HHSC: Perinatal Advisory Council
June 23, 2021

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. The report was published on time and can be found here:

Perinatal Advisory Council Report on Determinations and Recommendations (PDF)

Dr. Emily Briggs, Chair
Family medicine physician who provides obstetrical care in a rural community
New Braunfels

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Neonatologist in Level III or IV NICU
San Antonio

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Neonatologist from rural area
Midland

Dr. Sadhana Chheda
Neonatologist in Level III or IV NICU
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Rural Hospital representative
Childress

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Ex-officio
Austin

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Ms Patricia Carr
Children's hospital representative
Corpus Christi

Welcome, logistical announcements, and roll call. The meeting was convened by Dr. Emily Briggs, Chair.

Consideration of the March 31, 2021, meeting minutes. The minutes were approved as written.

Neonatal and maternal designation programs – Department of State Health Services (DSHS).

The purpose of the Maternal Levels of Care Designation is to implement House Bill 15, 83rd Legislature, Regular Session, 2013, which added Health and Safety Code, Subchapter H, Hospital Level of Care Designations for Neonatal and Maternal Care, Sections 241.181 - 241.187. House Bill 3433, 84th Legislature, Regular Session, 2015 amended Health and Safety Code, Chapter 241 and requires the development of initial rules to create the neonatal/maternal level of care designation by March 1, 2018. The maternal levels of care designation rule became effective on March 1, 2018 and the designation for maternal level of care is an eligibility requirement for Medicaid reimbursement beginning September 1, 2021.

The purpose of the Neonatal Levels of Care Designation is to comply with House Bill 15, 83rd Legislature, Regular Session, 2013, which added Health and Safety Code, Subchapter H, Hospital Level of Care Designations for Neonatal and Maternal Care, Sections 241.181 - 241.187. House Bill 3433, 84th Legislature, Regular Session, 2015 amended Health and Safety Code, Chapter 241 and requires the development of initial rules to create the neonatal/maternal level of care designation by March 1, 2018. The neonatal levels of care designation rule became effective on June 9, 2016

and the designation for neonatal level of care is an eligibility requirement for Medicaid reimbursement beginning September 1, 2018. The Perinatal Advisory Council (PAC) is developing recommendations for the maternal rules.

A new staff person has been added to the division. There are 131 maternal designations:

- Level IV--24
- Level III--28
- Level II---53
- Level 1---26

There are 55 applications in process. Level ones may receive a 1,2 or 3 year designation

Neonatal designations 228

- Level IV ---22
- Level III----62
- Level II-----61
- Level 1-----83

There is a new process for expiration extension.

Facilities renewing neonatal designations will receive a new designation date due to work load issues. Monthly calls have been made with facility staff and are open to staff and managers. July 1 is the deadlines for maternal designations. Every designation should be awarded August 1st. The files will then be sent to TMHP. Hospital licensure information is used to upload to TMHP. HB1164 will be discussed later in the meeting. The application process is taking about 40 days presently.

Questions/ Answers/Comments

The process seems to have stabilized and the barriers seem to not be an issue for rural and smaller areas. Staff stated the things they have heard is that there is not enough volume in a given hospital to support the OB and neonatal services.

What is the effect on the population when a facility closes? In the panhandle there were 7,600 people in the town. The county holds 35,000 which is considered rural. In east Texas the county was 73,000 people.

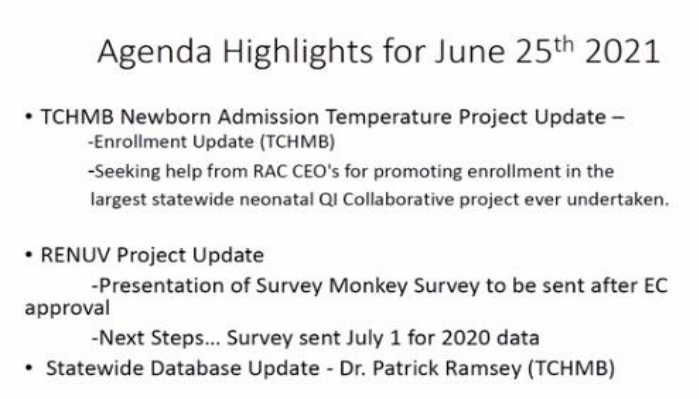
Are any closures related to COVID? DSHS stated that they are not sure, but staff guess COVID has had some effect on the facility. There was discussion about what might be the cause of the facility closures and why they could not remain open even as a level one.

Is there going to be a report on the maternal designations piece for a strategic review? This is planned for February 2022.

The Chair stated that there is an opportunity for a presentation from facilities that are considering closing their units.

We should be providing support to these facilities: Technical assistance and funding. DSHS stated that they struggle with a level zero facilities (those that don't plan on delivering a baby, but a pregnant woman shows up also.

Regional Advisory Council/Perinatal Care Regions (RAC/PCR) Alliance Activities updates.



Neonatal Temperature Enrollment

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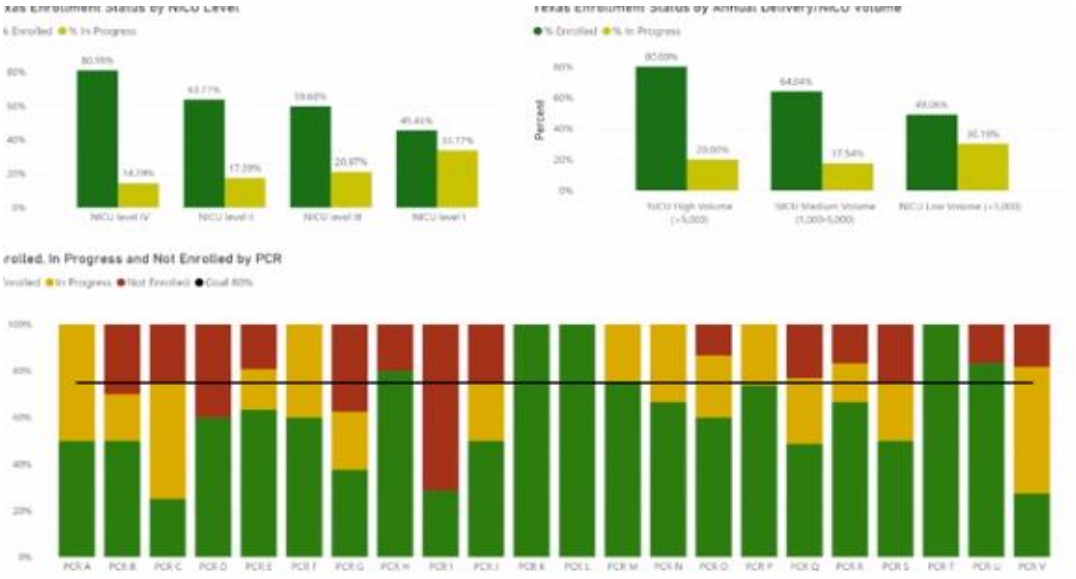

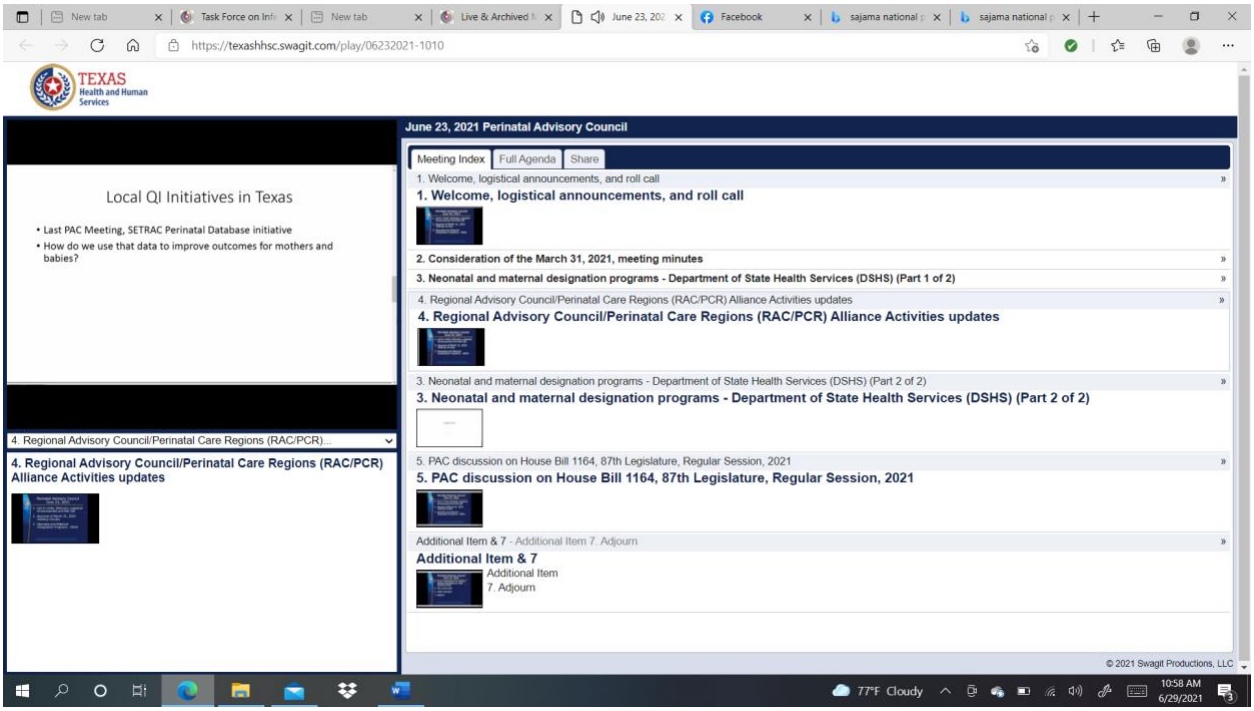

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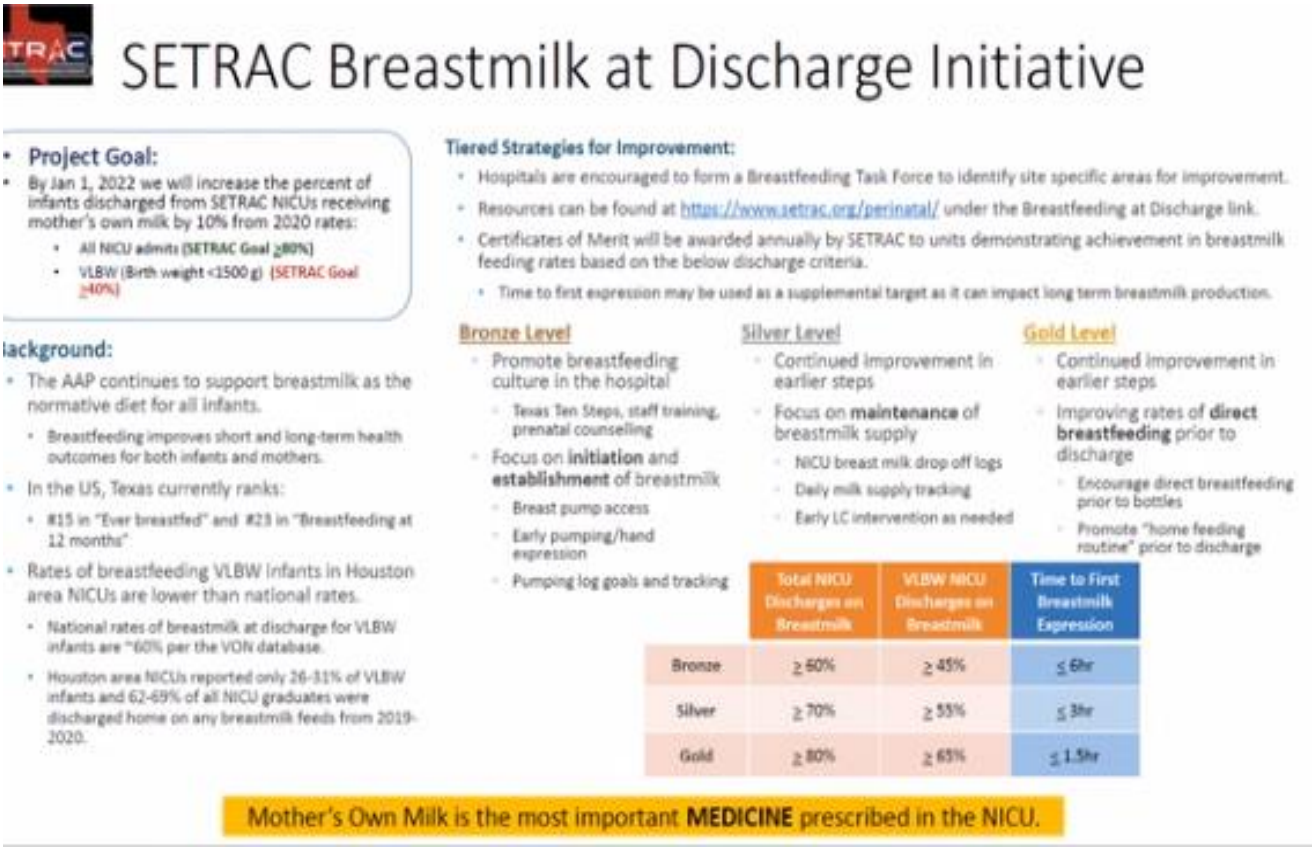
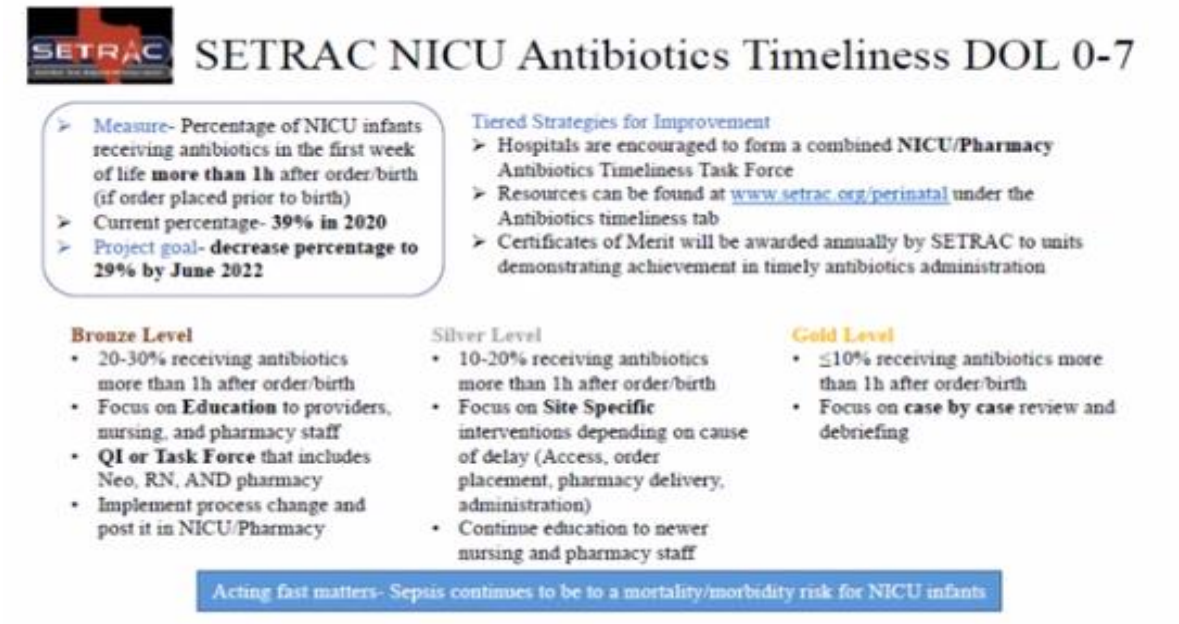

SETRAC Breastmilk at Discharge Initiative
Project Goal:
By Jan 1, 2022 we will increase the percent of infants discharged from SETRAC NICUs receiving mother's own milk by 10% from 2020 rates:
All NICU admits (SETRAC Goal ≥80%)
VLBW (Birth weight <1500 g) (SETRAC Goal ≥40%)
Background:
The AAP continues to support breastmilk as the normative diet for all infants.
Breastfeeding improves short and long-term health outcomes for both infants and mothers.
In the US, Texas currently ranks:
#15 in "Ever breastfed" and #23 in "Breastfeeding at 12 months"
Rates of breastfeeding VLBW infants in Houston area NICUs are lower than national rates.
National rates of breastmilk at discharge for VLBW infants are ~60% per the VON database.
Houston area NICUs reported only 26-31% of VLBW infants and 62-69% of all NICU graduates were discharged home on any breastmilk feeds from 2019-2020.
Tiered Strategies for Improvement:
Hospitals are encouraged to form a Breastfeeding Task Force to identify site specific areas for improvement.
Resources can be found at https://www.setrac.org/perinatal/ under the Breastfeeding at Discharge link.
Certificates of Merit will be awarded annually by SETRAC to units demonstrating achievement in breastmilk feeding rates based on the below discharge criteria.
Time to first expression may be used as a supplemental target as it can impact long term breastmilk production.
Bronze Level
Promote breastfeeding culture in the hospital
Texas Ten Steps, staff training, prenatal counselling
Focus on initiation and establishment of breastmilk
Breast pump access
Early pumping/hand expression
Pumping log goals and tracking
Silver Level
Continued improvement in earlier steps
Focus on maintenance of breastmilk supply
NICU breast milk drop off logs
Daily milk supply tracking
Early LC intervention as needed
Gold Level
Continued improvement in earlier steps
Improving rates of direct breastfeeding prior to discharge
Encourage direct breastfeeding prior to bottles
Promote "home feeding routine" prior to discharge
Total NICU Discharges on Breastmilk
VLBW NICU Discharges on Breastmilk
Time to First Breastmilk Expression
Bronze ≥ 60% ≥ 45% ≤ 6hr
Silver ≥ 70% ≥ 55% ≤ 3hr
Gold ≥ 80% ≥ 65% ≤ 1.5hr
Mother's Own Milk is the most important MEDICINE prescribed in the NICU.


SETRAC NICU Antibiotics Timeliness DOL 0-7
Measure- Percentage of NICU infants receiving antibiotics in the first week of life more than 1h after order/birth (if order placed prior to birth)
Current percentage- 39% in 2020
Project goal- decrease percentage to 29% by June 2022
Tiered Strategies for Improvement
Hospitals are encouraged to form a combined NICU/Pharmacy Antibiotics Timeliness Task Force
Resources can be found at www.setrac.org/perinatal under the Antibiotics timeliness tab
Certificates of Merit will be awarded annually by SETRAC to units demonstrating achievement in timely antibiotics administration
Bronze Level
20-30% receiving antibiotics more than 1h after order/birth
Focus on Education to providers, nursing, and pharmacy staff
QI or Task Force that includes Neo, RN, AND pharmacy
Implement process change and post it in NICU/Pharmacy
Silver Level
10-20% receiving antibiotics more than 1h after order/birth
Focus on Site Specific interventions depending on cause of delay (Access, order placement, pharmacy delivery, administration)
Continue education to newer nursing and pharmacy staff
Gold Level
≤10% receiving antibiotics more than 1h after order/birth
Focus on case by case review and debriefing
Acting fast matters- Sepsis continues to be to a mortality/morbidity risk for NICU infants

Questions/Answers/Comments

How do we intertwine temperature control and the council designation process? All the hospitals have to state the projects they are working on. Surveyors are required to look at individual hospital data and participation in the RAC is a requirement.

Some Regions have several hospitals as collective or as individual systems. We are trying to use the Perinatal systems as enrollers for the projects. Data fatigue is a huge issue.

The PAC is involved in the implementation of the levels of care. The process is equitable and accessible. We highlight best practices.

There is a lot of data burnout at hospitals.

PAC discussion on House Bill 1164, 87th Legislature, Regular Session, 2021.

House Bill 1164 requires the Health and Human Services Commission (HHSC), in consultation with the Department of State Health Services (DSHS) and the Perinatal Advisory Council, to establish rules for patient safety practices related to placenta accreta spectrum disorder. HHSC and DSHS indicated that the provisions of the bill could be implemented within existing resources.

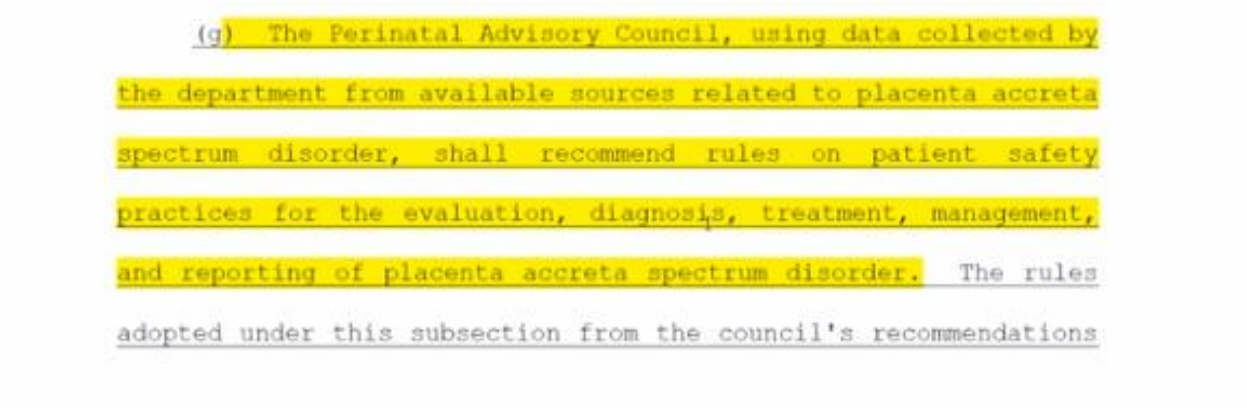
H.B. 1164 seeks to create improved patient safety practices regarding Placenta Accreta Spectrum Disorder (PAS) and require all hospitals with a maternal level of care designation to implement those practices.

Concerned parties have identified maternal hemorrhaging as a leading cause of the state's maternal mortality rate. PAS is a serious and complex condition where placenta grows into, and sometimes through, the uterus during pregnancy, resulting in massive obstetric hemorrhages requiring blood transfusions. Treating patients with placenta accreta spectrum disorder is time-sensitive, making it essential that hospital staff are properly educated and trained to respond quickly to a patient in need.

H.B. 1164 seeks to help reduce the state's maternal mortality rate by requiring the adoption of patient safety protocols for placenta accreta spectrum disorder at level IV maternal level of care designated hospitals. To achieve this goal, the bill directs the Health and Human Services Commission, in conjunction with the Department of State Health Services and the Perinatal Advisory Council, to recommend rules on patient safety practices for the evaluation, diagnosis, treatment, management, and reporting of placenta accreta spectrum disorder. In implementing these recommendations and practices, designated hospitals would be required to have available

a multidisciplinary team of health professionals with training and experience in team responses for treating or managing placenta accreta spectrum disorder.

By improving patient safety protocols through increased education and training for treating placenta accreta spectrum disorder, the bill would help reduce the maternal morbidity rate in the state.



(g) The Perinatal Advisory Council, using data collected by the department from available sources related to placenta accreta spectrum disorder, shall recommend rules on patient safety practices for the evaluation, diagnosis, treatment, management, and reporting of placenta accreta spectrum disorder. The rules adopted under this subsection from the council's recommendations

The rules will have to be opened to address the requirements of 1164 since they impact level four facilities. HHSC is soliciting recommendations from the PAC on what should be included in the rule.

Placenta accreta is a serious pregnancy condition that occurs when the placenta grows too deeply into the uterine wall. Typically, the placenta detaches from the uterine wall after childbirth. With placenta accreta, part or all of the placenta remains attached. This can cause severe blood loss after delivery.
It's also possible for the placenta to invade the muscles of the uterus (placenta increta) or grow through the uterine wall (placenta percreta). Placenta accreta is considered a high-risk pregnancy complication. If the condition is diagnosed during pregnancy, the patient will likely need an early C-section delivery followed by the surgical removal of the uterus (hysterectomy).

Placenta accreta - Symptoms and causes - Mayo Clinic

Recognition and identification in advance of delivery is the focus of the effort.

Comments from the Council:

- All levels of care should have some level of preparedness to address Placenta Accreta

- Is screening available for high risk patients? Yes, but the education has to be formalized. The goal is to get to 70-80 percent participation. There is some kind of bundle being developed.
- In the designation process this should be addressed, and a plan developed.
- The women who need to be screened must be screened
- The approach should be to spread this uniformly across the state
- Europe has adopted standards and are we incorporating these? Staff answered in the affirmative.
- The literature provides pretty good guidance to the care teams
- There appear to be reporting requirements and perhaps a workgroup be developed to address this.

MOTION: (paraphrase) Develop a workgroup to address the issues in HB1164 Placenta Accrita prevailed.

Public comment. No public comment was offered.

Additional Item: Rotation off of Council Members in September of 2021. About two thirds of the membership will be turning over. There are two member solicitations under way.

Adjourn. Next meeting is on September 22. There being no further business, the meeting was adjourned.

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This summary contains supplemental information from third-party sources where that information provides clarity to the issues being discussed. Not every comment or statement from the speakers in these summaries is an exact transcription. For the purpose of brevity, their statements are often paraphrased. These documents should not be viewed as a word-for-word account of every meeting or hearing, but a summary. Every effort has been made to ensure the accuracy of these summaries. The information contained in this publication is the property of Texas Insight and is considered confidential and may contain proprietary information. It is meant solely for the intended recipient. Access to this published information by anyone else is unauthorized unless Texas Insight grants permission. If you are not the intended recipient, any disclosure, copying, distribution or any action taken or omitted in reliance on this is prohibited. The views expressed in this publication are, unless otherwise stated, those of the author and not those of Texas Insight or its management.