

# Responding to Data Requests from the Texas Maternal Mortality and Morbidity Task Force

A Learning Module for Facilities

Prepared by the Department of State Health Services



# Webinar Overview

- Overview of charge and authority of the Maternal Mortality and Morbidity Task Force
- Discussion of the function of the Task Force as Quality Assurance
- Overview of maternal mortality and morbidity statistics for Texas
- Your role in the process



# Charge and Authority of the Task Force



# What is the Maternal Mortality and Morbidity Task Force?

- Established by the Texas Department of State Health Services (DSHS) in December 2013, in accordance with Texas Health and Safety Code Chapter 34 (HSC. 34) as created by Senate Bill 495 83(R).
  - Will study all pregnancy-related deaths
  - Examine trends in severe maternal morbidity
  - Will make recommendations to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas.
- Pursuant to the legal authority of Texas Health and Safety Code §§ 34.008, DSHS is given the broad authority to obtain access to health and medical records relevant to cases of pregnancy-related deaths and severe morbidity.



# How is the information protected?

- Records are stripped of information that could identify a patient, hospital, or health care provider.
- Any information that can be connected with any specific individual, case, or health care provider will be strictly confidential, privileged, protected, non-discoverable and will not be reported.
- All protocols comply with the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule and state medical privacy statutes.



# Who is the Task Force?

- Four physicians specializing in obstetrics, at least one of whom is a maternal fetal medicine specialist
- One certified nurse-midwife
- One registered nurse
- One physician specializing in family practice
- One physician specializing in psychiatry
- One physician specializing in pathology
- One epidemiologist, biostatistician, or researcher of pregnancy-related deaths
- One social worker or social service provider
- One community advocate in a relevant field
- One medical examiner or coroner responsible for recording deaths
- A representative of the department's family and community health programs
- The state epidemiologist for the department or the epidemiologist's designee



# Maternal Mortality and Morbidity Review is Quality Improvement Process



# Quality Improvement Process

- Maternal Mortality and Morbidity Review is a Quality Improvement Process – it is **not a punitive process** or seeking to find fault with individual facilities or providers – the goal is to examine cases statewide and identify **opportunities for systems-level improvement**.
  - Changes in clinical practice that can be adopted statewide
  - Changes in data collection and management
  - Opportunities for improvement in training and preparation of clinical staff
  - Opportunities to improve systems that affect quality of care (access, transportation, insurance coverage, etc.)

**De-identified case review is intended to address aggregate modifiable contributors to maternal mortality.**





# Local vs. State-Level Review

- At the facility level, information-sharing about sentinel events helps facilities learn from experience and from one another.
- State-level examination of sentinel events allows facilities to learn from aggregated findings and outcomes.
- State-level recommendations can have broad impact, can be disseminated by state-level agencies and organizations.

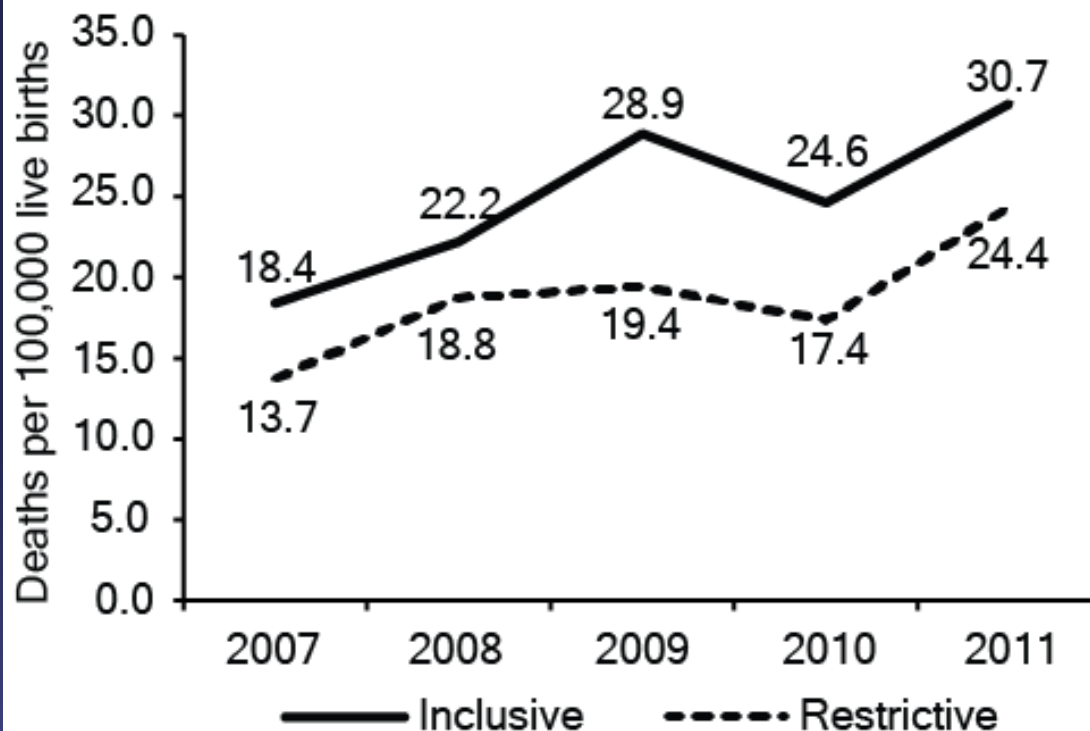


# Magnitude of the Problem: Statistical Overview



# What is the magnitude of the problem?

Maternal Mortality Rate in Texas 2007-2011: Differences between Vital Statistics Definitions Inclusive of All Obstetrics Codes and Restricted Based on the Pregnancy Checkbox

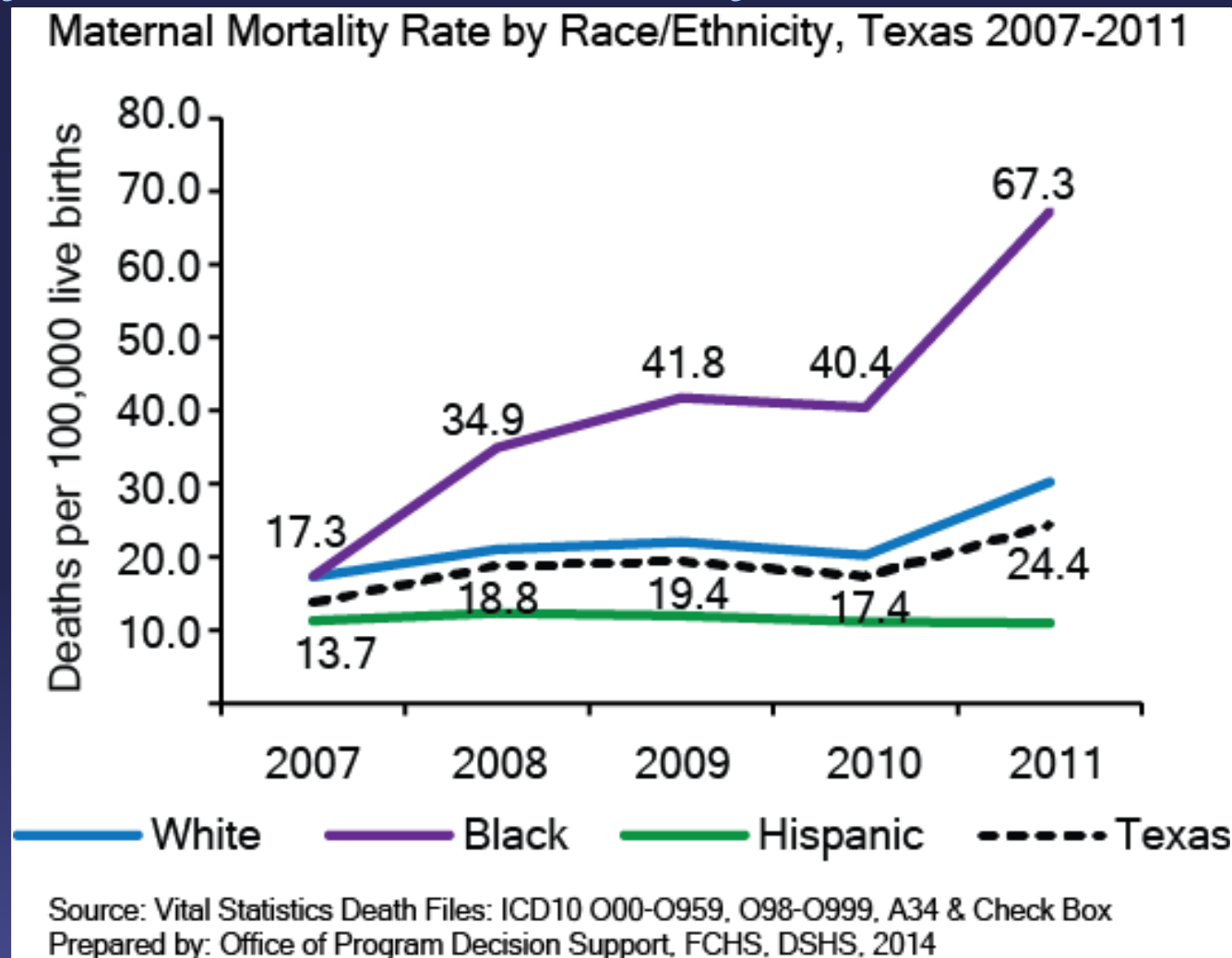


Source: Vital Statistics Death Files

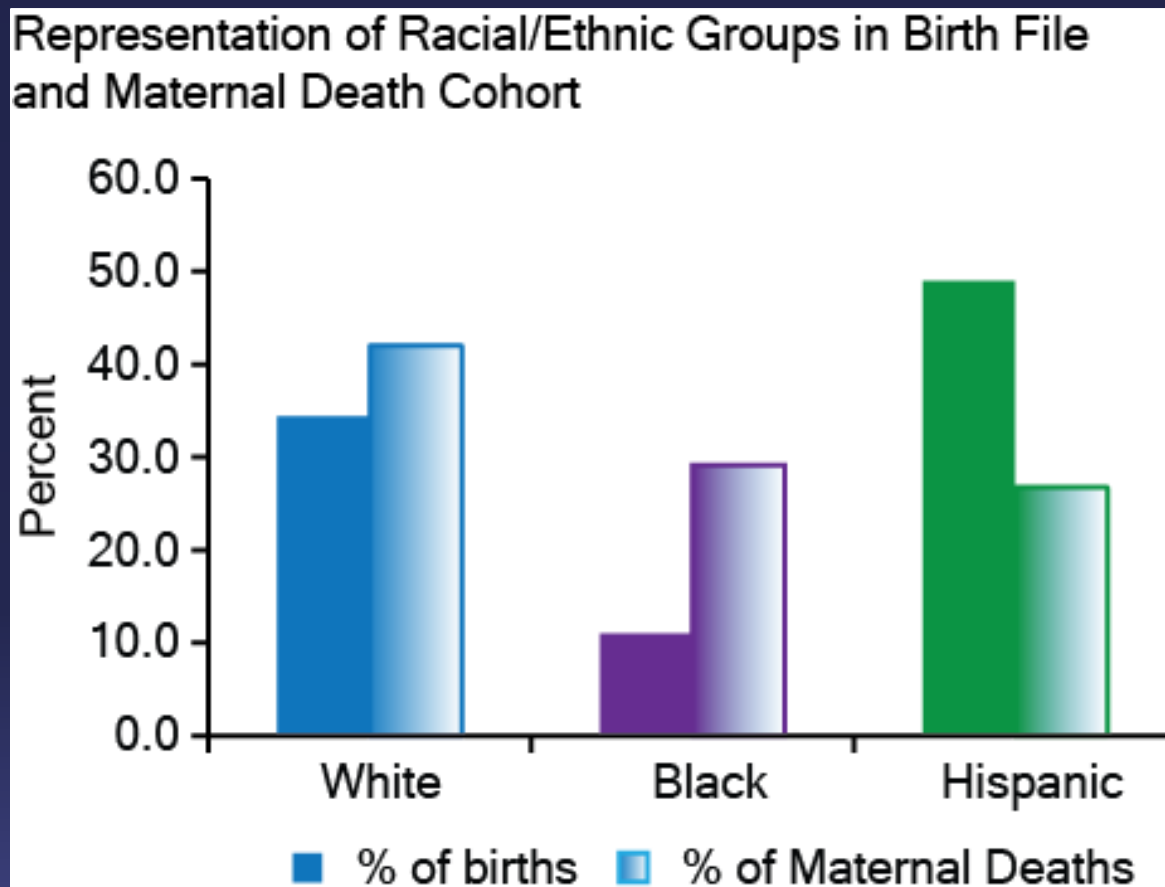
Prepared by: Office of Program Decision Support, FCHS, DSHS, 2014



# Racial Disparities are Highlighted by Maternal Mortality



# 2011 & 2012 Maternal Death Cohort



Source: Linked Death-Birth Files, 2011 & 2012 Maternal Death Cohorts  
Prepared by: Office of Program Decision Support, FCHS, DSHS, 2014



# Inclusion Criteria

## Included

- Women with “currently pregnant” check box at time of death
- Women successfully matched to a live birth file or a fetal death file
- Deaths to women within one year of a live birth or fetal death

## Excluded

- Motor Vehicle Deaths
- Cancer Deaths
- Women older than 50 years old
- Deaths occurring more than 365 days after delivery

## Resulting Cohorts for Inclusion:

- 2011 Death Cohort: 145
- 2012 Death Cohort: 150
- 137 w/live birth &
- 158 checkbox



# Characteristics - Maternal Death Among Women with a Live Birth

## 2011 Birth File

- Caesarian Sections:
  - 21.6% Primary
  - 13.7% Repeat
- Obesity
  - 23.2%
- First Trimester Prenatal Care
  - 62.4%
- Hypertension
  - 6.3%
- Diabetes
  - 4.9%

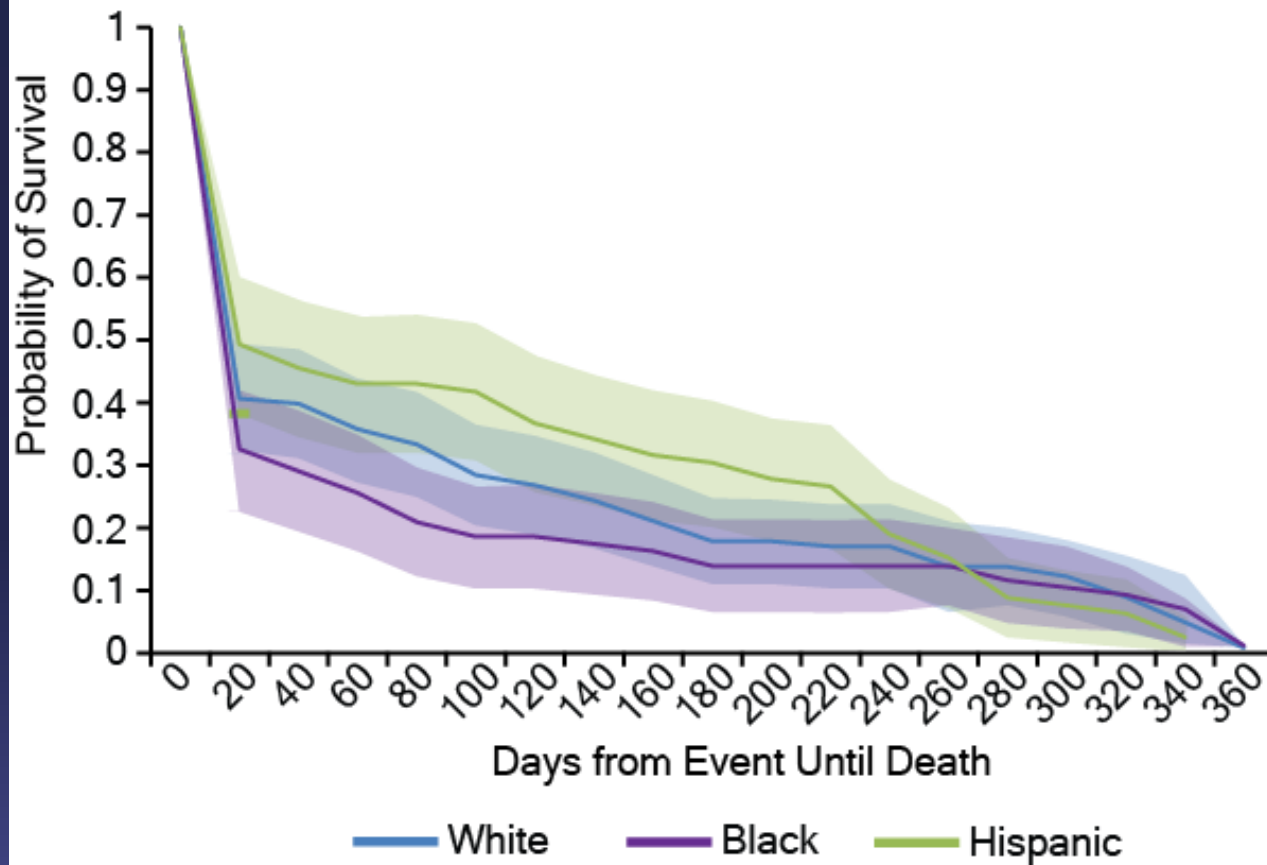
## 2011 & 2012 Death Cohort

- Caesarian Sections:
  - 30.7% Primary
  - 22.6% Repeat
- Obesity
  - 29.3%
- First Trimester Prenatal Care
  - 57.7%
- Hypertension
  - 19.0%
- Diabetes
  - 13.1%



# Survival Time from Birth by Race and/or Ethnicity

2011 & 2012 Maternal Death Cohorts, Survival Time by Race/Ethnicity

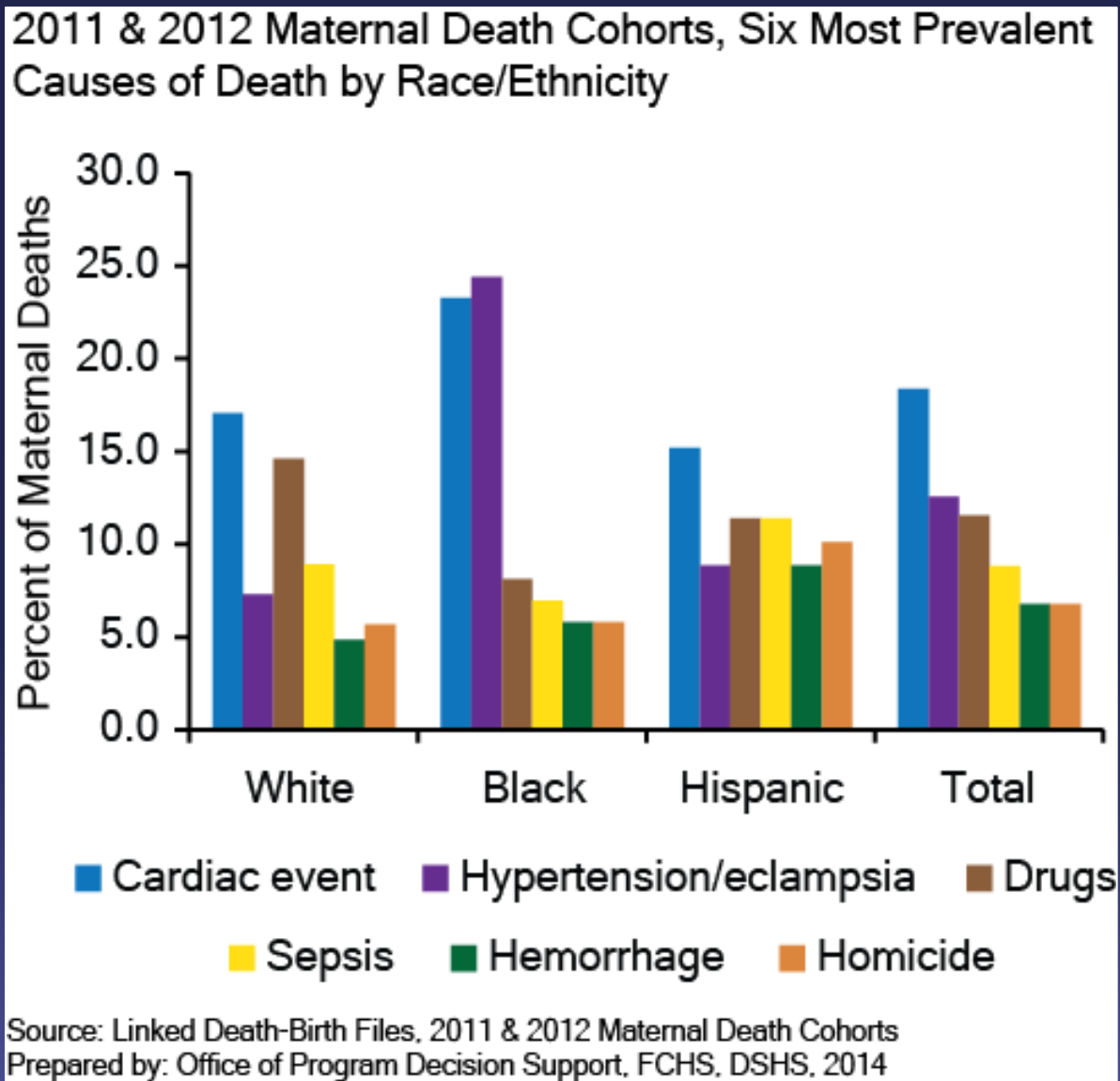


Source: Linked Death-Birth Files, 2011 & 2012 Maternal Death Cohorts  
Prepared by: Office of Program Decision Support, FCHS, DSHS, 2014





# Causes of Death By Race/Ethnicity



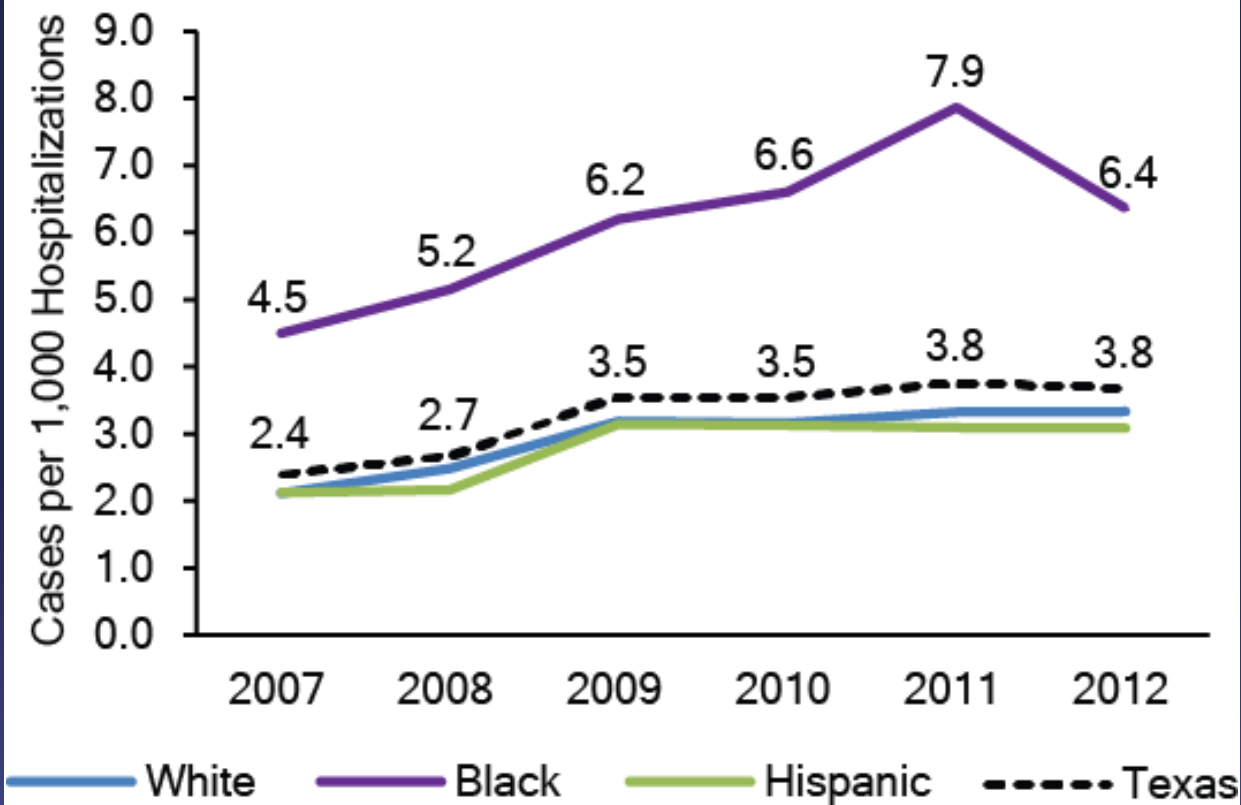
# Summary of Trends in Mortality

- Drug overdoses as the third leading cause of death
- Significant disparity seen in the death rate between black women and women of other races
- Women with late prenatal care, obesity pre-pregnancy, hypertension, or diabetes are over-represented in the identified death cohort



# Trends in Severe Maternal Morbidity

Texas 2007-2012 Severe Maternal Morbidity Rate  
by Race/Ethnicity



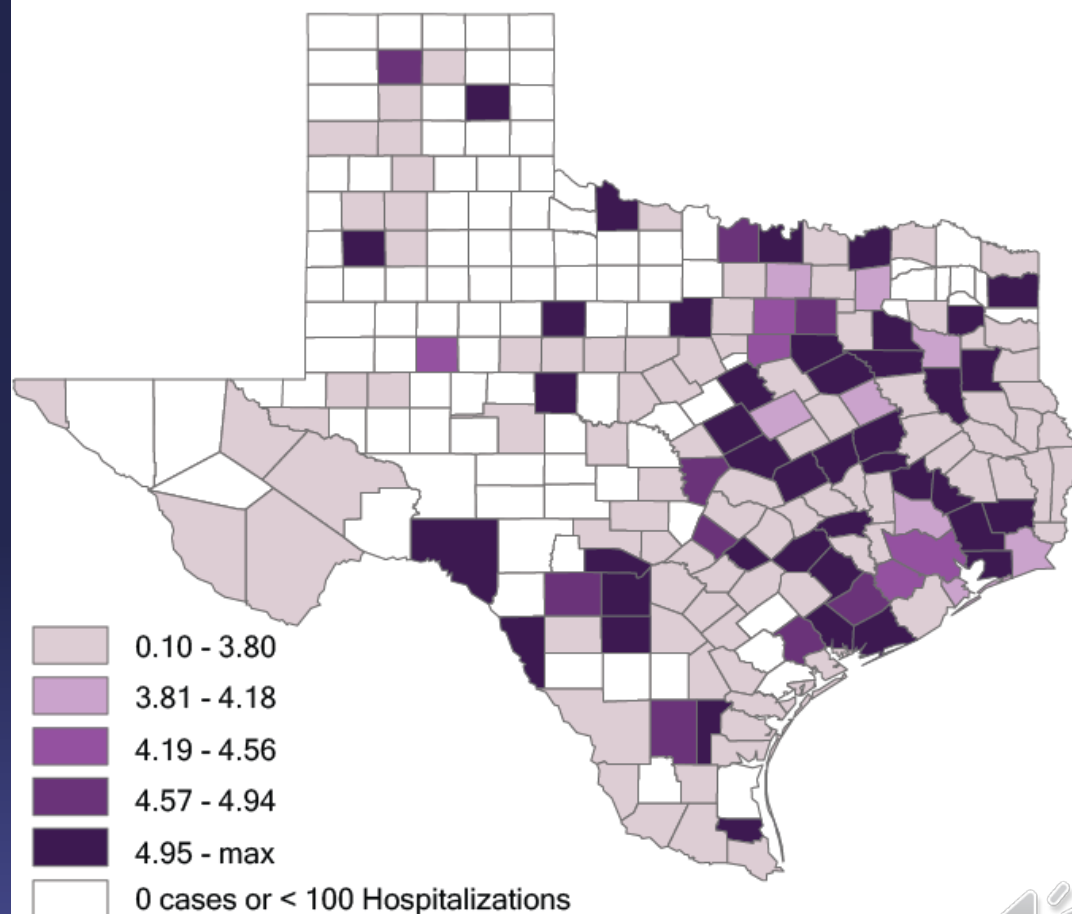
Source: 2007-2012 Texas Hospital Discharge Public Use Data:  
Risk of Mortality High & Extreme for Identified Deliveries  
Prepared by: Office of Program Decision Support, FCHS, DSHS, 2014



# 2011 County-Level Risks for Severe Morbidity

- No Significant Relations:
  - Low birth weight
  - Preterm birth
- Significant Relations:
  - Prenatal Care (PNC) ( $r^2=.06$ )
  - Obesity ( $r^2=.09$ )
  - Obesity & PNC ( $r^2=.11$ )

Texas, 2011 Severe Morbidity Rates (per 1,000 Hospitalizations)

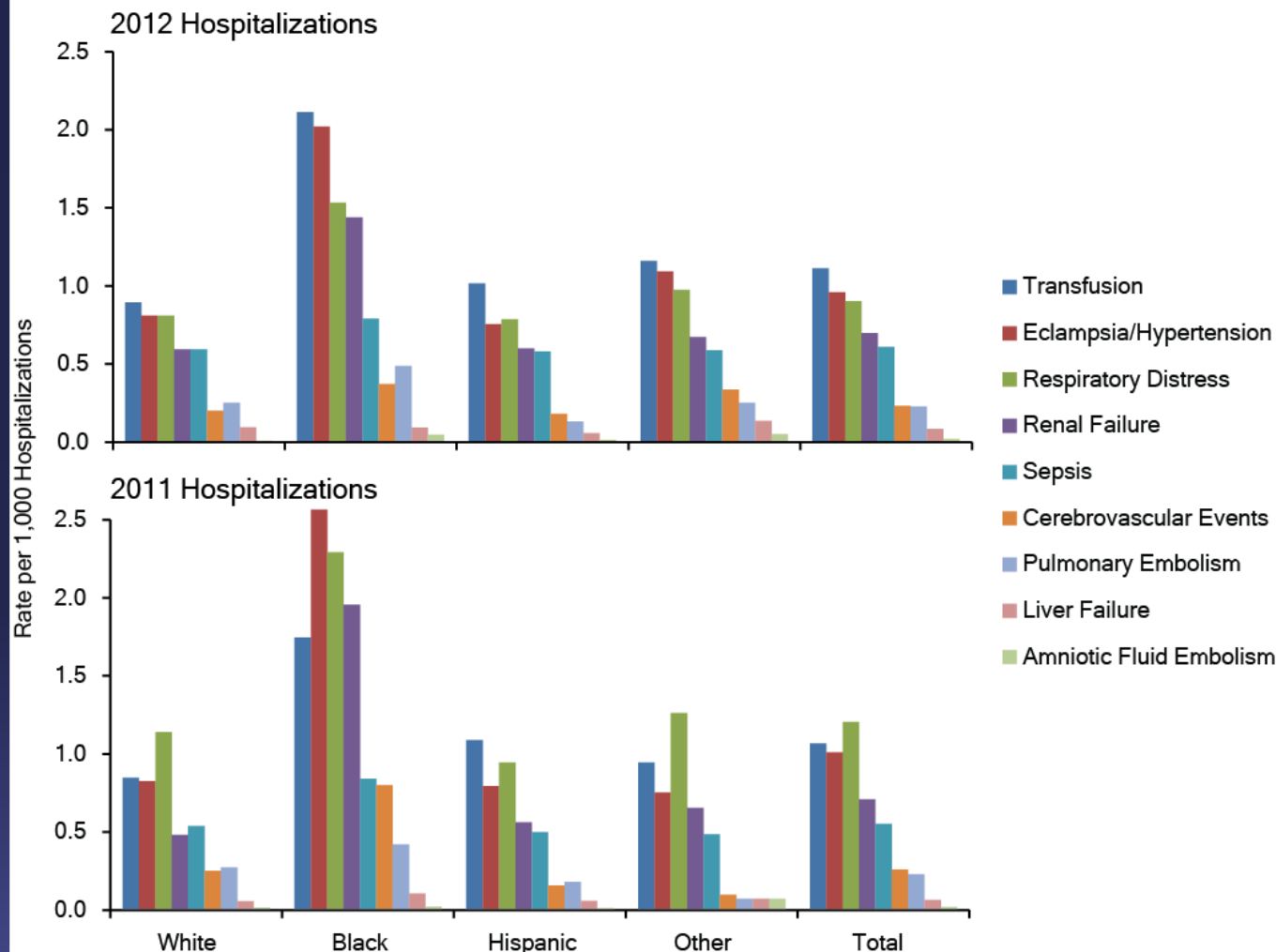


Source: Texas Hospital Discharge Public Use Data:  
Risk of Mortality High & Extreme for Identified Deliveries  
Prepared by: Office of Program Decision Support, FCHS, DSHS, 2014



# Severe Morbidity Diagnoses

2011 & 2012, Rates\* of Different Severe Morbidity Diagnoses by Race/Ethnicity



\*Rates are not mutually exclusive as the majority of women have more than one diagnosis

Source: Texas Hospital Discharge Public Use Data:

Risk of Mortality High & Extreme for Identified Deliveries

Prepared by: Office of Program Decision Support, FCHS, DSHS, 2014



# Summary of Trends in Morbidity

- Disparity and sharp increase in the morbidity for black women, especially for older women
- Differences between racial and ethnic groups for leading causes of morbidity
- Concentration of late prenatal care and pre-pregnancy obesity in the county is predictive of the county's morbidity rate



# Your Role in the Process



# Records Request Process and Case Preparation

- DSHS staff is authorized to request and obtain medical records for this purpose without the authorization of the patient or the patient's family.
- Information is gathered from vital records, medical and clinic records, hospital data, autopsy and coroner reports, and other pertinent records.
- Records are abstracted at DSHS by clinical and epidemiology subject matter experts following standardized protocols.





# Records Request Process and Case Preparation - continued

- The information is stripped of identifying information (*i.e.*, name, address or specific location, and date of birth) of a patient, hospital, or health care provider.
- Information is then synthesized into de-identified case summaries for review by the task force.
- So that the review of information may be conducted in a timely manner, **DSHS expects receipt of requested records within no more than 30 calendar days from the date of request.**
- **The Maternal Mortality and Morbidity Task Force cannot be successful without your assistance and participation in the records request process.**



# For More Information...

- DSHS appreciates your cooperation should records be requested from your institution.
- Information about the task force is available at:  
[http://www.dshs.state.tx.us/maternal\\_mortality\\_and\\_morbidity.shtm](http://www.dshs.state.tx.us/maternal_mortality_and_morbidity.shtm).
- For more information about this initiative or to follow up with questions from this webinar you may contact DSHS at [MaternalHealth@dshs.state.tx.us](mailto:MaternalHealth@dshs.state.tx.us).



THANK YOU!

