HHSC: Perinatal Advisory Council, February 12, 2020

The Perinatal Advisory Council develops and recommends criteria for designating levels of neonatal and maternal care. The Perinatal Advisory Council, created by House Bill 15 of the 83rd Texas Legislature (Regular Session), develops and recommends criteria for designating levels of neonatal and maternal care, including specifying the minimum requirements to qualify for each level designation and a process for the assignment of levels of care to a hospital, makes recommendations for dividing the state into neonatal and maternal care regions, examines utilization trends in neonatal and maternal care, and recommends ways to improve neonatal and maternal outcomes.

House Bill 3433 of the 84th Texas Legislature (Regular Session) amended House Bill 15 by adding two new members to the Perinatal Advisory Council and extended the date of its report. The council must submit a report with its recommendations to the Health and Human Services Commission and the Department of State Health Services by September 1, 2016.

Council members are as follows:

Dr. Emily Briggs, Chair Family medicine physician who provides obstetrical care in a rural community New Braunfels	**Dara Lankford, RN** Nurse with expertise in perinatal health Ft. Worth
Dr. Cynthia Blanco, Co-chair Neonatologist in Level III or IV NICU San Antonio	**Dr. Alyssa Molina** Family medicine physician who provides obstetrical care in a rural community Eagle Lake
Dr. Andy Bowman Neonatologist from rural area Midland	**Dr. Patrick Ramsey** Maternal fetal medicine San Antonio
Dr. Sadhana Chheda Neonatologist in Level III or IV NICU El Paso	**Karen Rhodes, RN** Nurse with expertise in maternal health Brownsville
Stephanie Ferguson, RN Rural Hospital representative Childress	**Saundra Rivers, RN** Rural Hospital Representative Sweetwater
Dr. Ryan Van Ramshorst Ex-officio Austin	**Dr. David B. Nelson** Maternal fetal medicine Dallas
Dr. Alice Gong General hospital representative San Antonio	**Dr. Michael Stanley** Neonatologist Richardson
Dr. Charleta Guillory Pediatrician Houston	**Dr. Eugene Toy** Obstetrics-gynecology Houston
Allen Harrison Representative from a hospital with Level II NICU Austin	**Ms Patricia Carr** Children's hospital representative Corpus Christi
Dr. Lisa Hollier Obstetrics-gynecology Houston	

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

1. Call to order. The meeting was called to order by the Chair, Dr. Emily Briggs, on February 12th, 2020.

2. Roll call. A quorum was established.

3. Approval of the minutes (Meeting on November 12, 2019). The minutes were approved as written.

4. Perinatal Advisory Council (PAC) By-Laws Review. The existing bylaws were reviewed to see if changes were needed. Dr. Stanley commented on the focus of the bylaws and the use of the term "outcomes." The Chair stated that the Council does have outcomes as a focus, and the Council is moving in that direction. A comment was also made about the Center for Excellence. The Chair stated that though there has not been a briefing by this group, they do still exist and there is interaction.

MOTION: *Approval of the bylaws, as written - prevailed*.

5. Results from The Agency for Healthcare Research and Quality's (AHRQ) survey of the top Texas Newborn Hospitals about The Dartmouth NICU Atlas - David C. Goodman, MD MS Professor of Pediatrics and Health Policy Geisel School of Medicine at Dartmouth, Adjunct Professor of Pediatrics University of Texas McGovern Medical School, Houston.

A summary of the findings of the report follow. "Striking variation was observed in the care of Medicaid-insured newborns across regions and hospitals, with and without adjustment for differences in health risk. This variation in rates of NICU services and imaging occurred in both the high- and low-risk cohorts (i.e., VLBW and LPT). The overall Medicaid program payment for newborn care in 2014 was $1.1 billion, with newborns requiring special care (i.e., elevated care in either a NICU or a maternal-newborn care unit) accounting for 85% of the total. Most (85%) of the payments were for facility charges (i.e., hospitals), with the balance accounted for by professional services, primarily physician bills.

Preliminary analyses failed to find either benefit or harm in differences in NICU length of stay. If confirmed for other aspects of care, there are opportunities to reduce the intensity of care and payments and to increase the value of newborn care in the Texas Medicaid program."

Dr. Goodman stated that the purpose of the study was to look at patterns of care across Texas. The report was distributed to Texas hospitals and is available online (see link above). 150 Level II and Level IV hospitals were contacted to participate in the study. There were 26 questions in the survey that were open- and closed-ended. There was a 50% response rate.

807 BRAZOS ST, SUITE 607, AUSTIN, TX 78701 TEL: 512-708-8424, WWW.THBI.COM

The Dartmouth Institute for Health Policy & Clinical Practice — Dartmouth

Hospital Characteristics I

Hospital Characteristic	Responding Hospital	Non-responding Hospital
Hospital type (%)		
Government – not for profit	17%	8%
Non-government, not for profit	47%	52%
Investor-owned, for profit	36%	40%
NICU (%)		
Level II	40%	52%
Level III	41	40
Level IV	19	8
Children's hospital (n)	6	2
Total births (mean)	2,419	2,568
Newborns delivered and admitted to NICU (mean)	358	311
Bed count (mean)	375	322

Data source: 2015 Texas Hospital Association and the American Hospital Association (AHA) Annual Survey

Measures were used and identified, and hospitals were asked if the measure identified was interesting and if it was useful. In addition to the measures provided for the survey, hospitals were asked what additional measures they would like to see. These were summarized on the table below.

The Dartmouth Institute for Health Policy & Clinical Practice — Dartmouth

Measures Feedback

Measure	Very interesting	Very useful
NICU admission rate	79.5%	63.0%
Special care days /newborn (NB)	64.4	52.1
% Special care days billed as intensive	56.2	49.3
Head MRI per NB	52.1	42.5
Chest films per NB	45.2	42.5
Abdominal films per NB	42.5	38.4
Head ultrasound per NB	54.8	50.7

- 37% of respondents were surprised by the information provided
- 82.2% found late preterm measures useful
- 72.6% found very low birth weight newborn measures useful

The top additional requested measures were: NAS, mortality, transfers, antibiotic use. data is available for the first three

02/12/2020 https://tdi.dartmouth.edu/ PRELIMINARY RESULTS 7

Q: The data presented here is utilization focused around rates. Is it intended that this would be a comparison study along with more outcome measures, like the VON measures? Dr. Goodman stated that it was focused on utilization and payment. VON has access to data that this study did not. There had been no work prior to this project on newborns across all levels of risk. Therefore, they started with utilization and could move beyond this in the future.

Dr. Stanley inquired if we could ask hospitals where they care for the late preterm baby. There may or may not be a transitional nursery. Perhaps we could look at admission patterns of babies that are late preterm. Dr. Goodman concurred with the idea to look into where these babies are cared for.

Vermont Oxford Network (VON) serves as a neutral, independent party in analyzing and providing benchmarking data for individual centers and groups that can be used to identify local opportunities for improvement of neonatal care. Four databases collect information on very low birth weight infants, all patients cared for in a NICU, follow-up for extremely low birth weight infants, and infants cared for in resource-limited settings around the world. See VON Data Bases.

Dr. Guillory asked if the data was available for transfers to the hospital? Dr. Goodman stated that data is available, including up- and back-transfers. Dr. Guillory asked if volume data was also collected. Dr. Goodman stated that in their NIH grant application, they have proposed to do volume outcome studies for the Texas Medicaid program. He stated that to do this, you have to also have the data on the non-Medicaid admissions.

Continuing with the presentation, Dr. Goodman stated that they also looked at stratification by hospital. This information is presented in the table below.

Negative comments included:

- Data is too old.
- Methods are not explained well enough (see Appendix of the report for methodology explanation).
- Not as pertinent to Level II NICU.

The next step is a qualitative study conducting interviews and the results will be shared in the future.

C: If the state will not provide the necessary data, it would be better to conduct the study in another state.

6. Neonatal and Maternal Designation Programs, Department of State Health Services. Elizabeth Stevenson made the presentation. We are on the second cycle of the neonatal designations. There are 232 designated neonatal hospitals, and 21 will re-designate this year. For the maternal levels of care, there are six Level IV designated facilities with 17 applications waiting to be reviewed. There are two new staff hired to total four designation coordinators.

Jane Guerrero stated that when the centers of excellence were developed, they build like a pyramid. The top level is fetal therapy designation. There is not an organization that can take on the designation yet and they are in discussion with the North American Fetal Therapy

Network. They are interested in developing the capability to provide the survey necessary for designation.

7. Report required by Texas Health and Safety Code §241.187(m)(3)(A), summarizing review of neonatal care, published December 31, 2019, and next steps – Dr. Emily Briggs and Jane Guerrero. The Chair stated that she has not received very much email feedback on items to be included in the report. Texas has focused on the health of mother and baby above all else. There is a strategic report to frame the discussion. (See Strategic Review of Neonatal Level of Care Designations 2019)

Pursuant to Senate Bill 749, 86th Legislature, Regular Session, amending Chapter 241, Health & Safety Code, the Department of State Health Services (DSHS), in consultation with the Perinatal Advisory Council (PAC), conducted a strategic review of the practical implementation of Hospital Level of Care Designations for Neonatal and Maternal Care. The strategic review should, at a minimum, identify:

- Barriers to a hospital obtaining its requested level of care designation
- Whether the barriers are appropriate to ensure and improve neonatal and maternal care
- Requirements for a level of care designation that relate to gestational age and
- Whether, in making a level of care designation for a hospital, the department or PAC should consider:
    - Geographic area in which the hospital is located, and
    - Regardless of the number of patients of a particular gestational age treated by the hospital, the hospital's capabilities in providing care to patients of a particular gestational age as determined by the hospital.

The report must summarize the Department's review of neonatal care and actions taken by the department based on the review and be submitted to the legislature not later than December 31, 2019.

DSHS performed a strategic review encompassing analysis of 152 hospital survey reports with 2,257 patient records reviews, pertinent sections of the Texas Administrative Code, geographical considerations, and level of care requirements in other states. Based on this review, DSHS identified two main areas that prevented hospitals from receiving their requested level of designation:

- Level III - not providing comprehensive care to infants of all gestational ages with mild to critical illnesses or requiring sustained life support.
- Level IV - not providing a comprehensive range of pediatric medical subspecialists and pediatric surgical subspecialists available to arrive onsite for face-to-face consultation and care, and the capability to perform major pediatric surgery including the surgical repair of complex conditions.

Additionally, other contributing themes to a hospital not meeting requirements for the requested level of care designation were:

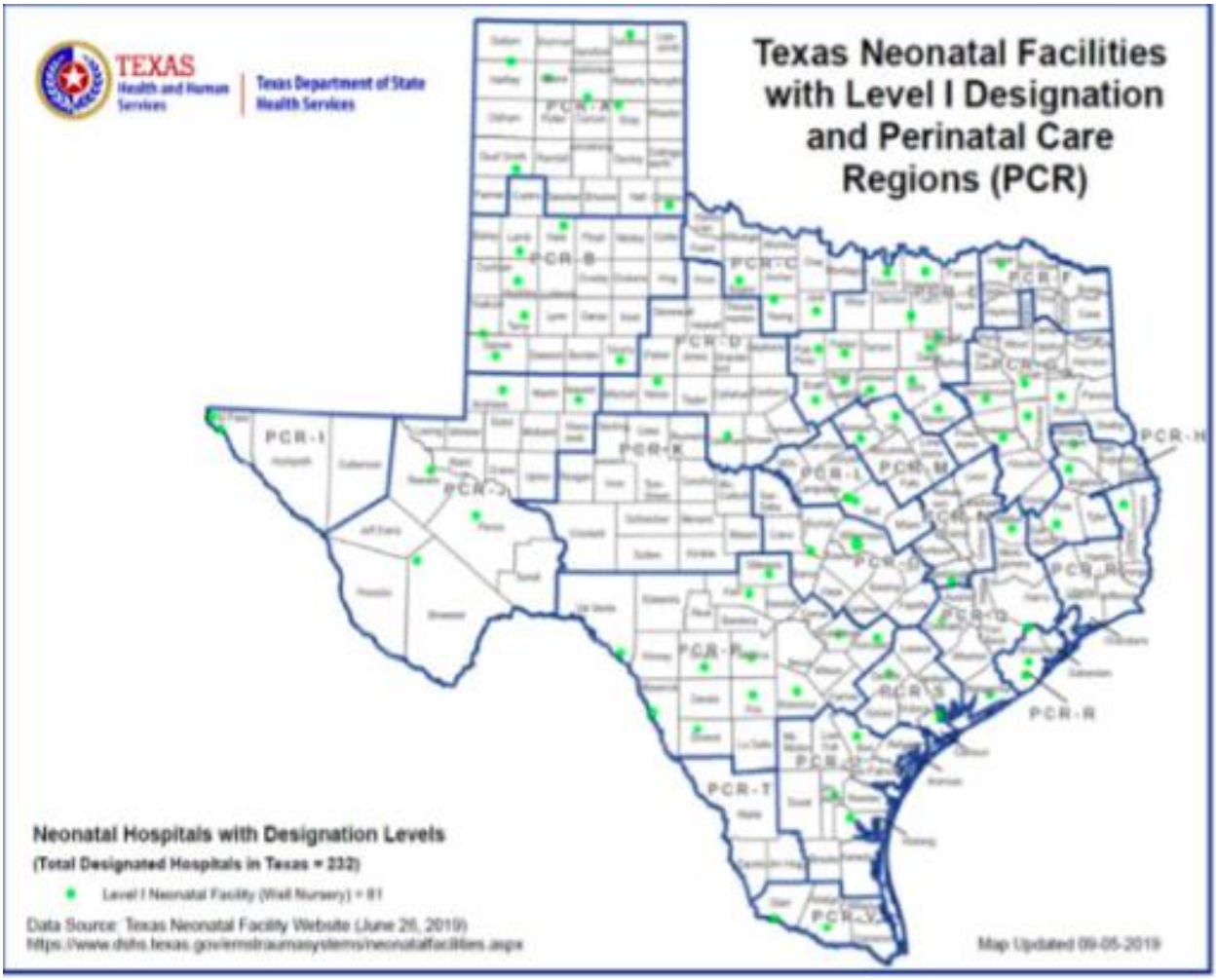
- Lack of 24/7 physician and Neonatal Nurse Practitioner (NNP) coverage;
- Lack of trained direct-care staff;

- Health insurance directives requiring transfer of certain neonates to specified hospitals; and
- Absence of high-risk neonatal admissions.

DSHS analysis has identified common causes and barriers to hospitals receiving their requested level of designation and compared these factors to rules in other states. However, additional consultation with the PAC is necessary to determine whether the identified barriers are appropriate or whether the Neonatal Level of Care rules should be revised. DSHS will collaborate with the PAC to begin a formal review of the neonatal levels of care following the appointment of new PAC members in early 2020. This collaboration will include a review of the barriers identified in this report and analysis of whether changes required by SB 749 help mitigate barriers to obtaining a hospital's requested designation level. Based on recommendations from the PAC, DSHS will initiate the public rulemaking process to implement SB 749 changes and address other issues identified during the review process.

By December 31, 2020, DSHS will submit a follow-up report to the legislature outlining the PAC's determinations and any next steps for rulemaking.

The Chair stated that Texas has a good distribution of Level I facilities.



The Chair stated that there are some facilities that did not get the level of care they wanted, but we should stay focused on the state as a whole to make sure that facilities are available where they are needed. She stated that we have to have a conversation about the needs of the state.

Mr. Harrison stated that on page four of the document and SB 749, the PAC focused on rural areas. The sensitivity to geographical isolation is important but there are also areas of geographical concentration. He stated that this has directed facilities to certain levels of care designation. There are systems delivering a lot of babies. There are some that have achieved a Level III NICU. These may decide to transfer babies to a Level IV facility, and then are told they are no longer a Level III. This denies the facility to serve families at the level that they have paid and prepared for. There are no winners in this kind of decision/punishment.

The Chair stated that there is a tentative meeting for March 24th to continue this discussion if it needs more time.

Dr. Blanco stated that she does not see specifics about each hospital. For patients, there will always be other Level IIIs and IVs in areas of high concentration. There is an area on the map where there are no, or not many Level Is. The designation needed may be in another health network.

Dr. Stanley stated that that will not be seen on the report. The fact is that this is a competitive world. There are many areas with hospitals right across the street from each other. Economic considerations are part of the equation. He stated that we cannot put volume into the designation. In some cases, we have made care worse, not better. We have to look at SB 749 again.

The 83rd Legislature passed H.B. 15, authored by Representative Kolkhorst. The bill directed the establishment of designation levels for neonatal intensive care units (NICUs) and maternal levels of care. The Perinatal Advisory Council (PAC) developed the standards for each level of designation, and the Department of State Health Services (DSHS) determines and assigns the level of designations.

S.B. 749 seeks to improve the current level of designations process. The bill requires DSHS to establish a process for a hospital to appeal its level of designation to an independent third party, and clarifies the role of telemedicine and practitioners' scope of practice. The bill also provides a waiver process from certain designation rules to address variability in hospital volume and capability, requires a strategic review of the designation rules, and aligns the PAC sunset date with the sunset date for DSHS. (Original Author's/Sponsor's Statement of Intent)

S.B. 749 amends current law relating to level of care designations for hospitals that provide neonatal and maternal care.

The bill requires the Health and Human Services Commission (HHSC), in consultation with the Department of State Health Services (DSHS), to adopt additional rules relating to level of care designations for hospitals that provide neonatal and maternal care.

The bill repeals the provision abolishing the Perinatal Advisory Council on September 1, 2025, and require the Sunset Advisory Commission to review the Perinatal Advisory Council during the period in which DSHS is reviewed. DSHS and the Sunset Advisory Commission assume that the agencies could support this strategic review process using existing staff.

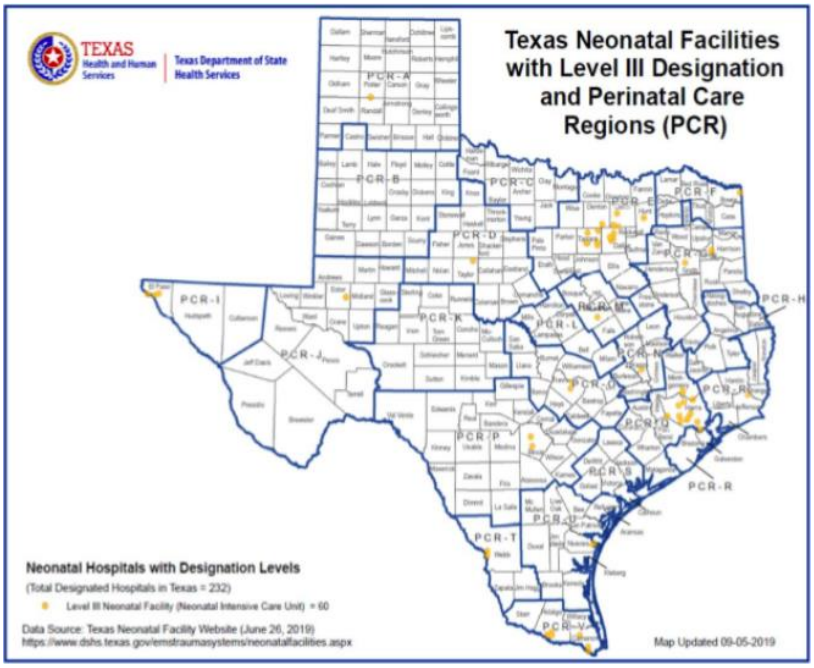
The bill requires DSHS, in consultation with the Perinatal Advisory Council, to conduct a strategic review of the practical implementation of current rules relating to hospital level of care designations for neonatal and maternal care. Based on the review, DSHS would be required to recommend a modification of these rules as appropriate. The bill also requires DSHS to submit two reports to the Legislature relating to its review of neonatal and maternal care rules.

Dr. Gong stated that she is a surveyor and she has surveyed across the state. The systems have gotten together to manage patient care across the different level designations. With cooperation, things do work.

Dr. Molina stated that Appendix E has graphs with mileage reported. She stated that 99 miles is not a small distance and Uber can be very expensive if a child is in the NICU. The document states that the state does not restrict care based on cost, but that is not always the way it is. They do limit care if the care is outside the scope of the facility because of liability. All it takes is one bad outcome and then the liability issues kick in.

Dr. Stanley disagreed with the previous statement. He stated that the problem is, parents have transportation issues when babies are sometimes transferred within their system.

Dr. Guillory stated that Texas is leading the US in designations of care. She stated that we have actually increased Level IVs. In Houston, there are three within a few miles of each other. The Level III map looks pretty good.



Ms. Guerrero, DSHS, stated that a facility can care for an infant at the level of care within its capability even if it is beyond the designation, and then document it. Many facilities not designated at the level they requested self-proclaimed at that level using the old standards.

Dr. Stanley stated that if you are a designated Level II and you keep the baby beyond the time allowed, the lawyers will state that the hospital will be liable. There are hospitals trying to take care of smaller babies beyond their capability, thus compromising care.

Ms. Ferguson stated that she works at a Level I facility. She stated the length of stay (LOS) issues are a problem for them, and they have concerns about this.

Dr. Blanco stated that we have to keep the positive things that have come out of this report. The new rules have resulted in new accountability for quality improvement. She stated that we need more concrete data to see if these are real barriers to care and how we can evaluate those barriers. Sometimes, the physicians want to keep the patient and therefore, they do not get the full array of services.

Dr. Stanley stated that he disagrees. All the HCA programs have quality improvement programs.

Dr. Gong stated that there was quality improvement in the past, but nursing was not involved; now they are looking at bedside care and the culture has changed.

Mr. Harrison stated he cannot speak for all the hospitals in the state. He stated that they did not suddenly involve nurses because of the NICU process. Having nurses at the front of the process is important.

Dr. Guillory commented on the transfers to Levels III and IV and transfers back. She stated that there are travel issues and they do not like that, but when we talk to the parents, they recognize why they are transferred. Parents do not want to go back because the care is so much better in the facility they were transferred to. The biggest struggle is insurance because they do not pay for back-transfers (transport and care).

Ms. Guerrero, DSHS, stated that she would like to come back at the next meeting with the associated risk of keeping an infant who is outside the designation of the level of care. DSHS does not have the ability to waive the Administrative Code. We would have to look at the language in the rule to address the risk factors raised at this meeting, while keeping the integrity of the level of designation. The state is not directing the practice of medicine and the determination of "who you keep." In the rules, the term "generally" was used as a suggestion from TORCH. It sounds like maybe this helped or maybe it did not.

Ms. Guerrero stated that designation is of a single facility. When we talk about a system of hospitals, this becomes problematic. If we are talking about a system approach, how do we verify that multiple facilities are meeting part of the code?

Mr. Harrison stated that as it relates to the system-ness, he recognizes that individual facilities are being surveyed based on their individual qualifications. He said the issue developed when we talk about transfers to a Level IV facility. Part of becoming a Level IV is, you agree to collaborate with all facilities in your area. There was to be a plan of care that is well-defined. The state might want to look at reciprocity for a Level III facility.

Dr. Stanley stated that there will be an opportunity to re-write some of the rules. Ms. Guerrero concurred.

Dr. Van Ramshorst, HHSC, stated that there is not a policy on home transferred and they rely heavily on the advisory committees such as this one. If there is a new process or service, there is a process of topic nomination.

If you would like to submit a proposal for a Medicaid medical or dental benefit, please complete the Topic Nomination Form (MS Word) and submit it with supporting documentation to MedicaidBenefitRequest@hhsc.state.tx.us.

8. PAC Program update. David Lynch HHSC made the presentation. He stated that quality oversight is designed to get the most out of Medicaid and health programs. Another area they focus on is improving birth outcomes for babies. A requirement of all Medicaid programs is to have an External Quality Review Organization (EQRO). A new contract was signed with the University of Florida, Institute of Child Health Policy and this is the first year of the five-year contract. The new contract provides 15 modest dedicated research slots for improving birth outcomes. Outcome and quality measures will be reviewed across several touchpoints. They previously had looked at C-sections and outcomes.

- The overall rate in C-sections is too high (30%)
- Wide regional variations in the rate of C-sections
- Some hospitals had low complicated C-section rates

The quality office is looking to this council to help identify research topics. Current topic ideas include:

- Neonatal home or back transfers
- Continuation in C-section rates

Dr. Stanley stated that it is fine to do the research, but it is like quality improvement— you have to go to each hospital and ask them what they are going to do about it. He asked about next steps. How do we effect change? Mr. Lynch stated that this is foundational research and early in a process. In the past, C-section rates were sent to hospitals but that is not going on now.

Dr. Guillory asked about the transfers. Mr. Lynch stated that they want to look at transfers in either direction. The doctor stated that one of the things they have been looking at is the trickle-down impact on babies if their mothers die.

The Chair stated that they appreciate using the term "Home Transfers."

Dr. Bowman stated we have to address the racial disparities in maternal mortality. There is a rural/urban divide as well. Babies in rural areas have worse birth outcomes.

Dr. Blanco stated that if there are three spots for research every year, you should try to focus on a holistic view of the effect on neonatality, as opposed to expansion of the topics. We have to know if the neonatality issues are changing. We have the neonatal mortality rates, but we do not know why they have occurred.

Dr. Gong commented on the return transfer; this is impacted by the available resources. We also have difficulty with payors and transfers back. The current infrastructure is an issue that should be considered. Mr. Lynch stated that other states pay for transportation for transfers, but Texas still does not.

Mr. Harrison stated that the Level III NICUs have been downgraded up to 40%. They are receiving a mixed message. The PAC has to recognize what has happened. We are replacing a lack of uniformity in standards with a lack of uniformity in practice. We are saying the facility cannot perform below the level of designation. The fix for Level IIs instead of Level IIIs does not work.

Section of report that concerned Mr. Harrison:
Hospital designations are classifications that establish formal recognition of a hospital's level of care in a specific category, based on the hospital's compliance with established standard requirements. Designations help provide patients and families confidence that care provided by hospitals are substantially similar, regardless of geographical area or hospital size, when the hospitals have the same designation level.

Hospital designations advance care and create systems that, over time, improve health outcomes for patients. Designations do not dictate who a hospital may care for or what services a hospital may provide. Designations do not mandate patient transfers or limit a doctor's decision about patient care. Instead, designations recognize the highest functional level of care provided by a hospital inclusive of all lower level care provided. In Texas, hospitals may receive designations for the following care categories: trauma, stroke, neonatal, and maternal.

9. Public comment.

John Lloyd, Dell Children's Hospital, stated that this work has moved the needle forward. He stated that without data, we do not know if we have made things better. He expressed their support for the process. He stated that regarding access, there should be a more sophisticated analysis other than distance. We have to create a system of excellence for all levels of our patients/citizens.

10. Adjourn. The next meeting will be March 24th. There being no further business, the meeting was adjourned.

***