Texas CHIP Coalition
Meeting Minutes

August 15, 2014

Present:	Anne Dunkelberg, CPPP Nikki Metzgar, CPPP Kathy Eckstein, CHAT Maria Serafine, Lonestar Circle of Care Kit Abney Spelce, insure-a-kid Julie Stagg, DSHS David Williams, HHSC Clayton Travis, Texans Pediatric Society Megan Randall, CPPP Sister JT Dwyer, Daughters of Charity Alice Bufkin, Texans Care for Children Tammy Sajak, DSHS Laura Guerra-Cardus, CDF Chris Yanas, THOT
Conference Line:	Beth Keating, Parkland Hospital District Miryam Bujanda, MHM Betsy Coats, Maximus Will Francis, NASW TX Robin Chandler, Disability Rights TX Diane Rhodes, TDA Rose Marie Linan, HHSC Carrie Kroll, THA Stacy Wilson, THA
Chair:	Clayton Travis, Texas Pediatric Society
Minutes Scribe:	Megan Randall, Center for Public Policy Priorities
Next meeting:	September 19, 2014

I. Legislative Principles Update

LGuerra-Cardus

- Next steps on lege agenda. Went through 3-page brief principles document last meeting. Incorporated everyone's edits. We hope that this will be the final version. If you have any additional edits, it should only be because your organization would be unable to sign on if not changed. Have any additional edits in by next Friday. E-mail Laura if any major changes need to occur. Will have finalized by next Friday.
- For the background doc, we don't have a new draft at this moment to show you, but in the next week or two we will e-mail a revised background doc. We can do edits for the background doc offline.

Clayton Travis

- I will take Principle 1 for revision in the background document.

KEckstein

- For Principle 4: bolster workforce, for “Ensure available funding for loan repayment,” it specifies in medically underserved areas. Is this broad enough? What about for Medicaid/CHIP populations more generally?

CTravis

- We want to support all loan repayment, not just in medically underserved areas.

II. Update on progress of Maternal Mortality and Morbidity Task Force: Julie Stagg, DSHS

JStagg:

- Increasing number of chronic health conditions. Rise in maternal mortality.
- Slide depicting racial ethnic rates of maternal mortality in TX. Hispanics have lowest rate.
- Studying maternal death is complicated. No nat’l standards for data collection. Issues with data quality. Different ways to look at vital statistics records, each of those methods there may be deaths that are missed.
- Maternal death review process is a more comprehensive way to identify cases and dig deeper into each case to find those areas where there might be an opportunity to act at a systemic level to improve health outcomes.
- Other mortality teams, for other populations, are local because the numbers are greater. Maternal mortality review occurs at state level.

ADunkelberg

- What is the scope of what counts as maternal death? Time from delivery? Cause?

JStagg

- Not standardized. The WHO defines maternal deaths as deaths in the first thirty days postpartum. ACOG has a broader definition that looks at deaths in first year postpartum. Those are pregnancy-associated deaths. The type of deaths included also varies based on the review team’s perspective. Sometimes, it just considers deaths that are directly as a result of obstetric event or conditions developed during pregnancy. Other reviews might take a broader approach. They might look at anything that is clearly not an accidental death. Might look at domestic violence, suicide, overdose, etc. Part of the charge of the taskforce in TX is to define what types of deaths will be looked at.
- The TX task force was created last session. Having the Healthy Texas Babies initiative was critical to providing infrastructure to implement the task force in our state.
- Studying trends in severe maternal morbidity is a bigger problem. Mortality is often the tip of the iceberg. Each maternal death represents thousands of cases of morbidity. Death is the most severe outcome of morbidity, but this task force is asked with studying morbidity as well.
- There are different factors that appear to be contributing to deaths by race/ethnicity. Homicide is a huge issue for Hispanic moms, whereas chronic health conditions are more common in the non-Hispanic black population.
- There is an issue with nonstandard data collection. There is not a clear emerging silver bullet and so that is why there is a national move to increase state review of deaths and to coordinate state-to-state definitions and processes so that there can be some standard data being collected. It is different in each state right now.

LGuerra-Cardus

- I don’t see how drug use is one of the things that groups could say are related to birth. If it is with postpartum depression, I could see that beyond that, but I have a hard time connecting those things.

JStagg:

- We are seeing an increased use of opioids nationally in the maternal population and so that is one of the things being looked at. If the death is related to previous addiction, how those drugs may be interacting with medications related to the birth process, etc. is different. Specifically, we are interested in looking at opioid use and abuse.

TSajak

- It is primarily a concern with prescription based drug deaths. Not necessarily street drugs.

III. Update on NICU/Perinatal Advisory Council and Billing Modifiers: David Williams, HHSC

DWilliams

- The NICU Council and Perinatal Advisory Council were a result of HB 2636 from 82nd lege session. That bill charged this council to look at the situation of NICU stays in the state of Texas. The NICU Council produced a report that ended up being the starting point for the Perinatal Advisory Council.
- The Perinatal Advisory Council met six times this year, and is on schedule with its charge. For the first part of the year, HB 15 asked the council to look at recommending levels of care for neonates, and next two years will look at maternal levels of care. The council completed the initial work to submit a set of recommendations for neonatal standards for levels of care. The council submitted them in July to DSHS. Those recs are based on the latest AAP guidelines out of the seventh edition. Where we are now is that DSHS has the report and have started a draft of the rulemaking. The rulemaking process will define for hospitals what the levels of care are for neonatal.
- The next meeting for the Perinatal Advisory Council is October 7th. DSHS will have a meeting tentatively scheduled for the middle of September and will show a draft of the rules. The meeting will generate questions and concerns and the Perinatal Advisory Council will address those concerns at the October 7 meeting. Also looking to get started on maternal levels of care at that point.
- In September, DSHS is going to be scheduling a public meeting that is going to allow stakeholders, primarily from hospital associations and such to meet and review the draft of the minutes/rules. Two weeks prior to September 23rd, DSHS intends to circulate that draft so folks have a chance to review and digest it.
- Go through line-by-line.
- The billing modifier. I helped write and implement guidelines surrounding this new billing situation. This modifier started October 1st, 2011. Prior to this, for any birth in Texas we didn't have a way to tell if it was before 39 weeks, etc. So, we implemented the billing modifiers, three of them, wherein we ask if the birth is after or before 39 weeks but medically necessary, or before 39 weeks but not medically necessary.
- All MCOs are compliant with use of the modifier. Based on claims data, 8% of all claims/births (158,000) did not have a modifier on them. The following year, FY 2013 only 1% did not have a modifier. People are following the rule.
- We put a survey together with 20 questions that went out to the health plans. 18 responded. Gave us a clue in terms of perception and use of the modifier. Some of the questions included:
    - Do you think required use of the modifier is working: 53% said yes. Means that they are using it. We haven't seen a large reduction in medically unnecessary births prior to 39 weeks, but this may be because a lot of hospitals were already on board in terms of being aware they needed to look at those births prior to 39

weeks. Results don't show any marked decreased in births prior to 39 weeks because hospitals already doing things prior to state putting payment restriction in place.
    - Another question we asked was whether or not the hospital system that you deliver at has a hard-stop policy: 53% said do not. In a nut-shell, a hard stop policy means a process that a hospital has to ensure that the deliveries prior to 39 weeks are medically justified.
- The HB 15 policy is primarily restricted to professional services. It is the doctor doing the delivery. Other players that this policy doesn't apply to include hospital, specialties like anesthesiologists. They don't have to fill out these modifiers. One question was that perhaps the next step is to extend payment restrictions to hospitals. So that hospital has a stake in it.

JBanda
- We checked with HHSC and TMHP and they said hospitals *are* getting denied payment.

DWilliams
- Hospitals are not required to fill out the modifiers.

JBanda
- We would have to physically pull the medical record to see why a physician chosen to deliver a baby before 39 weeks. But the nonpayment provision of the modifier applies to the physician and hospital. Will forward you the e-mail from HHSC. Hospitals are not getting paid when the not medically necessary modifier goes on.

KEckstein
- Since the trend in the last couple of years didn't see reduction, might be attributable to other approaches for reducing pre-term births, if you go back further does it show a decline?

DWilliams
- If you go back prior to 2010, births are in different buckets. We didn't have the modifier to code the data, so we couldn't tell prior to 2010 what the breakout of births were.

ADunkelberg
- Because the billing process doesn't allow that information to be generated. You would have to do a chart review study.

JBanda
- In regards to weeks of delivery, I thought that info was on the vital statistics record that goes to DSHS.

DWilliams
- We are looking at this from different angles, but the payment policy was focusing on claims data. What Jennifer brought up is valid. Vital statistics or birth records. Our partners at DSHS are looking at hospital births based on birth certificate data. It is not a measure of this policy, because this one is based on claims data, but we are peeling back the onion a little bit there.

KEckstien
- Also have to wonder how accurate birth certificate data is. Range for early births across the state was was 4% to 92%.

TSajaka
- The center for health statistics has been looking at that data. At a recent meeting, they presented data and a lot of discussion about methodology because the medical directors

are focused on billing definitions and that one measure of did the elective non-medically necessary induced births go down or not. Center for health statistics wanted to look at it more specifically. They did a report for each facility in Texas and sent a letter saying we've got your information and statistics related to delivery, here is your facility number and password to go into the secure site to look at your data.

- Other states who have done a similar thing did have a direct impact on quality of birth certificate data. We all know that hose birth certificates get filled out by a lot of different people, and it is an exact science on how to assign some of these categories on the birth certificate.

JBanda

- We met with vital statistics group at DSHS concerned that people not filling out birth certificate data correctly. Working with DSHS to try to work with hospitals to fill out correctly.

ABufkin

- Will an analysis of that be available? What are trends contributing to rates of reduction?. It sounds like hospitals can view own rates. Is there going to be some sort of analysis of that across the board be done and made public?

TSajaka

- I don't know. They have a lot more work to do on measures and consensus-building with facilities statistically. When looking at infants and how things can happen, it is such a precise science will need to get consensus around basics. Many times hospitals are not in favor of every hospital system knowing what their data looks like from their own specific facility.

IV. ACA Implementation Update: Valerie Eubert and Claire Middleton, HHSC

VEubert

- Account transfers update: increases in numbers, but overall trends haven't changed. Have received over 225,000 account transfers. This data is at the application level, there are more individuals than that total number. Processed more than 222,000 of those. Not in backlog.
- From the beginning of year until now we have transferred 577,672 accounts to marketplace. Have been giving a lot of different outcome data. Percentages haven't really moved over the last few months. Approving about 18%. Of those 18%, just under 50,000 of those are children, the majority.
- One of the things that is occurring at the federal level is the federal Marketplace is working on systems changes and defects for new open enrollment period beginning in November of this year. Last time we talked about some defects.
- We want to share what we have been made aware of from CMS. Income is a big driving factor.

ADunkelberg

- We have been trying to get a sense from either you or the feds of a profile of all cases being referred that are being denied. What are the big groups that are erroneously transferred?

VEubert

- We don't have an empirical breakdown, but we are seeing a large number of them are adults. It appears that their income is well over the income limit and anecdotally and we have been talking with some of the staff, and some of the transfers say they don't have income, but they may have self-employment income, etc.

kAbneySpelce

- So, it's just people who the marketplace is saying have no income?

ADunkelberg

- Are they mostly parents and just really serious defects in income counting?

VEubert

- A lot of them are parents. We also have concerns about how accurately they are capturing adults' relationships to Medicaid-eligible children.

ADunkelberg

- But those are standard, so if that is the problem here, then it would be the problem in other states, too.

CoalitionMember

- What about the issue of someone who had been sent over to HHSC by the feds and was already in Medicaid and is now being categorized as a denial.

VEubert

- Anyone who has an existing case who is already enrolled would be counted as a denial.

KAbneySpelce

- We need to see what the buckets are, because if it is an issue with people being already enrolled, that is not a systems issue – that is an outreach issue.

CMiddleton

- Presumptive eligibility. The ACA requires that we allow hospitals to make presumptive eligibility determinations for parents, caretakers, relatives, etc. Short-term Medicaid coverage until state can make a determination. Working to get a website up and running, have started work with vendor to develop the website. This website will be a place where you can access the policy, info on the program, and a notice of intent that you can fill and out and submit. There is also an MOU hospitals must sign to participate. Once that process has started, the MOU is signed, then they can access the training. Once training is completed, they can submit PE determinations when the program goes live. Mid-October for website to deploy.
- Early November, looking at training deploying on website. For actual implementation of program, will be between December 13 and January 1. Latest date.

KAbneySpelce

- Is intent for hospitals to submit through YTB? If you are not a CP now, is this an agreement memorandum giving you access to that platform?

CMiddleton

- Separate program from CP, but will function in a similar way. Will submit determinations electronically and nce= av completed qualification process will receive access to submit those through portal submitted through HHSC. Will also be required to assist applicants in completing application for ongoing Medicaid. Will be through YTB.com.

KAbneySpelce

- Will this MOU allow for that higher-level CP role where we can do case tracking, etc.?

CMiddleton

- You will be able to have access to view certain things. I don't know what exactly they are able to see for CPP. Through the PE portal will have access to see if someone has been qualified or not, and if currently receiving Medicaid.

KAbneySpelce

- But what about where they are in application process? Pended for more information, etc.?

CMiddleton

- Will we be able to see if they are certified and it is responsibility of hospitals to help person understand what additional information and documentation is needed. In terms of pending status, etc. won't have access to that.

MSerafine

- They are not giving us access to the higher level CP roles any more. Only level 2's are permitted. Some of us in the beginning were level 3, but they are keeping us at level 2 now. Level 1 is kiosk, level 2 is application assistance, and level 3 was going to give case tracking capabilities. A few people got level 3 after six months.

KAbneySpelce

- How does this program interface with outstation eligibility workers? If you submit a PE app where does it go?

CMiddleton

- The PE determination is made by the hospital.

KAbneySpelce

- The PE standards are really high. If we are going to do this, I have to make sure we can track where the application is, that we get things submitted. And what is the relationship with outstation eligibility workers?

KEckstein

- Before, Gina told us that HHSC wouldn't propose rules until the SPA was approved. Are you all on the verge of getting that approved?

VEubert

- We had a discussion with CMS and we have not received approval for the hospital-based SPA.

CMiddleton

- We have the timeline for the rules on next slide.

VEubert

- We have to have rules in place to put program in place at the end of year.

CoalitionMember

- You can move forward without getting CMS approval?

VEubert

- Yes. Our preference would be to establish rules based on what we know the program will be structured like. So, our preference would be to know what we have authority to do first. But those timelines don't always line up.

SisterJt

- PE portal vs. YTB. When it goes into PE portal, does it go to YTB site?

CMiddleton

- We've got two processes. We have PE determination which will set up PE period, but as hospitals are required to assist in submitting a full application, that will be YTB.

VEubert

- We can't require all information needed for full a determination for. Different amount of information needed for the PE vs. the ultimate eligibility determination.

KAbneySpelce

- So, the PE starts the date you submit the presumptive eligibility application.

CMiddleton

- PE starts the day determination is made by hospital.

KAbneySpelce

- If that day that the PE determination is made is after the admit date, we can't bill for the admit date.

CMiddleton

- If the full application is submitted, that will follow regular rules, so that would go back to Jan 1 or months prior if you ask for it.
- Part of the regulation is that PE is for the date that the determination is made. This is federal. That doesn't change the final date rules for regular application.

VEubert

- We can invite folks from the Medicaid division who understand billing to come join us.

CMiddleton

- HHSC setting up survey to discuss interest in PE.

VEubert

- Administrative renewals. We will be looking at the electronic info available, and making a determination. We will notify clients whether we have what we need, whether we need more info, or that they are not eligible.
- Systems process going into place next weekend.
- New piece of info is that we will be sending pre-populated renewal form to persons with disabilities and the elderly. Looking at making additional changes to process going forward.
- Those packets will go out in October and if we haven't head form them within 45 days, will reach out again with reminder notices.
- Renewal process for enrollment will continue. Default is that if they haven't chosen a plan they stay where they are. But have opportunity to make change. Will follow existing enrollment practices. Not making changes to enrollment. This is our internal process for eligibility.

CoalitionMember

- Some health plans reach out to members to remind them that it is time to review. Don't want to duplicate these efforts and hold up a renewal.

ADunkelberg

- What cross-fertilization has there bene done in the health plan division?

KAbneySpelce

- Our health plan came to me about CHIP renewal and went to their HHSC contact and they said we don't know. Does sound like some training and education on the health plan side is needed.

VEubert

- We are working with our counterparts in the Medicaid/CHIP division. Materials are scheduled to go out. Doing a blast to let folks know.

LGuerra-Cardus

- Would like some info at what the cost would be to add that pre-populated form for additional folks because this population might have some fluctuating income. If it is a cost issue, can we figure out what the cost is? Also, moving forward, tracking the impact of enrollment. If any problems needed to be relooked at.

VEubert

- We will be tracking the process by population. We have it built in, who aren't we hearing from, specific groups, etc.

V. ACA Implementation Update: Valerie Eubert and Claire Middleton, HHSC

CTravis

- CHIP is authorized in 2019 but runs out of funding in 2015. Consumer and provider advocates are working to get funding reauthorized. TPS will be making this a priority in coordination with our national organization.

- Wanted to have a conversation through the CHIP Coalition. See what kind of advocacy we can do together before our governor answers this letter.
- Question of whether kids can go into exchange instead of CHIP. Questions around formula, etc.
- Craft this letter for our governor and prepare responses for him. Basics, what CHIP should look like going forward, how it is specifically designed for kids and families when it comes to cost-sharing and benefit structure that the exchange doesn't offer. Can probably include that in the letter to governor, start talking to congressional reps and senators to read that same message. May find some advocates. Joe Barton. Congressional representative.
- Thinking CHIP Coalition as primary signee, potentially.

LGuerra-Cardus

- I agree and think it will be good to make the letter as public as possible. Send to entire congressional delegation. Only other thing we might want to discuss is that nat'l groups have been pushing state advocates to meet with congressional delegations on CHIP. If we could get any and all members interested to help us identify a strategy to contact the entire congressional delegation, that would be fabulous. Make sure to connect with ALL of them, Democrats included.

CTravis

- There are bills going through congress right now, mostly marker bills. They ask for more benefits in CHIP, up to 300% FPL, eliminating cost-sharing altogether, etc.
- I will work on drafting letter and send it around. Laura will work on organizing visits.

VI. Other Updates

ADunkelberg

- Made conference room reservations for legislative briefing.
- Also in recent e-mail was included a registration form for free CTN convening on October 14, which will be a place to come together for outreach and app assistance and to talk about the Coverage Gap.
- Foundation Communities press release. Missing information re: immigration documents.

ABufkin

- PE standards are very strict, and are likely to discourage participation. TCFC will be distributing a letter on this for sing-ons. Hopefully I can send that out through CHIP coalition.

TEXAS
Health and Human
Services Commission

Status of Federally-Required Medicaid and CHIP Eligibility Changes

August 15, 2014

Status of Account Transfers

Account Transfers from the Marketplace to HHSC (Inbound)

- The federal Marketplace began sending applications to HHSC on January 17, 2014. HHSC currently receives applications daily from the Marketplace and processes them as they are received. As of August 8, 2014:
  - HHSC has received 225,462 unduplicated transfers from the Marketplace.
  - Staff has processed approximately 222,500 applications, of which, approximately 218,600 were completed and approximately 3,900 were in progress.

Account Transfers from HHSC to the Marketplace (Outbound)

- Between January 5, 2014 and August 8, 2014, HHSC transferred 577,672 cases to the Marketplace. Transfers occur daily.

Note: Each account transfer may contain multiple individuals.

Account Transfer Outcomes

- Of the applicants received via an account transfer:
  - HHSC denied 78 percent based on Texas eligibility rules.
  - HHSC approved 18 percent.
  - 4 percent withdrew their application.

- As of August 8, 2014, approximately 49,406 individuals referred from the Marketplace have been approved for Medicaid or CHIP. The majority of approvals have been for children's programs (89%).

Note: This data is based on outcomes for 274,955 individuals.

Website

- HHSC is working with a vendor to develop a website for the presumptive eligibility (PE) program.
- The PE website will provide policy and information about the program, including:
  - Notice of intent
  - Memorandum of understanding
  - Training materials

Tentative Timeline

- *Mid October* — Website deploys. Providers may submit the notice of intent to begin the qualification process.
- *Early November* — Training deploys on the website.
- *December 13 - January 1* — Program deploys. Qualified hospitals may submit presumptive eligibility determinations.

Presumptive Eligibility

Texas Administrative Code Rules

- Proposed rules relating to presumptive eligibility are scheduled to be published in the September 5, 2014 edition of the *Texas Register*. The proposed rules:
  - Provide the eligibility requirements for individuals to qualify for presumptive eligibility and the requirements for providers making presumptive eligibility determinations.
  - Specify HHSC responsibilities for oversight of providers making presumptive eligibility determinations.
  - Amend existing rules for qualified entities making presumptive eligibility determinations for pregnant women.
- A public hearing is scheduled for September 15, 2014.

Survey

- HHSC is developing a survey to gauge interest in the presumptive eligibility program.
- This information will help HHSC to plan for administration of the PE program. We encourage and appreciate hospital participation in the survey.

New Renewal Process: Background

- **Effective January 1, 2014, the Affordable Care Act (ACA):**
  - Requires HHSC to use electronic data to the greatest extent possible before requesting information or verification from the client for all Medicaid and CHIP redeterminations
  - Requires clients to be provided a pre-populated renewal form
  - Requires clients who are determined ineligible based on electronic data to be provided an opportunity to update information
  - Prohibits HHSC from requiring in-person interviews

HHSC Programs Subject to Administrative Renewals			
Medicaid for Parents and Caretakers	Medicaid for the Elderly and People with Disabilities (MEPD)	Children's Medicaid and CHIP	Medicaid for Transitioning Foster Care Youth (MTFCY) and Former Foster Care Children (FFCC)

New Renewal Process

1

Administrative Renewal Initiated

HHSC runs admin renewal with electronic data sources to determine eligibility

2

Renewal Letter Sent

All clients will receive a renewal letter notifying them of their eligibility outcome

3

Outcome 1 - Eligible

- Client asked to check over pre-populated form for accuracy
- ***Action <u>only</u> needed*** if information is incorrect (must report changes)

Outcome 2 - Information Needed

- Request for information form sent
- Includes all required verifications needed to complete the renewal
- Client must sign and return

4

All clients are provided three ways to fill out or check pre-populated renewal form*

1) Your Texas Benefits .com

Fill out online
Or
Print from online

2) 2-1-1 TEXAS Connecting People and Services

Option 2
Request paper packet mailing

3) *Local HHSC Office*

**MEPD clients will be mailed the pre-populated renewal form.*

New Renewal Process: Implementation Timeline

- Renewals will be initiated during the 9th month of eligibility.

- Former Foster Care Children (FFCC): First renewal letters sent in September
- All other programs: First renewal letters sent in October

2014				2015
September	October	November	December	January
Renewal letters sent			**Renewals due**	
• FFCC				
	• Children's Medicaid and CHIP • Medicaid for Parents and Caretakers • MEPD, MTFCY			**Renewals due**

DSHS Update: Texas Maternal Mortality and Morbidity Task Force

August 15, 2014

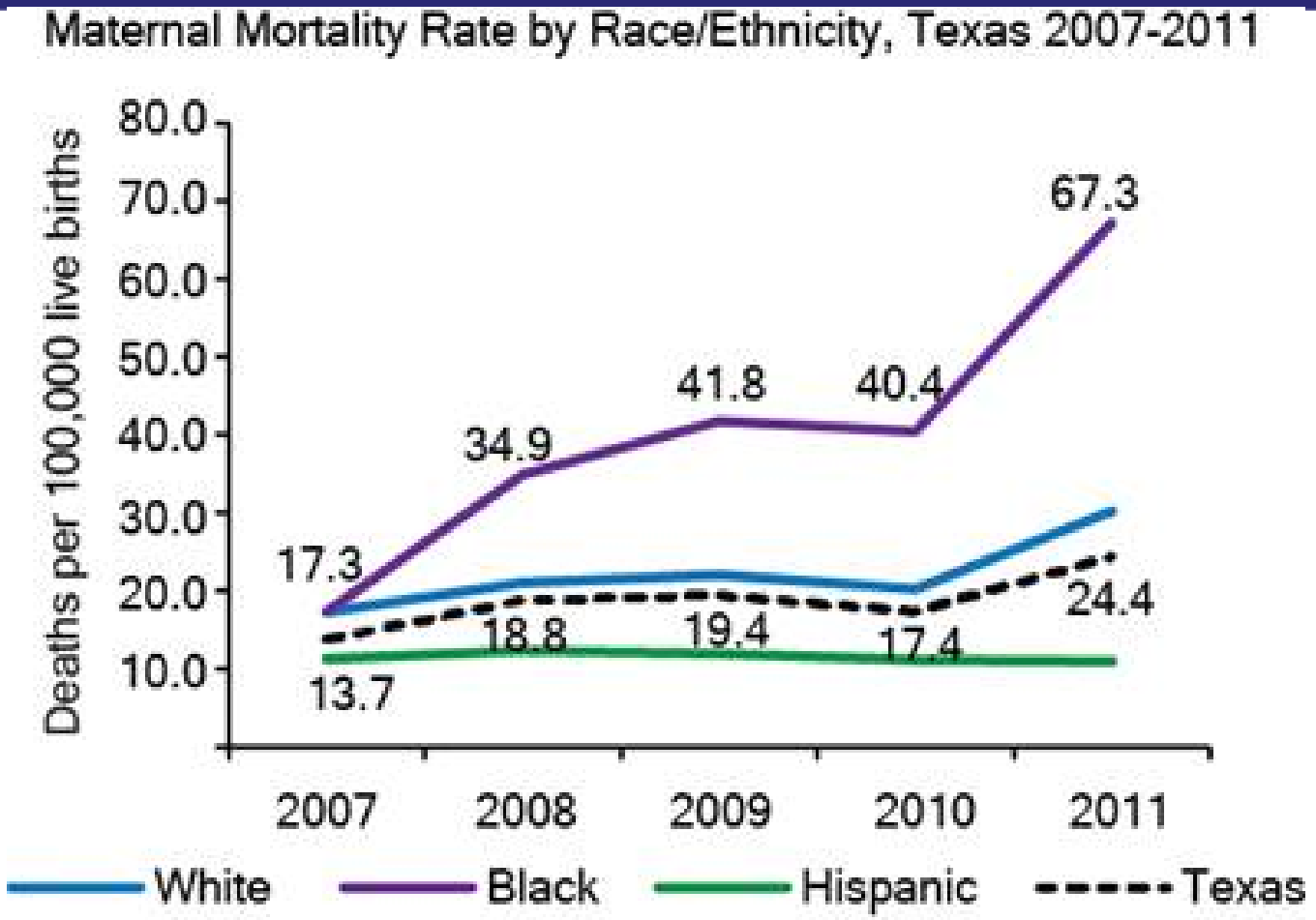
Julie Stagg, MSN, RN, IBCLC, RLC
Women's and Perinatal Health Nurse Consultant
512-776-6917
julie.stagg@dshs.state.tx.us

TEXAS
Department of
State Health Services

Issue

- Increasing number of pregnant women with chronic health conditions
- Rise in maternal mortality over past ten years nationally and in Texas
- Racial/ethnic and geographic disparities

Maternal Mortality Rate by Race/ Ethnicity, Texas 2007-2011



Source: Vital Statistics Death Files: ICD10 O00-O959, O98-O999, A34 & Check Box
Prepared by: Office of Program Decision Support, FCHS, DSHS, 2014

Issue

- Nationally and in Texas, there are issues with data standards and quality
- Maternal death review processes use information beyond vital statistics data to comprehensively identify and assess cases, and most importantly, identify opportunities for effective intervention
- Between 20% and 50% of maternal deaths in the U.S. are preventable
- State based reviews can identify deaths, review the factors associated with them, and take action on the findings

Other Death Reviews in Texas

- Two Fetal and Infant Mortality Review (FIMR) teams (Tarrant County and Dallas) look at systems-level issues that contribute to fetal and infant deaths
- State Child Fatality Review Committee and 73 active local CFR Teams examine child deaths in 200 TX counties (94% child population) to promote understanding and prevention of child death at the state level
- Position statements and reports: http://www.dshs.state.tx.us/mch/Child_Fatality_Review.shtm

Texas Maternal Mortality and Morbidity Task Force

Created by Senate Bill 495, 83(R) to:

- Study and review cases of pregnancy-related deaths, and trends in severe maternal morbidity;
- Determine the feasibility of the task force studying cases of severe maternal morbidity; and
- Make recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in this state.

Texas Maternal Mortality and Morbidity Task Force

- 15-member multidisciplinary task force appointed by Commissioner
- Six-year staggered terms
- Meet quarterly in closed meetings
- All information pertaining to morbidity or mortality is confidential
- may consult with any relevant experts and stakeholders, and representatives of any relevant state professional associations and organizations to perform the functions of the task force
- Biennial reports (status-2014; findings and recommendations-2016)

Current Members

- Dr. Lisa Hollier, Chair, Physician specializing in Obstetrics, maternal fetal medicine specialist, Houston
- Dr. Gary Hankins, Vice-Chair, Physician specializing in Obstetrics, maternal fetal medicine specialist, Galveston
- Evelyn Delgado, DSHS representative - Family and Community Health Services, Austin
- Dr. Meitra Doty, Physician specializing in Psychiatry, Dallas
- Dr. Linda Gaul, DSHS representative - State Epidemiologist, Austin
- Dr. Kidada Gilbert-Lewis, Physician specializing in Pathology, Houston
- June Hanke, Community advocate, Houston
- Armilla Henry, Registered Nurse, Houston
- Dr. James, Maher, Physician specializing in Obstetrics, maternal fetal medicine specialist, Odessa
- Dr. D. Kimberley Molina, Medical examiner, San Antonio
- Dr. Carla Ortique, Physician specializing in Obstetrics, Houston
- Dr. Ronald Peron, Physician specializing in Family Practice, Greenville
- Dr. Amy Raines Milenkov, Researcher of pregnancy-related deaths, Fort Worth
- Nancy Jo Reedy, Certified Nurse-Midwife, Arlington
- Nancy Sheppard, Social Worker, Austin

Status

- First meeting-February 28, 2014:
  - Reviewed legislative directives, roles and responsibilities, best practices and analytic framework, resources and data;
  - Developed components of a logistical action plan for short term actions
- Interim work on communications; policies; process tools

Status

- Second meeting-June 27, 2014:
  - Data update
  - Technical assistance from William Callaghan, MD, MPH, Director, Maternal and Infant Health Branch, Division of Reproductive Health, at the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) at the Centers for Disease Control and Prevention
  - Policy and tool review; action planning
- August TA Webinar: Elliott Main, MD, Chairman and Chief of Obstetrics, California Pacific Medical Center and Medical Director of the California Maternal Quality Care Collaborative (CMQCC)

Next Steps, DSHS

- Coordinate meeting and communications logistics;
- Develop the internal infrastructure necessary to collect, compile, and disseminate de-identified cases of maternal deaths to the task force for review;
- Review legal considerations to ensure maintenance of full confidentiality of information acquired by DSHS pertaining to a pregnancy-related death or severe maternal morbidity, including identifying information of an individual or health care provider; and
- Provide technical assistance and subject matter expertise to support the activities of the task force members

Next Steps, Task Force

- Continue to develop structure and processes
- Refine and finalize rules of operation
- Establish clear processes to review cases
- October and December meetings

More Information

DSHS MMMTF Website:
http://www.dshs.state.tx.us/maternal_mortality_and_morbidity.shtm

DSHS Grand Rounds: *Healthy Texas Babies: Maternal Mortality and Morbidity Review*

The presentation is archived online at
http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589988193

Questions?

MaternalHealth@DSHS.state.tx.us