ADRIANA KOHLER
SENIOR HEALTH POLICY ASSOCIATE
AKOHLER@TXCHILDREN.ORG
AUGUST 2017

Senate Bill 17: Extending the Maternal Mortality & Morbidity Task Force

Continuing the Task Force is the First Step Towards Improving Maternal Health and Safety

On August 16, 2017, Governor Greg Abbott signed into law Senate Bill 17, authored by Senator Kolkhorst. This new law extends the life of the Texas Maternal Mortality & Morbidity Task Force to 2023, allowing it to continue its critical work to review cases of pregnancy-related deaths and complications, evaluate disparities and trends, and make recommendations on ways to reduce maternal mortality and morbidity in the state. SB 17 also includes provisions directing the state health agency to evaluate options for reducing maternal deaths and treating postpartum depression; develop and disseminate best practice tools in maternal health and safety; and disseminate best practices for substance use screening during pregnancy.

This is an important step forward, but extending the Task Force must be the beginning – not the end – of the Legislature's efforts to save mothers' lives, reduce disparities, and improve maternal health. When the Task Force makes its recommendations, we urge state leaders to follow through on them for the sake of moms and families all over Texas.

Background

Texas faces a maternal mortality crisis. State leaders must take action to prevent more Texas women from dying during pregnancy, childbirth, or in the weeks after delivery. Taking steps to support healthy moms and healthy pregnancies is also critical for the health and development of Texas children. Texas' data paints a troubling picture:

- According to a 2016 study published in *Obstetrics and Gynecology*, Texas leads the country in the rate of women who die from pregnancy-related causes.[1] The rate of pregnancy-related deaths in Texas doubled between 2011 and 2012.[2] Other states also saw an increase in maternal deaths, but not at as high a rate as Texas. Globally, according to the same study, maternal mortality rates continue to decrease.
- The July 2016 report of the Texas Maternal Mortality and Morbidity Task Force found an increase in maternal mortality and morbidity in Texas, with African American women bearing the greatest risk of maternal death. In fact, while Black women only account for 11.4 percent of Texas births, they account for 28.8 percent of pregnancy-related deaths in Texas.[3]

- The Task Force's findings reveal that many of these deaths occurred from treatable or preventable conditions, such as cardiac disease, hypertension, and behavioral-health disorders, including opioid addiction and suicide.[4]
- The Task Force found substantial regional and racial/ethnic disparities, signaling that some Texas populations are at greater risk and in need of additional supports.

Summary of SB 17

In addition to extending the life of the Task Force to 2023, SB 17 includes provisions to help the Task Force, the Texas Department of State Health Services (DSHS), and the Health and Human Services Commission (HHSC) take specific steps to further evaluate options for reducing maternal deaths and promote the use of best practices in maternal health and safety.

Expanded Task Force Duties

- SB 17 extends the Maternal Mortality & Morbidity Task Force to 2023. Previously, the Task Force was set to sunset in September 2019.
- Expanding upon the Task Force's current duties, the Task Force is now directed to:
    - Look at rates, trends, or disparities in pregnancy-related deaths and severe maternal morbidity;
    - Review best practices and programs in other states;
    - Evaluate the health conditions and factors that disproportionately affect the most at risk population as determined by the Task Force in its biennial report;
    - Compare rates of pregnancy-related deaths based on socioeconomic status of the mother; and
    - Make recommendations, in consultation with the Perinatal Advisory Council, to help reduce the incidence of pregnancy-related deaths and morbidity.
- SB 17 adds two seats to the Task Force's membership: one nurse who specializes in labor and delivery and one physician specializing in critical care.

HHSC Activities

SB 17 outlines additional duties and activities for HHSC to complete.

- HHSC must evaluate options for reducing pregnancy-related deaths and identify options for treating postpartum depression.
- HHSC, in coordination with DSHS and the Task Force, must identify strategies to lower costs in the Medicaid program and improve quality outcomes related to underlying causes of maternal mortality and morbidity.
- HHSC must issue a report each even-numbered year describing HHSC and DSHS' efforts to accomplish the tasks above.
- Substance use screening and domestic violence screening: HHSC, in consultation with the Task Force, must:

- give providers materials with best practices for verbally screening pregnant women for substance use and for domestic violence;
- disseminate to providers a list of substance use treatment resources and domestic violence prevention and intervention resources in each geographic area of the state;
- promote use of educational materials on consequences of opioid use and resources on domestic violence prevention during pregnancy; and
- make information and educational materials described above available on DSHS' website.

DSHS Activities

SB 17 outlines additional duties and activities for DSHS to complete.

- Maternal Health and Safety Initiative: DSHS, in collaboration with the Task Force, must promote among health providers the use of maternal health and safety informational materials, such as best practice tools and procedures for maternal health.
  - DSHS must submit a report to HHSC with a summary of implementation, outcomes, and recommendations for improving this Maternal Health and Safety Initiative.
  - HHSC must study and determine the feasibility of using these best practice procedures as an indicator of quality for Medicaid quality-based payments.
- Cause of Death Data Improvement: DSHS must submit a report on processes and procedures for collecting cause of death information, including any barriers to collecting accurate information on maternal mortality.
  - DSHS, in consultation with the Task Force, must examine national standards on collection of death certificate information and convene a panel of experts to advise DSHS and the Task Force in developing recommendations for improving cause of death information on death certificates.

Open Meetings of the Task Force

- The Task Force is subject to the Texas Open Meetings Act (Chapter 551, Government Code)
- However, the Task Force must conduct a closed meeting to review cases of pregnancy-related deaths and complications.
- The Task Force must allow opportunity for public comment during at least one public meeting; present in an open session on its recommendations to reduce incidence of maternal death and morbidity; and must post a public notice of meetings held to review cases for selection.

****

[1] MacDorman, Marian et. al, Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends from Measurement Issues, Obstetrics & Gynecology, Vol. 128, No. 3 (2016).

[2] Texas rates rose from 18 per 100,000 live births to 38 per 100,000 live births. *Ibid.*

[3] Department of State Health Services, Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report, 1, July 2016, https://www.dshs.texas.gov/mch/pdf/2016BiennialReport.pdf.

[4] *Ibid.*