Texas Maternal Mortality and Morbidity Review Committee
Meeting Minutes
Friday, September 18, 2020
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, September 18, 2020 meeting.

MEMBER NAME	IN ATTENDANCE
Ms. Nancy Sheppard- Alderman	No
Dr. Eumenia Castro	Yes
Dr. Meitra Doty	No
Dr. Pamala Gessling	Yes
Dr. Manda Hall	Yes
Dr. Lisa Hollier	Yes
Dr. James Maher	Yes
Dr. K. Kimberley Molina	Yes
Dr. Sherri Onyiego	No
Dr. Carla Ortique	Yes
Dr. Lavannya Pandit	No
Dr. Amy Raines-Milenkov	Yes
Dr. Christina Murphey	Yes
Dr. Patrick Ramsey	Yes
Ms. Nancy Jo Reedy	Yes
Dr. Kelly Fegan-Bohm	No

Agenda Item 1: Call to Order and Determination of Quorum

Dr. Lisa Hollier, Chair, called the meeting to order at 9:00 a.m. and requested a moment of silence for all families who have been forever impacted by the loss of a Mother. Dr. Hollier turned the floor over to Ms. Sallie Allen, HHSC, Advisory Committee Coordination Office. Ms. Allen read logistical announcements, called roll, and determined a quorum.

Agenda Item 2: Welcome and Introductions

Dr. Hollier thanked all members of the review committee for their dedication and time. Dr. Hollier requested members introduce themselves.

Agenda Item 3: Approval of March 6, 2020 Meeting Minutes

Ms. Allen noted members received a copy of the March 6, 2020 meeting minutes in their packet. Ms. Allen requested a motion.

MOTION:
Dr. Patrick Ramsey made the motion to approve the March 6, 2020 meeting minutes. Dr. Carla Ortique seconded the motion. Ms. Allen conducted a roll call vote, and the motion passed unanimously.

Agenda Item 4: Subcommittee on Maternal Health Disparities Update

Dr. Hollier introduced and turned the floor over to Dr. Carla Ortique to provide the subcommittee update.

Highlights included:

- Preventable maternal morbidity and mortality and the disparity rates based on race and ethnicity represent the intersections of inequality of access, gender inequality and racial inequality.
- Inequality of access is not limited to deficits based on low economic status or lack of insurance, but also limited access to high-quality, compassionate, and respectful care that many black women report regardless of income. These three factors represent structural issues and are reinforced by systemic policy and societal norms.
- Appreciation and mutual respect to the multidisciplinary members of the committee for their early recognition that social determinants of health can be impacted by discrimination, bias, and racism.
- COVID-19 has impacted black, indigenous, and people of color disproportionally based on multiple factors such as greater likelihood of living in more crowded conditions, working in service and other industries not conducive of telework options, greater reliance on public transportation, and economic inability to stockpile.
- The Texas Maternal Mortality and Morbidity Review Committee (MMMRC) has actively engaged in activities to identify factors that play a role in disparate outcomes in case review materials while identifying best practices to inform recommendations to address racial inequities in maternal health.
- The Texas Social-Spatial Dashboard has been incorporated into the final revised Health Disparities Tool. Next step is to collaborate with the CDC and other states with Enhanced Reviews who have received the Enhancing Reviews in Surveillance to Eliminate Maternal Mortality (ERASE-MM) grant on the potential for using the tool on a national level.
- Acknowledgement that this meeting is the first public Texas MMMRC meeting since the death of George Floyd and the movement to address race relations and racism.

Agenda Item 5: Consultation for Cause of Death Data Improvement Report: DSHS to consult with the Maternal Mortality and Morbidity Review Committee on Cause of Death Data Improvement under Health and Safety Code, Section 1001.0712.

Dr. Hollier introduced and turned the floor over to Tara Das, PhD, DSHS, Vital Statistics.

Highlights included:

- Cause of death data comes from death certificates, following an international standard, is used for collecting information, publishing statistics on the opioid epidemic, maternal mortality, among other causes.
- The death certificate's cause of death section contains two parts: 1) used to report the causal chain of events that led directly to death; and 2) used to record any other significant conditions that may have contributed to death but did not directly cause death.
- Pregnancy check-box question is included in the death certificate to help identify pregnancy-related and maternal deaths.
- Issues with data quality are not unique to Texas and occurs with paper certificates and electronic registration systems.
- Findings from focus groups and environmental scans in Texas include the need for more medical certifier education and training; the need for additional administrative support for physicians to complete the death certificate; and that the pregnancy checkbox is often completed inappropriately.
- "Pregnant at time of death" on the pregnancy check-box is often over-reported.
- The new electronic registration system, TxEVER, went live January 1, 2019.
- A pop-up message is displayed for the medical certifier to confirm their choice on the pregnancy checkbox. Preliminary review of the data, the confirmation message has not made a difference in the number of "pregnant at time of death" responses.
- Feedback is wanted on:
    - As physicians completing death certificates, are you able to obtain pregnancy history on a decedent? Is that information readily available?
    - What challenges do you see related to maternal mortality and the completion of death certificates?
    - What recommendations do you have to improve the death registration process as it relates to maternal mortality?

Members discussed:

- An issue is that now that the death registration process is in electronic form, sometimes it is difficult when you are also in an electronic medical record to go back and forth between the fields.

  Dr. Das explained that capacity has been built into TxEver to interface with health information exchange or electronic health record systems. This is something that is planned to be rolled out in the future.

- There is an opportunity, since TxEVER has been live for two years, to assess if there has been an improvement in coding using our refined identification of maternal death cases.

  Dr. Hollier thanked Dr. Das for her presentation and her work around reporting accuracy.

Agenda Item 6: Maternal Mortality and Morbidity Review Committee Operational Updates

Dr. Hollier introduced and turned the floor over to Mr. Jeremy Triplett, Maternal and Child Health Section Director, Department of State Health Services, and Ms. Julie Stagg, DSHS, Healthy Texas Mothers and Babies Branch Manager.

Mr. Triplett informed members:

- Many DSHS staff, including MCH epidemiologist and program staff, provided expertise on different dashboards, contact tracing, data entry, and data analysis as part of the COVID-19 response. Due to this shift in duties, some work for the MMMRC had to be put on hold. As of September, many of the staff are back working their regular jobs and will work hard to continue support of the MMMRC.
- The MMMRC Legislative Biennial Report has been delayed due to COVID-19. The MMMRC is required by Texas statute to report on the findings and recommendations to the legislature by September 1st of every even numbered year. An extension to delay the submission of the report until December was granted. DSHS is currently in the final stages of the draft and is getting ready for executive leadership review. The report is on schedule to be submitted by the December deadline.
- DSHS is required to submit the Maternal Health and Safety Biennial Report per Senate Bill 17 to the HHSC Executive Commissioner detailing the work of maternal health and safety initiatives. This report will focus on the status and accomplishments of the Texas AIM program, updates on the Women with Opiate Use Disorders pilot, and the new high-risk care coordination pilot for pregnant women. This report will be available in December of this year.
- DSHS was awarded the Enhancing Reviews in Surveillance to Eliminate Maternal Mortality (ERASE-MM) grant through the CDC in August of 2019. It allows for DSHS to receive $600,000 per year in four full-time employees

(FTEs) to enhance the work being done by the MMMRC. The four FTEs hired includes a:

- Records analyst who will specialize in requesting medical records and work with hospitals to coordinate and gather records;
- Program specialist who will help lead the review committee operations which includes overseeing the coordination of consultation with other agencies, organize and facilitate meetings, and facilitating the development of the Bi-Annual Report;
- Administrative assistant who will help organize and scan the documents used to review cases and prepare cases for review as well as schedule meetings and case calls;
- DSHS is working with the CDC to train DSHS and University of North Texas staff on the Texas-MMRIA system which will allow data to be entered in a standardized way.
- Twenty-two cases will be reviewed today. These cases are part of the 2013 Cohort. DSHS plans to finalize the 2013 Cohort in December and move to 2019 Cohort cases later this year. The skip in years from 2013 to 2019 is to align the work and requirements with the ERASE-MM grant.

Mr. Triplett turned the floor over to Ms. Stagg.

Ms. Stagg informed members:

- TexasAIM is an initiative to support hospital obstetric units with process and quality improvement through shared learning and collaboration using a IHI breakthrough series model for collaborative improvement to support hospitals with implementing the Council on Patient Safety in Women's Health Care bundles, supported by the Alliance for Innovation in Women's Health (or AIM for short).
- The TexasAIM Team hosted a two-day *Teamwork, Communication and Simulation Course* in five locations across the state.
- Prior to COVID-19, the TexasAIM Team was deeply engaged in planning activities for the TexasAIM Plus Obstetric Hemorrhage Learning Collaborative Action Period 3.
- The first TexasAIM OB Care and COVID-19 Webinar was held on March 20, 2020, covering literature and guidelines on COVID-19 and on using simulation for readiness to recognize and respond to COVID-19. Between the live and recorded call, over 500 attendees participated.
- Calls were held weekly through May 15, with two biweekly calls occurring in May and June and a final call on September 4.
- Each call began with literature updates, and then covered topics of interest including simulation, anemia protocols, transport, considerations for Rural Hospitals, staff wellness, outpatient care, neonatal care, anesthesia, critical

care, surge planning, case studies and lessons learned, rural hospitals response and lessons Learned, Q&A panels, strategies for reopening, and disparities and COVID-19.

- A newsletter full of resources was sent out bi-weekly through August. An online resource and communication portal with over 1200 health care professional subscribers from hospitals with obstetric services across the state.
- Hospital TexasAIM teams have expressed their gratitude for the support they have received from each other and TexasAIM to prepare and respond to COVID-19 in their units.
- Based on requests from hospitals, TexasAIM is resuming Action Period 3 for the TexasAIM Obstetric Hemorrhage Learning Collaborative and will continue to update TexasAIM improvement teams on new and emerging issues as they continue their work to make health care safer for every mother across Texas.

Agenda Item 7: COVID-19 and Considerations for Maternal Mortality Review

Dr. Hollier advised the public that the article titled *Maternal Mortality from Coronavirus Disease 2019 (COVID-19) in the United States* pertaining to this topic is linked to the posted public agenda for your reference.

Dr. Hollier stated:

- Information related to COVID-19 infection and the impact on maternal mortality is gradually becoming available.
- A systematic review published last month identified 37 maternal deaths that were believed to be due to COVID-19. All maternal deaths were seen in women with co-morbidities, which the most common were obesity, diabetes, asthma, and advanced maternal age. Acute respiratory distress syndrome and the severity of pneumonia were considered as leading causes of all maternal deaths except in one woman who died of thromboembolism during the postpartum period.
- It is anticipated that the majority of COVID-19 related maternal deaths will be identified based on birth and death certificates through Vital Statistics processes that are already in place for maternal mortality review committees across the United States.
- Texas has a very detailed process to optimize identification of maternal deaths and it is anticipated that this process will be effective in identifying cases affected by COVID-19.
- Several important factors to consider for evaluating maternal deaths attributed to COVID-19 including the timing of the reviews, assessing contributing factors unique to COVID-19, and addressing health disparities.

- With respect to COVID-19 death reviews, we will need to evaluate contributing factors including the context and location of the possible infection, the availability and use of personal protective equipment for work related infections, the availability and timing of testing, and the timeliness and location and quality of medical care received. The stage of clinical knowledge, resources, public health practices, and local and national COVID-19 policies at the time of the death will also need to be considered as part of the review.
- Cause of death should be determined from multiple sources such as medical history, lab results, autopsy reports, and clinical judgment.
- There are concerns for widening disparities during the pandemic. COVID-19 has disproportionally affected people of color and lower socio-economic status. Geographic differences may become more pronounced based on encouraged social isolation, decrease in access to health care resources, and lack of available COVID-19 testing in rural areas.
- Recent published studies in Louisiana and Michigan have shown large disparities in mortality rates based on race due to COVID-19.
- Recent publications also raise concern that people with medical emergencies have avoided the emergency department due to fears of contracting COVID-19 leading to increased mortality and morbidity.
- Rates of primary intervention during COVID-19 has decreased.
- Rates of certain pregnancy-associated deaths may have decreased such as car accidents due to stay-at-home orders.

Members discussed:

- The need to review potential cases related to COVID-19.
- The impact of COVID-19 on rural areas. MMMRCs across the country are beginning to review cases related to COVID-19 and enter these cases into the MMRIA system to evaluate things like rural vs urban nationally and in Texas. A clear definition of urban and rural may be needed.
- Most COVID-19 related clinical trials have excluded pregnant and lactating women.

Dr. Hollier presented the following recommendations to the Committee for review of deaths occurring during the pandemic:

- Identify all potential pregnancy-associated deaths during 2020 COVID using standard processes
- Consider reviewing all 2020 cases by adding additional dates for the full MMMRC Committee review, rather than delaying COVID-19 cases or the other reviews.
- Enter all maternal COVID-19 deaths into the CDC MMRIA System to allow for national aggregation of the data.

MOTION:
Dr. Hollier made the motion to accept the three recommendations. Dr. Carla Ortique seconded the motion. Ms. Allen conducted a roll call vote, and the motion passed unanimously.

Agenda Item 8: Future Agenda Items
Dr. Hollier opened discussion for new business and potential agenda items for the December 11, 2020 meeting.

Members discussed:

- Inviting a person with the appropriate background to speak on capacity and access issues in rural geographic areas.
- The Texas Collaborative for Healthy Mothers and Babies have had dialogues on potential ways to work with the MMMRC to implement messaging similar to Florida's Urgent Mortality Messages (UMMs).
- The Collaborative for Healthy Mothers and Babies, under the leadership of Dr. Ramsey, developed a Race Equity Workgroup. Suggestions for the MMMRC to begin to explore ways to collaborate with the Race Equity Workgroup to operationalize certain recommendations made by the MMMRC including recommendations related to COVID-19.
- The potential for the MMMRC to focus on population health topics related to untoward consequences of COVID-19 precautions such as mental health conditions and the increase in domestic violence. This suggestion was seconded

Agenda Item 9: Public Comment
No public comment, oral or written, was received or presented at the meeting.

Agenda Item 10: Executive Session
Dr. Hollier read the legislation allowing the Review Committee to move into a closed executive session at 10:26 a.m. Ms. Allen conclude the open meeting Live Event and the public was informed that the review committee would return later in the afternoon to open the closed session.

Agenda Item 11: Open Session & Adjournment
Dr. Hollier opened the MMMRC meeting and hearing no new business, adjourned at 5:16pm.

To view or listen to the archived recording of the September 18, 2020 meeting please click on this link: https://texashhsc.swagit.com/play/09212020-554