

**Texas Maternal Mortality and Morbidity Review Committee
Meeting Minutes
Friday, December 3, 2021
9:00 a.m.**

Due to COVID-19 pandemic, this meeting was conducted virtually using Microsoft Teams only. There was not a physical location for this meeting.

Table 1: Texas Maternal Mortality & Morbidity Review Committee attendance Friday, December 3, 2021 meeting.

MEMBER NAME	IN ATTENDANCE
Ms. Nancy Sheppard- Alderman	No
Dr. Eumenia Castro	Yes
Dr. Kendall Crowns	No
Dr. Meitra Doty	Yes
Dr. Kelly Fegan-Bohm	Yes
Dr. Manda Hall	Yes
Dr. James Hill	Yes
Dr. Lisa Hollier	Yes
Ms. Nancy Puig	Yes
Dr. Sherri Onyiego	No
Dr. Carla Ortique	Yes
Dr. Lavannya Pandit	Yes
Dr. Amy Raines-Milenkov	Yes
Dr. Christina Murphey	Yes
Dr. Patrick Ramsey	Yes
Dr. Robin Page	Yes
Ms. Nakeenya Wilson	Joined late

Agenda Item 1: Call to Order, Welcome, Introductions, Roll Call and Determination of Quorum

Dr. Lisa Hollier, Chair, called the meeting to order at 9:00 a.m. and welcomed all of the committee members, the wonderful staff that support the committee and all of the members of the public who are in attendance. She then introduced the new committee members: Dr Kendall Crowns, Dr. James Hill, Dr. Robin Page, Ms. Nancy Puig and Ms. Nakeenya Wilson, and welcomed them to the committee.

Dr. Hollier, Chair, paused for a moment of silence for Texas families forever impacted by the loss of a mother. She then turned the floor over to Ms. Sallie Allen, HHSC, Advisory Committee Coordination Office. Ms. Allen read logistical announcements, called roll, and asked the members to provide a brief introduction, providing their name, profession/organization and location, and determined a quorum was present.

Agenda Item 2: Consideration of June 4, 2021 draft Meeting Minutes

Ms. Allen noted members received a copy of the June 4, 2021 meeting minutes in their electronic packet and she requested a motion.

MOTION:

Dr. Carla Ortique made the motion to approve the June 4, 2021 meeting minutes as presented. Dr. Patrick Ramsey seconded the motion. Ms. Allen conducted a roll call vote, and the motion passed unanimously with eleven approves, no disapproves, and no abstentions.

Agenda Item 3: Subcommittee on Maternal Health Disparities Update

Dr. Hollier introduced Dr. Carla Ortique and announced that Dr. Ortique was recently recognized for her tremendous contributions and work in equity and will soon receive the Founders Award from Texans Care for Children. She then turned the floor over to Dr. Carla Ortique to provide the subcommittee update.

Highlights included:

- Dr. Ortique provided new members with a brief review of the subcommittee's role.
- The Subcommittee meets bimonthly, and most recently met October 29, 2021. The subcommittee's key role is to review and provide recommendations regarding populations that are disproportionately affected by maternal morbidity and mortality in our state.
 - First role:
 - Using data obtained from administrative and Review Committee analysis to identify key drivers of inequity in Texas maternal mortality and morbidity rates to inform development of actionable recommendations with the goal of eliminating maternal health disparities. The data requested relates to:
 - Cause of death categories by race and socioeconomic status to determine existence of cost specific differences, preventability likewise by race, ethnicity, and socioeconomic status and provider and facility level contributing factors by race and socioeconomic status
 - We also requested data on cause of death and preventability by geographic location of the loss mother to determine if there are differences in rural vs urban outcomes, as well as maternal morbidity data from rural and urban regions by race, ethnicity and socioeconomic status.
 - Second role:
 - To ensure that the maternal Mortality Review Committee members have basic understanding of the impact of bias discrimination and other social determinants of health on maternal health outcomes and to foster the use of common language and standardized approach during review of the Texas maternal death cohort.

- At October meeting, the members discussed three articles of interest related to physician use of stigmatizing language. Dr. Ortique requested that Ms. Waage distribute these documents to the full committee.
- Although the full committee is not able to participate in activity on implicit bias, it was agreed that, as a full committee, a mock case review be established so everyone can standardize their approach as well as ensure that common language is being used as we discuss our cases.
- To date, that mock review has been completed by three of the four MMRC teams, and once the fourth team has completed, an analysis of the data will be performed and will be reviewed at the March meeting. Additionally, the subcommittee will discuss and attempt to gain insight from that activity.
- A multi-state ongoing pilot study related to the discrimination assessment of social determinants of health facilitated discussion tool or dash tool is being conducted. State participation includes New York, Washington, South Dakota, Ohio, Georgia, Michigan and the city of Philadelphia. These states and cities are participating in refining, reviewing, and using the tool that this committee created with input from the full MMRC. The feedback received from these states are being reviewed at the subcommittee level to help refine the tool.
- Extended heartfelt thanks to subcommittee members, and DSHS staff for their time and dedication to eliminating disparity in maternal health outcomes in Texas and that the work being done will also create unity and uphold the ideals upon which this nation was founded.

Agenda Item 4: Texas Maternal Mortality and Morbidity Review Committee Operational and Maternal Health and Safety Initiative Updates

Dr. Hollier introduced and turned the floor over to Ms. Julie Stagg MSN, RN, IBCLC, RLC, DSHS, Healthy Texas Mothers and Babies (HTMB) Branch Manager, to provide the updates.

Ms. Stagg introduced and announced Ms. Lori Gabbert-Charney is the new Maternal and Child Health Section Director, Community Health Improvement Division. Lori is replacing Mr. Jeremy Triplett, who is the new Deputy Associate Commissioner, Community Health Improvement Division.

She then referenced a handout and PowerPoint presentation, *HTMB Maternal Health and Safety Initiatives Update*, and provided the following highlights:

- The 2020 Texas Maternal Mortality Morbidity Review Committee and DSHS Joint biennial report outlines some of the ways the Review Committee's recommendations are being translated, via DSHS, into public health action through the HTMB programs and activities.
- Mission is to improve maternal and infant health and safety by advancing quality, equity, and evidence-based prevention for all Texas mothers and babies.
- The HTMB framework is directed at increasing activities and efforts in five areas which are, individual and public awareness and knowledge, professional education, community and empowerment, community improvement, and perinatal quality improvement network.

- Performance measures from Title V, Maternal and Child Health Block Grant, serves as a road map for healthy Texas mothers and babies' programs.
- State and national performance measures in Texas are guided by an extensive five-year needs' assessment process.
- Some of those performance measures focus on healthy women of childbearing age who self-rate their health; healthy mothers who smoked during pregnancy; and a newly added state performance measure to address disparities in maternal morbidity, severe maternal morbidity, and the ratio of black to white severe maternal morbidity.
- Following is an outline of ten recommendations in the biennial report which addressed DSHS programmatic efforts to work towards the advancement and movement of these recommendations into action. This is not the work of DSHS alone and is not comprehensive or complete by any means. It takes many organizations and individuals across the state to make this impact.
- **Recommendation 1:** to increase access to comprehensive health services during pregnancy, the year after pregnancy and throughout preconception and interpregnancy periods to facilitate continuity of care, enable effective care transitions, promote safe birth spacing and improve the lifelong health of women.
 - DSHS is charged with the development and implementation is a high-risk maternal care coordination services pilot program and develop a maternal risk assessment tool and provide training to CHW support staff to screen patient with the tool. The overarching purpose is to support identification of women at higher risk for poor maternal health outcomes during and after their pregnancy throughout the postpartum period and to provide supportive care to avert preventable morbidity and mortality. The pilot will focus on testing feasibility and acceptability of the intervention and its components.
 - The DSHS team has completed a scan of the existing tools, models and trainings, and are working to develop a new scope of training tools for the community health worker and technical support of the pilot staff.
- **Recommendation 2:** engage Black communities and apply health equity principles in the development of maternal and women's health programs.
 - There is an appendence that includes additional specifications around this recommendation, including a focus on full engagement of members of populations most impacted by maternal mortality, morbidity and specifically non-Hispanic black mothers and their support networks for class standards, to assess health and psychosocial risk and determinants, and promote and disseminate models of patient centered care and shared decision making which recognize these women as experts in their values and preferences and to support and inform collaborative approach for making health care decisions.
 - DSHS will be incorporating these principles throughout the programs and the HTMB branch, as well as our other programs in maternal and child health.

- One example is the incorporation of the components of the Council on Patient Safety reduction of prepaid peripartum, racial and ethnic disparities bundle into our Texas AIM, Health Care Quality Improvement initiative.
- **Recommendation 3:** To improve access to integrated behavioral health care from preconception through one year postpartum, for women with mental and substance use disorders. The agency does not have a direct role in health care delivery however we do have a role in promotion of best practices and partnering for health care quality improvement.
- **Recommendation 4:** To improve statewide infrastructure and programs to address violence and intimate partner violence at the state and community levels.
 - DSHS apply for and was awarded a competitive five-year grant to implement the Texas Strategic Action Partnership to Reduce Violent Pregnancy- Associated Deaths program.
 - The grant came from the Federal Department of Health and Human Services, Office of the Assistant Secretary for Health and is part of the state, local, territorial and tribal partnership program designed to reduce maternal deaths due to violence.
 - This is a five-year grant which began September 30, 2021 and will end in 2026. It will be housed within HTMB branch with support from our Maternal Child Health Epidemiology unit.
 - The grant is two-fold, 1) it will focus on increasing infrastructure and quality of information and data around violent deaths, including homicide and suicide, and 2) deepen the study and understanding of these deaths and use that information to translate into action. Outcome of data collected will be used to implement evidence-based interventions through partnerships statewide, and then state local partnerships to address the tragic preventable deaths in our state.
- **Recommendation 6:** To foster supportive community environments and leverage programs and services that help women of childbearing age achieved their full health potential.
 - DSHS has partnered with nine community coalitions across the state, composed of multidisciplinary community stakeholders. Most of these are housed out of local public health departments, with one hospital district as well, and they are grassroots community-based maternal child health focused.
- **Recommendation 5 and 8** are paired because the program's work is best represented in recommendation 8, through the work that is being done with the Texas AIM initiative.
 - Recommendation 5: to implement statewide maternal health and safety initiatives to reduce maternal mortality and morbidity, and
 - Recommendation 8: to improve postpartum care management and discharge education for patients and families.

The Alliance for Innovation on Maternal Health, AIM for short, is a national program used by hospitals and communities across the country to implement best practices to improve maternal safety outcomes through implementation of maternal safety bundles.

Texas AIM is the DSHS maternal health and safety initiative designed to focused on a specific maternal health and safety topic, and it supports Texas hospitals with tools and technical assistance and quality improvement as they implement these bundles in their hospital settings.

Following are several areas TexasAIM has supported:

- Texas AIM supports the implementation of the obstetric hemorrhage bundle. We had a learning collaborative for the obstetric hemorrhage bundle that ended in 2020. DSHS is currently working to implement the severe hypertension in pregnancy bundle and are working on the opioid bundle and hope to launch the opioid and other substance use disorders initiative in the winter of 2021.
- From 2018 to 2020, 219 hospitals across the state implemented the obstetric hemorrhage bundle, with significant improvements and increased uptake for a stage-based management plan, risk level assessment, and quantification of cumulative measurement of blood loss throughout delivery and through recovery. Collectively, examples of the preliminary data hint towards a reduction in severe maternal morbidity, however more data is needed and will continue to monitor the outcome data as it's available to look at those that impact.
- Great buy-in and participation across the State, is a collaborative initiative and currently 210 hospitals are enrolled in severe hypertension in pregnancy, with an initiative of 85% participating in TexasAIM Plus Learning Collaborative.
- Support provided to hospitals responding to the COVID-19 pandemic. As the need arose in hospital units across the state, we've paused the learning collaborative to provide intensive support around information and collaboration for learning new practices from March-September 2020, and again from August-November of 2021.
- Anticipate the relaunch of the learning collaborative for severe hypertension in pregnancy in January 2022.
- Provided additional support to rural hospitals across the state through conversation forums to facilitate collaboration between rural facilities.
- Plan to launch innovation and improvement learning collaborative for the opioid and other substance use disorder, learning collaborative in the spring.
- In January, plan to launch the Texas AIM Birthing Center Workshop series to bring concepts of the Texas AIM bundles to licensed birthing centers.
- In addition to the learning collaboratives, and also through Texas AIM, brought Simulation Train the Trainer events to hospitals across the state to support regular on-site simulations and drills of obstetrics emergencies.

- In February 2020, right before the pandemic, hosted 5 live, Train the Trainer events across the state, which consisted of 227 nurses and physician trainers lead from 120 hospitals.
- Birthing simulators kits have been sent to all hospitals in the state with birthing services.
- In May and June of 2021, have hosted similar events for severe hypertension in pregnancy drills through a virtual platform and train more than 550 multidisciplinary team members from 98 hospitals across the state.
- Another key component of perinatal quality improvement network is the Texas Collaborative for Healthy Mothers and Babies (TCHMB) which is the state perinatal quality collaborative (PQC), that is supported through funding from the programs. This collaborative oversees four committees: neonatal, obstetrics, community health and data.
- **Recommendation 7:** To support coordination between emergency and maternal health services and implement evidence based standardized protocols to identify and manage obstetric postpartum emerged emergencies.
 - Partnering with TCHMB to develop an initiative focus specifically on the emergency department response to severe hypertension in pregnancy.
- **Recommendation 9:** To continue and strengthen activities to increase public awareness and prevention.
 - In October, had a soft launch of the Hear Her Texas campaign, in partnership with the Centers for Disease Control and Prevention. The campaign is to amplify the message of hearing women's concerns and then acting on those concerns to prevent severe maternal morbidity and worse outcomes.
 - The first stage of this campaign is to amplify syndicated content from the CDC, Hear Her Campaign.
 - Next phase - we will add co-branded Texas content and incorporate components to address mental behavioral health, violent interpersonal violence and then also focus on the action components of amplifying this message through other programs that we work with through Healthy Texas Mothers and Babies.
- **Recommendation 10:** To support strategies to continuously improve the maternal mortality investigation and case review process.
 - Applying for and receiving and now implementing our components of the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Grant from the Centers for Disease Control and Prevention.
 - This is a five-year grant, and funds are used to support staff and services to assist in timely case develop management and review, and to have continuous improvement of our review processes.
 - Allows use of the Centers for Disease Control, Maternal Mortality Review Information Application, or MMRIA, which is a system for

managing all aspects of the case review process and is used by many other states to increase standardization and deepen understanding of maternal mortality both in our state, and also nationally.

- The grant requires identification of pregnancy, associated deaths, that is death to women that occur during or within a year of the end of pregnancy, within a year of the death and case review of committee decisions must be completed and entered into the MMRIA system within two years of death.
- The grant has been instrumental in supporting timely contemporary case review and ongoing quality improvement of the case review process.
- The last biennial report included findings and recommendations for cases of pregnancy related deaths occurring in 2013, and our next report will include more contemporary findings and recommendations for deaths that occurred in 2019 and in 2020.
- This has been a very significant part in the improvement of case review process and findings.

Dr. Hollier thanked Ms. Stagg for her outstanding summary of the material and the progress that the state is making to meet the recommendations of the Maternal Mortality and Morbidity Review Committee. The presentation is a reminder to other organizations or groups to review the recommendations of the Review Committee as they put together their strategic plans for the coming year. Dr. Hollier also called attention and wanted to ensure the meeting transcript reflects that under Recommendation 2, the population most impacted by maternal mortality is non-Hispanic, Black women.

Agenda Item 5: Future Agenda Items

Dr. Hollier opened discussion for new business and potential agenda items for the next meeting scheduled for March 4, 2022. The members did not provide any information for the next meeting.

Agenda Item 6: Public Comment

No written public comment was received.

Agenda Item 7: Executive Session

Dr. Hollier read the legislation allowing the Review Committee to move into a closed executive session at 10:10 a.m. Ms. Allen announced to members of the public that this concluded the open meeting for the morning and the public was informed that the review committee would return later in the afternoon to open the closed session and then adjourn.

Agenda Item 8: Open Session & Adjournment

Dr. Hollier opened the MMMRC meeting at 4:17 pm and hearing no new business, adjourned at 4:17 pm.

Below is the link to the archived video of the December 3, 2021 Texas Maternal Mortality and Morbidity Review Committee (MMRC) that will be available for viewing approximately two years from date meeting was posted on website and based on the DSHS records retention schedule.

<https://texashsc.swagit.com/videos/151577>