HHSC: Maternal Mortality and Morbidity Task Force, March 6th, 2020

The Maternal Mortality and Morbidity Task Force 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. Members appear below.

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. Linda Gaul,** DSHS representative - State Epidemiologist, Austin **Ms. Kimberly Griffen**, Community Advocate, Pearland **Dr. Pamala Gessling**, Registered Nurse, Dallas **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

1. Call to Order and Determination of Quorum. Dr. Hollier convened the meeting on March 6th, 2020. A quorum was established.

2. Welcome and Introductions. Members introduced themselves.

3. Approval of December 6, 2019, Meeting Minutes. The minutes were approved as written.

4. Subcommittee on Maternal Health Disparities Update. Dr. Carla Ortique, Vice Chair stated that they have developed a tool to help identify the presence of bias in care. They are using federal forms (MMRIA Forms). They are having to define what constitutes bias and a workgroup with CDC was formed.

Maternal Mortality Review Committees (MMRCs) are multidisciplinary committees in states and cities that perform comprehensive reviews of deaths among women within a year of the end of a pregnancy. They include representatives from public health, obstetrics and gynecology, maternal-fetal medicine, nursing, midwifery, forensic pathology, mental and behavioral health, patient advocacy groups, and community-based organizations. CDC works with MMRCs to improve review processes that inform recommendations for preventing future deaths.

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. Standardized data collection is a first step toward fully understanding the causes of maternal mortality and eliminating preventable maternal deaths. MMRIA helps MMRCs organize available data and begin the critical steps necessary to comprehensively identify and assess maternal mortality cases. MMRIA provides the following:

- A repository for the collection of clinical and non-clinical information surrounding a woman's life and death, which can help facilitate review by a jurisdiction-based maternal mortality review committee.
- Documentation of committee deliberations on1) whether the death was related to pregnancy; 2) if it could have been prevented; 3) factors that contributed to the death; and 4) recommendations to prevent future deaths.
- Standardized indicators, common to most pregnancy-related deaths that can be used for surveillance, monitoring, and examining maternal mortality.

CDC has made 24 awards, supporting 25 states for the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program. This funding directly supports agencies and organizations that coordinate and manage Maternal Mortality Review Committees to identify, review, and characterize maternal deaths; and identify prevention opportunities. This work will:

- Facilitate an understanding of the drivers of maternal mortality and complications of pregnancy and better understand the associated disparities.
- Determine what interventions at patient, provider, facility, system, and community levels will have the most effect.
- Inform the implementation of initiatives in the right places for families and communities who need them most.
- Texas was a recipient of one of the awards.

The CDC has determined that women of color are three to four times more likely to die post pregnancy than white women. There is disparity in all health measures. To-date, the efforts look only at the hospital and physician level. We cannot get out of this easily. It is not just being Black… it is being Black in this country. The subcommittee recommended that they all go through antibias training together. The Vice Chair stated that shame prohibits action and that the response to disparity should not be shame, but action.

5. Health and Human Services Commission Consult on Senate Bill 748 Maternal Teleservices Pilot Program Meghan Young, MPAff Manager, Policy and Program Development Meghan.Young@hhsc.state.tx.us

SB748 amends Chapter 531 of the Government Code to require HHSC to conduct a study by September 1, 2020 on the costs and benefits of permitting Medicaid reimbursement for telehealth and telemedicine services for prenatal and postpartum care.

The bill requires HHSC to develop a pilot program to establish pregnancy medical homes with maternity management teams for women who receive coverage through the Medicaid managed care model. HHSC is required to provide a report on the pilot program by January 1, 2021.

The bill amends Chapter 33 of the Health and Safety Code to require the executive commissioner of HHSC to adopt rules for newborn screening fees and ensure that amounts charged are sufficient to cover the cost of performing the screening.

The bill establishes the Newborn Screening Preservation Account as a dedicated account in general revenue to be administered by the Department of State Health Services (DSHS). The bill would require the Comptroller to transfer unexpended and unencumbered funds from Medicaid reimbursements collected by the agency for newborn screening services to the new account. The account will also be composed of grants, gifts, donations, legislative appropriations, and interest earned on the investment of money in the account. Money in the account could only be appropriated to DSHS and only for the purposes of carrying out the newborn screening program, performing additional newborn screening tests, or for certain capital expenditures.

The bill amends Chapter 34 of the Health and Safety Code to require HHSC to submit a report summarizing actions taken to address maternal morbidity and reduce maternal mortality rates on December 1 of each even numbered year. HHSC, in collaboration with the Maternal Mortality and Morbidity Task Force, is also required to perform program evaluations on various programs and policy options related to maternal health services.

HHSC, in consultation with the task force, is required to develop a program to deliver prenatal and postpartum care through telehealth or telemedicine services. HHSC would be required to submit a report on the program by January 1, 2021. The bill would also require HHSC to apply for grants under the federal Preventing Maternal Deaths Act of 2018 (Pub. L. No. 115344).

The bill adds syphilis to the diagnostic testing required during delivery.
The bill would require DSHS to develop and implement a high-risk maternal care coordination services pilot program in one or more geographic areas of the state. DSHS is required to submit a report evaluating the effective of the pilot program and whether it should be continued, expanded, or terminated by December 1 of each even numbered year.

DSHS and the executive commissioner of HHSC are not required to establish a high-risk maternal care coordination services pilot program, unless a specific appropriation for its implementation is provided in a general appropriations act of the 86th Legislature.

This legislation will do one or more of the following: create or recreate a dedicated account in the General Revenue Fund, create or recreate a special or trust fund either within or outside of the Treasury, or create a dedicated revenue source. The fund, account, or revenue dedication included in this bill would be subject to funds consolidation review by the current Legislature.

The bill took effect September 1, 2019.

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Texas Senate Bill (SB) 748 directs HHSC to:

- Evaluate the use of teleservices during pregnancy and the postpartum period.
- Conduct a study on the costs and benefits of providing reimbursement for maternity care through telehealth and telemedicine.
- Develop a pilot program to deliver prenatal and postpartum care through teleservices for women with low-risk pregnancies.

The following teleservices are supported:	**The following modalities are supported**:
• Telemedicine • Telehealth • Home Telemonitoring	• Live two-way synchronous • Store-and-forward • Remote patient monitoring • mHealth

Telemedicine services are defined in Texas Government Code §531.001(8) as: "Health care service[s] delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology."

Telehealth services are defined in Texas Government Code §531.001(7) as: "Health service[s], other than telemedicine medical service[s], delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology."

Home telemonitoring services are defined in Texas Government Code §531.001(4-a) as the: "…scheduled remote monitoring of data related to a patient's health and transmission of the data to a licensed home and community support services agency or a hospital."

The Health Teleservices for Prenatal and Postpartum Care issue brief was written by the Texas Medicaid External Quality Review Organization (EQRO) in December 2019. It reviews scientific literature, policies, and programs to understand the benefits of and recommend use of teleservices for perinatal care.

The benefits identified by the EQRO include:

Access to care

- Appointment availability and uptake—Reduces the burden of in-person visits and costs associated with personal days, childcare, and transportation
- Provider base—Improved access to providers and specialized provider types

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Health outcomes

- Helps with the management of chronic health conditions (e.g. asthma, diabetes, and hypertension) during pregnancy
- Increased engagement and satisfaction of patients and clinicians

The barriers identified by the EQRO included:

Availability of

- Broadband connection
- Devices for communication
- Devices to monitor patient conditions

More research is needed to determine the cost effectiveness of teleservices and perinatal care

HHSC looked at utilization of telemedicine, telehealth, and home telemonitoring services among women with pregnancy-related Medicaid coverage during State Fiscal Year (SFY) 2018. Because the pilot program will be for low-risk pregnancies, we stratified utilization data by pregnancy risk status.

The majority of telemedicine and telehealth services are used to treat patients with behavioral health conditions. The procedure codes most frequently billed for telemedicine and telehealth services are for

- psychiatric diagnostic evaluations
- evaluation and management services
- psychotherapy services

1,037 out of 307,582 (.3%) pregnant women enrolled in Medicaid used these services in SFY 2018.

Risk Groups:

Low-Risk

- Considered routine
- Do not include any risk factors or complications that may benefit from medical intervention
- Expected to require 11 visits

Medium-Risk High-Risk

- One or more risk factors threaten the health or life of the mother or her fetus
- Often require care from a maternal-fetal medicine specialist
- Expected to require, but not limited to, 20 visits per pregnancy

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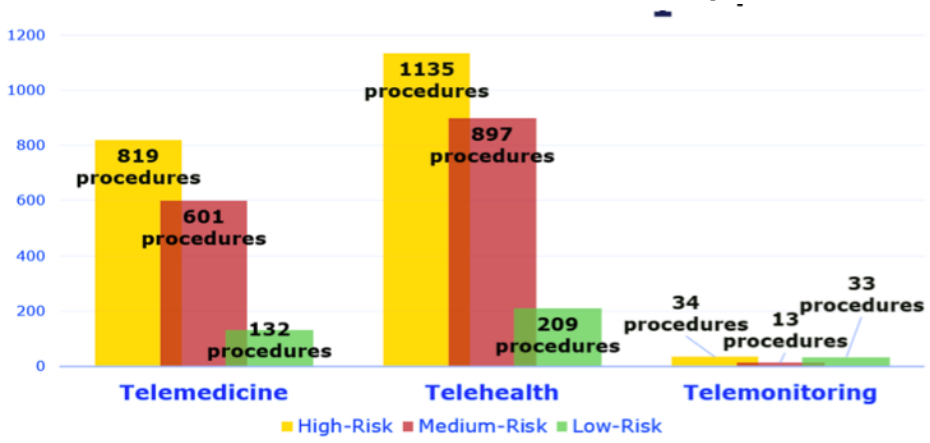
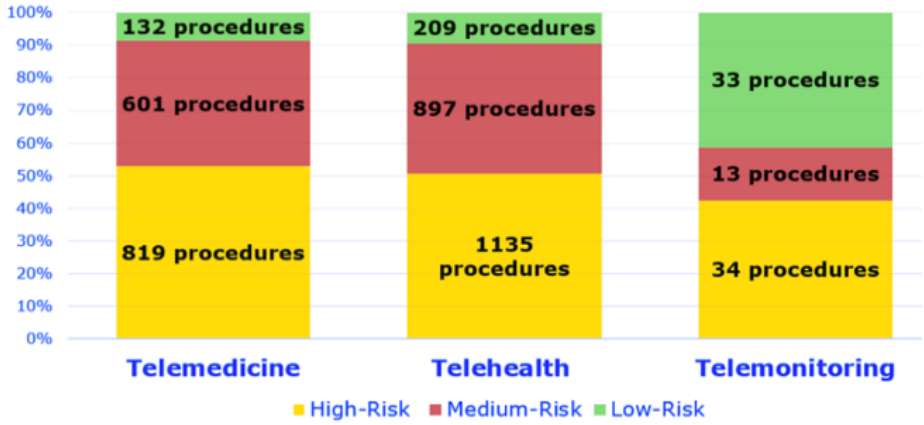
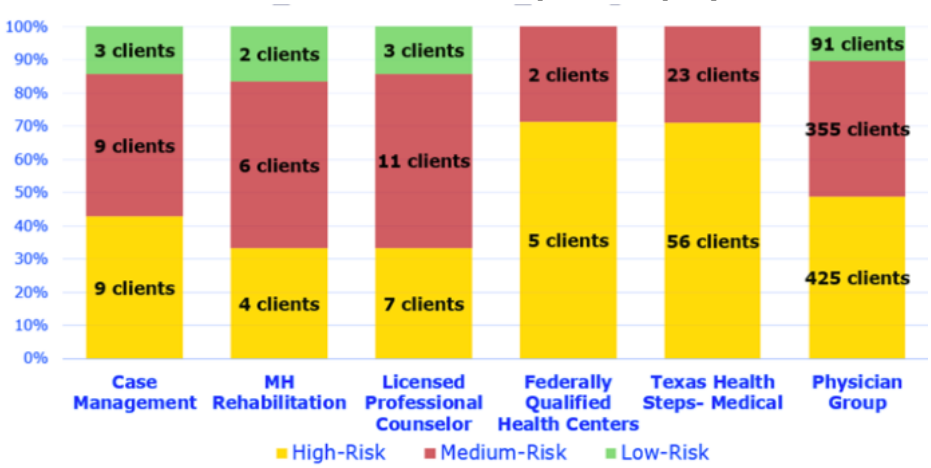
State Fiscal Year 2018 Service Use Comparison



State Fiscal Year 2018 Risk Group Makeup by Procedures



State Fiscal Year 2018 Risk Group Makeup by Providers



State Fiscal Year 2018 Clients, Providers, Services, and Expenditures By Risk Group

Risk Group	Clients	Providers	Services	Amount Paid	Average $ Per Provider	Average $ Per Client
High	521	72	1,176	$56,275	$782	$108
Medium	413	63	913	$43,798	$695	$106
Low	103	36	244	$11,633	$323	$113

The models identified by the EQRO include:

- Teleconsultation. The Periscope Project; Project ECHO (Extension of Community Health Outcomes)
- Low-risk pregnancy. OB Nest

> The OB Nest is a new prenatal care model developed at Mayo Clinic that combines traditional prenatal care office visits with Connected Care visits and in-home monitoring. Connected Care visits involve communicating with an experienced obstetrics nurse via phone call or Patient Online Services secure messaging. Throughout your pregnancy, you will listen to your baby's heartbeat and measure your own blood pressure with the provided Blood Pressure Cuff and Fetal Doppler.

- **High-risk pregnancy.** Maternal and Fetal Telemedicine Program at Colorado Fetal Care Center; ANGELS

EQRO recommendations relevant to pilot program included the following:

- Pilot teleservices in specific geographic areas or populations to assess feasibility and cost.
- Conduct future studies to determine continuity of care for clients who use teleservices.
- Provide tools to increase awareness of the availability and benefits of teleservices.
- Provide technical assistance and guidance on teleservices care provision.
- Identify avenues to successfully integrate teleservices into clinical workflows.
- Identify avenues for ensuring privacy and HIPAA compliance for teleservices.

Other Tele-Services activities included the following:

- SB 14, 86th Legislature
- Rider 94, 86th Legislature
- SB 670, 86th Legislature

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- HB 1063, 86th Legislature
- DSRIP Transition Plan Milestone M-9
- Continued monitoring of teleservices in Texas with the Telemedicine, Telehealth, and Home Telemonitoring Services in Texas Medicaid report
- Cost effectiveness study on teleservices to determine savings and clinical outcomes

The next steps involve:

- Feedback from Review Committee to develop pilot program
- Survey for STAR plans and providers to submit joint responses to HHSC on:
    - The number and location of interested pilot providers
    - Technical assistance needs
    - Time required to implement teleservices model
- Allow all newly awarded STAR health plans the opportunity to participate in the pilot by amending their managed care contract.

Comments, Questions and Answers

- There are two big challenges for providers: infrastructure and reimbursement. Staff stated that health plans must transfer members to an alternative payment methodology and that might address the reimbursement issue.
- Are women being included in discussions of acceptability? Staff stated that they are focused on the providers at this point, but the feedback from women would be a good thing to pursue.
- There was a taskforce for telehealth reported in Obstetrics and Gynecology: "Implementing Telehealth in Practice."

Abstract: The term "telemedicine" often is used to refer to traditional clinical diagnosis and monitoring that are delivered by technology. The term "telehealth" refers to the technology-enhanced health care framework that includes services such as virtual visits, remote patient monitoring, and mobile health care. Evidence suggests that telehealth provides comparable health outcomes when compared with traditional methods of health care delivery without compromising the patient–physician relationship, and it also has been shown to enhance patient satisfaction and improve patient engagement. Obstetrician–gynecologists and other physicians who practice telehealth should make certain that they have the necessary hardware, software, and a reliable, secure internet connection to ensure quality care and patient safety. To implement a telehealth program effectively, participating sites must undergo resource assessments to evaluate equipment readiness. Credentialing and privileging in telemedicine depend on the requirements of the facilities where the physician practices and the source of service payment or reimbursement. Obstetrician–gynecologists and other physicians who provide telehealth must meet many safeguards before delivering telehealth services, including federal, state, and local regulatory laws and licensure requirements. Insurance carriers should provide clear guidelines to physicians who provide telehealth to ensure appropriate health insurance coverage for telehealth encounters. Telehealth has quickly become integrated into nearly every aspect of obstetrics and gynecology, and current trends in patient-generated data and big data analytics portend

increased use. These technology-enhanced health care delivery opportunities enhance, not replace, the current standard of care.

It should be important to evaluate both urban and rural communities and expand the data set to a number of demographic points. Staff stated that the bill requires four counties in the state with rural and urban county inclusion.

6. Senate Bill 17 Pregnancy-Associated Outcome Measures. Diana Forester, Quality Assurance, HHSC.

SB17, 85th Legislature, First Called Session. 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.

Senate Bill 17, 85th Session, 2017 required the Health and Human Services Commission (HHSC), to evaluate options for reducing pregnancy-related deaths and for treating postpartum depression in economically disadvantaged women. This resulted in the 2018 Joint Biennial Report by DSHS and the Task Force reviewed the 2012 cohort of maternal deaths and analyzed maternal death trends for the years 2012-2015.

The bill further required Department of State Health Services (DSHS) and the Maternal Mortality and Morbidity Review Committee (MMMRC), to identify strategies to lower costs and to improve quality outcomes related to severe maternal morbidity (SMM) and chronic illness. (DSHS launched the maternal safety bundles initiative: Texas AIM in December 2017)

The bill required HHSC to study and determine feasibility of adding provider's use of procedures (AIM bundles) as an indicator of quality for quality-based payments.

SB17 Feasibility Study. HHSC studied the feasibility of adding the AIM maternal safety bundles as an indicator of quality. The limitations identified by the study were:

- MCOs' ability to influence hospital processes is limited.
- Hospitals contract with multiple MCOs.
- MCOs contract with multiple hospitals and the volume of members at each hospital may differ.

An MCO quality measure focused on member health outcomes would be better aligned with other MCO quality improvement activities than a measure focused on a hospital's adoption of AIM bundles. HHSC commissioned Texas's EQRO to explore applying the AIM maternal morbidity measures at the MCO level.

In 2018, the EQRO conducted a study (producing a report) to examine ways to leverage current data to evaluate maternal morbidity across Texas Medicaid/ and CHIP at the MCO-level. The study examined differences in maternal care utilization, pregnancy outcomes, and the cost of maternal care for a cohort of women enrolled in the STAR Program, with the goal of better understanding how these outcomes vary with pregnancy risk status and service plan enrollment.

The EQRO found:

- Rates of hemorrhage and preeclampsia were lower in women that had timely prenatal care
- STAR+PLUS had highest SMM rates
- Black, non-Hispanic mothers had the highest rates of SMM despite only accounting for 18% of deliveries
- Mothers in rural areas had higher SMM rates than women in metropolitan or micropolitan areas

The EQRO collaborated with DSHS and discussed changing the data capture period from 15 days after delivery to 42 days after delivery. DSHS staff agreed HHSC should move forward with the SMM measures.

Based on the EQRO study findings and recommendations and collaboration with DSHS, HHSC developed three measures as indicators of quality

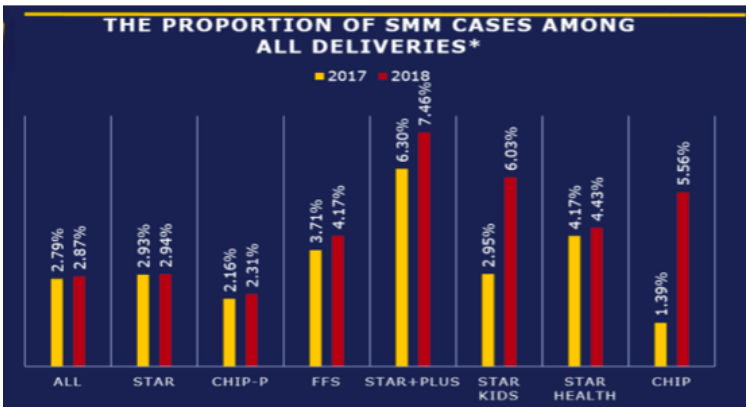
- The proportion of SMM cases among all deliveries.
- The proportion of SMM cases among deliveries having hemorrhage.
- The proportion of SMM cases among deliveries with preeclampsia

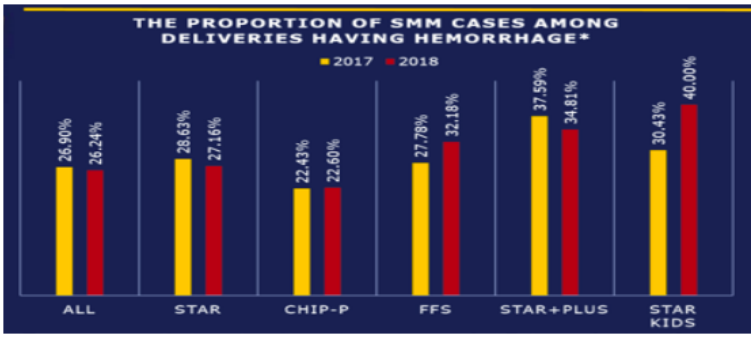
Data sources include

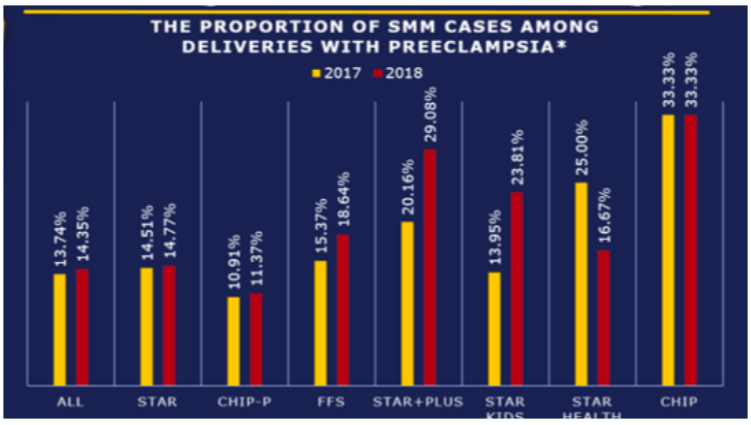
- Encounter and enrollment data
- AIM definitions for identifying Hemorrhage, Preeclampsia, and SMM

The data capture period is seven days prior to through 15 days after the delivery. HHSC is planning to change the data capture period to seven days prior to delivery encounter and 42 days after initial delivery admission. The following are base line data for use in developing measures.

Testing the Methodology







*These are results based on the data capture period 7 days prior to delivery and 15 days after. Data will be rerun using the new data capture period 7 days prior to delivery and 42 days after to establish a baseline

Next steps include:

- Present pregnancy-associated outcome measures to stakeholders
- Modify the measurement timeframe (seven days prior through 42 days after delivery)
- Track measures and begin public reporting in 2020
- Incorporate measures into existing quality initiatives

Comments, Questions and Answers.

- Is there any insight as to why STAR+PLUS is so much higher than other categories? Staff stated that they would like to look further into this. The Chair stated that comorbidity plays a factor.
- What is the number for the pre-eclampsia? Staff stated that they would get that number for the committee.
- One of the things they saw when they were looking at PPCs, hemorrhage was common. Sometimes hemorrhage went up even though other measures improved. Is this a concern that should be addressed? Staff stated that HHSC would want to provide guidance on this and would go back to ensure that there were no penalties tied to the measures.
- Unintended consequence could be patients not wanting to go to STAR. Facilities will be filling out the codes on this.

7. Maternal Mortality and Morbidity Review Committee Operational Updates

There were new staff who were introduced resulting from a new grant award and the exceptional item funding DSHS received.

SB748 had required DSHS to apply for the ERASE MM Grant. CDC has made 24 awards, supporting 25 states for the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program. This funding directly supports agencies and organizations that coordinate and manage Maternal Mortality Review Committees to identify, review, and characterize maternal deaths; and identify prevention opportunities. This work will:

- Facilitate an understanding of the drivers of maternal mortality and complications of pregnancy and better understand the associated disparities.
- Determine what interventions at patient, provider, facility, system, and community levels will have the most effect.
- Inform the implementation of initiatives in the right places for families and communities who need them most.
- Texas received this grant along with other states.

Yesterday 16 cases were reviewed. There will be five cases reviewed following this meeting. There will be meetings that will look at the data and findings for the legislative report to be released September 1.

Texas AIM added another hospital so that totals 218 of 224 hospitals. The Hemorrhage bundle is winding down. The Texas AIM summit will be this spring and 800-1,000 attendees are anticipated. The Hypertension bundle will be rolled out at that time.

TexasAIM 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.

What is AIM?
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.

AIM Maternal Safety Bundles
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 will first work 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.

A small group is being developed to address the Comprehensive High-Risk Screening Tool. There is no date at this time for completion, but DSHS will be partnering with HHSC.

There are ongoing discussions about the Birthing Center Pilot.

8. Future Agenda Items.

- Follow-up on issues that were presented previously, and
- Update on the Texas Collaborative for Healthy Mothers and Babies.

9. Public Comment. There was no public comment offered.

10. Executive Session. to review cases under Texas Health and Safety Code, Section 34.007 as authorized by Section 34.004.

The committee met in executive session to discuss the five cases referenced above.

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

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