the CDC on the use of the tool. The Subcommittee hopes to validate the use of the tool on a broader scale.

Consultation for Cause of Death Data Improvement Report: DSHS to consult with the Maternal Mortality and Morbidity Review Committee on Cause of Death Data Improvement under Health and Safety Code, Section 1001.0712.
Senate Bill 17 - Cause of Death Data Improvement: Requires a report on cause of death data improvement including any challenges to collecting accurate information relating to maternal mortality.

The issues we face with death data are varied:

Findings from Focus Groups and Environmental Scan:

- More medical certifier education and training is needed
- Physicians need additional support to complete death certificates
- Pregnancy checkbox is often completed inappropriately. The new electronic registration system, TxEVER, went live January 1, 2019

SB17, 85(1) Bill Summary. The Maternal Mortality and Morbidity Task Force (task force) established by S.B. 495, 83rd Legislature, is a multidisciplinary group tasked to study maternal mortality and morbidity in Texas. The task force has produced two reports since its inception, providing critical information on maternal mortality trends and demographics in Texas. Considering the findings of the task force, much work still needs to be done to more directly address the causes of pregnancy-related deaths in Texas and severe maternal morbidity. S.B. 17 as proposed extends the expiration date of the task force from September 1, 2019, to September 1, 2023.

S.B. 17 also directs the Health and Human Services Commission (HHSC) to evaluate options to address the most prevalent causes of maternal death as identified by the task force, including options for treating postpartum depression in low-income women.

S.B. 17 also directs the Department of State Health Services to implement a maternal health and safety initiative with healthcare providers to lower incidences of maternal mortality and morbidity. The bill also requires HHSC to determine the feasibility of adding maternal health and safety protocols and best practices as a measure of quality outcomes and for quality payment purposes in the Medicaid program. (Original Author's / Sponsor's Statement of Intent)

S.B. 17 amends current law relating to maternal health and safety, pregnancy-related deaths, and maternal morbidity, including postpartum depression.

Fiscal Note: The bill amends Health and Safety Code Chapter 34 to expand the Maternal Mortality and Morbidity Task Force's duties. The bill would require the Maternal Mortality and Morbidity Task Force and the Health and Human Services Commission (HHSC) to make information available to physicians and other licensed persons regarding best practices for screening pregnant women for substance use, a list of substance use treatment resources in the state, and review and promote educational materials regarding opioid drug use during pregnancy. The information shall be posted on HHSC's website.

The bill specifies how DSHS shall determine the number of cases of pregnancy-related deaths for review. The bill requires the HHSC and DSHS to report on efforts taken to reduce the incidence of pregnancy-related deaths. The bill would require DSHS, in collaboration with the Maternal Mortality and Morbidity Task Force, to promote maternal health and safety

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informational materials and submit a report to the executive commissioner on maternal health and safety initiative outcomes and recommendations.

The bill also requires HHSC to conduct a study on the feasibility of adding a provider's use of the materials as a pay-for-quality measure. The bill would extend the Maternal Mortality and Morbidity Task Force until September 1, 2023. The bill would require DSHS to submit a report on processes, procedures, and challenges associated with collecting cause of death information, including information regarding maternal mortality.

The bill requires meetings of the task force to comply with state requirements on conducting open meetings, pursuant to Government Code, Chapter 551 except in certain circumstances. The bill would take effect immediately upon receiving a two-thirds majority vote in each house. Otherwise, it would take effect 91 days after the last day of the First Called Session, 85th Legislature.

Questions/Answers/Comments

It can be difficult when you have to go back and forth between the fields for this form and the EMR.

This has been live for two years… have we done any assessment on the effectiveness of coding? HHSC stated that they have to consult with other colleagues.

Maternal Mortality and Morbidity Review Committee Operational Updates.

COVID-19 response has involved DSHS to provide the leadership in this effort. Because epidemiologists were pulled away for COVID, some of the effort for this committee had to be put on hold. The Biennial Report was delayed as a result. DSHS asked for an extension to postpone the report until December of this year. It will be available to the public in December.

The Maternal Health and Safety Biennial Report adds some new components that include the status and accomplishments of the Texas AIM project and an update on the Opiate pilot.

The CDC grant that Texas was awarded allows $600,000 to enhance the review committee.

There have been four FTEs hired; that speeds up the review of cases.

Texas AIM has been involved with COVID-19 response. Texas AIM became the platform to share COVID-19-related information.

Texas AIM: The Department of State Health Services (DSHS) has teamed up with the Alliance for Innovation on Maternal Health (AIM) and the Texas Hospital Association (THA) to create the TexasAIM initiative. TexasAIM will help hospitals and clinics in Texas carry out maternal safety projects.

Our goal is to end preventable maternal death and severe maternal morbidity. DSHS has put together a team of experts to guide the implementation of AIM throughout Texas.

AIM is a program used by hospitals and communities across the country. AIM helps hospitals and communities improve maternal safety through implementing best-practices. They work with state teams and health systems to achieve these goals.
More information on AIM can be found on the About AIM webpage.

An AIM Maternal Safety Bundle is a collection of best-practices for improving maternal care. Experts in the field have vetted these practices to ensure their effectiveness. Each bundle focuses on a specific maternal health and safety topic.

TexasAIM first worked on the Obstetric Hemorrhage Bundle. The initiative will then focus on the Obstetric Care for Women with Opioid Use Disorder Bundle and Severe Hypertension in Pregnancy Bundle. More information on the Obstetric Hemorrhage Bundle can be found on the Obstetric Hemorrhage Bundle page.

More information on the Obstetric Care for Women with Opioid Use Disorder Bundle can be found on the Obstetric Care for Women with Opioid Use Disorder Bundle page.
More information on the Severe Hypertension Bundle can be found on the Severe Hypertension Bundle page.

Any Texas birthing hospital system can join the growing and engaged Texas AIM community.

DSHS and AIM provide help and can connect you to the Patient Safety Bundles, AIM tools, and the AIM data portal.
Enrollment is voluntary, and there is no deadline to join.

Please visit the Obstetric Hemorrhage Bundle page for a list of upcoming events and webinars. Past webinar recordings can also be found on this page.

TexasAIM Frequently Asked Questions and Answers Document

COVID-19 and Considerations for Maternal Mortality Review.
Individual state maternal mortality review committees aim to comprehensively review all maternal deaths to not only evaluate the cause of death, but also to assess preventability and make recommendations for action to prevent future deaths. The maternal mortality review committee process remains critical during the coronavirus disease 2019 (COVID-19) pandemic. Maternal deaths due to COVID-19 have been reported in the United States.

Some state maternal mortality review committees may choose to expedite review of these deaths in an effort to quickly provide clinicians with information intended to prevent other deaths during the ongoing pandemic. If states opt to pursue rapid review, entry of data into the Maternal Mortality Review Information Application system for submission to the Centers for Disease Control and Prevention will allow for aggregation nationally without duplication. It will be important to review not only deaths directly attributed to COVID-19, but also those that may be indirectly related to the COVID-19 pandemic, such as those influenced by changes in care practices or delays in seeking care during the pandemic. Therefore, regardless of the timing of the review, maternal deaths that occur during the time of the COVID-19 pandemic must be evaluated within that framework to ensure that all factors contributing to the death are considered to better understand the context of each of these tragic events.

There were 37 maternal deaths due to COVID-19. The Chair was one of the authors of the article that can be accessed by following the link above. A number of women may be asymptomatic and COVID has complicated the reporting of maternal deaths. The Chair spoke from the article. Please see the article for detail.

Questions/Answers/Comments
Were you able to look at the impact of rural areas? The Chair stated that the review committees across the country are only now beginning to look at the impact of COVID-19 on maternal death. There is an effort to aggregate all data from across the country.

There have been missed opportunities because COVID trials have excluded pregnant women and lactating women.

The Chair made some recommendations related to review of deaths:

- Identify all potential pregnancy-related deaths during COVID using standard processes
- Add additional dates for the full committee review rather than delaying reviews
- Enter all maternal COVID deaths into the MMRIA System to allow for national aggregation of data

MOTION: *adopt the recommendations as stated above - prevailed*.

Maternal Mortality Review Information Application (MMRIA, or "Maria") is a data system designed to facilitate MMRC functions through a common data language. CDC, in partnership with maternal mortality reviews and subject matter experts, developed the system and it is available to all MMRCs.

Future Agenda Items. December 11, 2020.

- Speaker on how it is going in the different health regions (especially in the rural areas)
- Urgent Maternal Messaging (Florida system)
- Race Equity Work Group collaboration housed under the collaborative

- Unintended consequences of some of the lockdown COVID issues (mental health and family violence)

Public Comment. No public comment was offered.

Executive Session: to review cases under Health and Safety Code, Section 34.007 as authorized by Section 34.004. The committee moved into executive session.

Adjourn. There being no further business, the meeting was adjourned.

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