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Chairwoman Eshoo, Chairman Pallone, Ranking Member Walden, Ranking Member Burgess, and distinguished members of the Energy and Commerce Subcommittee on Health, thank you for inviting me to speak with you today on behalf of Parkland Hospital and the University of Texas Southwestern Medical Center on the hearing entitled, “Maternal Health: Legislation to Advance Prevention Efforts and Access to Care.”

For introduction, I am trained as an Obstetrician-Gynecologist as well as having sub-specialty fellowship training in Maternal-Fetal Medicine. Currently, I am an Assistant Professor at the University of Texas Southwestern Medical Center and serve as the Chief of Obstetrics at Parkland Hospital in Dallas, Texas. Parkland Hospital is one of the largest single, public maternity services in the country with 12,671 women delivered at our facility last year. This delivery volume at Parkland Hospital represents approximately 1 out of every 300 new Americans born each year, and in total, represents more births than occurred in ten separate states in the country last year.

I would like to share my appreciation of this committee for their efforts and celebrate the federal legislation, Preventing Maternal Deaths Act, signed into law on December 21, 2018, that encourages state programs to establish Maternal Mortality Review Committees (MMRC). By supporting multidisciplinary local expert review, and aligning with community advocates, this is a meaningful step forward in addressing the national crisis of maternal mortality in the United States; however, as you know our work is not done. A single preventable, pregnancy-related death is one too many, and as Mr. Charles Johnson stated last year to this committee that, “No statistic that [sic] can quantify what [it] is like to tell an 18 month old that his mother is never coming home.” So, what are the next meaningful steps in advancing maternal health and prevention of mortality? As a provider of maternal care services, I offer two themes which in my view are two important pieces to help solve this puzzle and prevent this tragedy: (1) access to prenatal care, and (2) use of relevant quality data to ensure well-informed decisions.

First, the significance of “access to care” depends upon how the issue of maternal mortality is framed. In 2013, the 83rd Texas Legislature established the Maternal Mortality and Morbidity Task Force for my home state of Texas. The most recent findings of this MMRC were reported in September 2018. This effort, chaired by Dr. Lisa Hollier—immediate past-president of the American College of Obstetricians and Gynecologists (ACOG)—identified that the majority of pregnancy-related deaths could be prevented. And, similar to other reports, there was a significant racial disparity with women of color significantly more likely to die when compared with non-Hispanic white women. Notably, the majority (68%) of maternal deaths in Texas under review were Medicaid-funded at delivery. So, how can we address pregnancy-related maternal deaths that are potentially preventable, among women of color, and receiving Medicaid-funding? I offer our experiences from Parkland Hospital as one strategy.

Parkland Hospital is unique as it represents a public hospital serving almost exclusively medically-indigent women. Of the 12,671 women delivered last year, 90% were Medicaid-funded. At Parkland, there has been a concerted effort to improve access to and use of prenatal care for decades. The goal has been to establish a program of seamless care beginning with enrollment during the prenatal period and extending through delivery at Parkland into the postpartum period. Today, 10 prenatal clinics are strategically located throughout the 909 square-miles of Dallas County to provide convenient access for entry into prenatal care. These 10 clinics are located in the neighborhoods where our patients live and are often co-located with comprehensive medical and pediatric services to enhance patient use. Indeed, of the 12,671 women delivered in 2018 at Parkland Hospital, 97% accessed prenatal care prior to delivery. Importantly, we were then able to identify conditions placing mothers and their infants at high-risk for complications including hemorrhage, infection, hypertension, diabetes, and HIV long before the mother presented for delivery. Moreover, these 10 clinics serve as the “healthcare home” for our patients. Also, these same clinics serve as the follow-up location after delivery for important postpartum services to include postpartum depression screening, mental health care, and family planning services.

Because the entire clinic system as well as the hospital is operated by Parkland, administrative and medical oversight is seamless. The same prenatal protocols are used by nurse practitioners at all 10 clinic sites to guarantee consistent, protocol-based care that includes standardized referrals of high-risk women to a centrally-located prenatal clinic specifically designed for women with high-risk pregnancy complications. This high-risk pregnancy clinic includes specific programs for women with conditions such as diabetes, infectious disease, placental abnormalities, and hypertensive disorders to just name a few. Each clinic is staffed by maternal–fetal medicine faculty with special interests in such complications. Importantly, Parkland has a closed medical staff, and all attending physicians are employed by the University of Texas Southwestern Medical Center Department of Obstetrics and Gynecology, whose members adhere to agreed-on practice guidelines using an evidenced-based outcomes approach. Many of these strategies can be found in the textbook *Williams Obstetrics*—now in its 25th edition—which is the most popular obstetric textbook worldwide. This reference text has been based at our institution for the last 40 years, and 17 of the faculty help co-author the current edition. We are fortunate to have such talented, local expertise to provide care for our patients as well as train future healthcare providers to include advanced practice providers, nursing students, medical students, resident physicians, and fellows.

Not all high-risk complications can be identified within the prenatal period. Within the hospital setting, a multidisciplinary team of nurses, advance practice providers, resident physicians, Maternal-Fetal Medicine fellows, and faculty work together according to standardized protocols alongside obstetric anesthesiologists, certified registered nurse anesthetists, and pediatric teams. Individualized care is stratified within labor and delivery based upon medical acuity and risk for complications. For example, we have standardized management strategies for response to obstetric emergencies—such as hypertension and obstetric hemorrhage—that have been in place for decades. This culture of safety emphasizes careful attention for hypovolemia due to blood loss. Dr. Jack Pritchard, recognized last year by Ranking Member Burgess, proudly established the “30/30 rule” for observation of blood counts and urine output using simple testing with reliable results. This grounded, and effective, approach has been honed over generations with continuous quality improvement and focus on patient-centered outcomes for safety. Recently, we have implemented an “urgent request to the bedside” with our nursing partners to electronically track and monitor timeliness to a patient’s bedside for immediate care. These efforts dovetail Parkland Hospital’s participation in the newly formed regionalization program known as “Maternal Levels of Care” as well as the Alliance for Innovation on Maternal Health (AIM) Plus program in Texas. Both are now national initiatives to standardize readiness, recognition, response, and reporting of high-

risk conditions placing mothers at risk for death and share similar principles with the California Maternal Quality Care Collaborative organization.

Putting this all together, this geographically-based public health prenatal care program specifically targets all populations of pregnant women to identify the high-risk conditions *before* a woman presents for delivery. Although this reduces her individual risk, it does not eliminate the potential for unanticipated obstetric emergencies. When such unexpected, life-threatening events arise, prompt identification and mobilization of resources is exercised. These same principles are part of the foundation of the AIM collaborative endorsed by our national professional organizations, such as ACOG. And more recently, we are encouraged by the August 21, 2019, release of The Joint Commission 13 new elements of performance (EPs) applicable to Joint Commission-accredited hospitals due to take effect July 1, 2020. These new requirements are within the Provision of Care, Treatment, and Services (PC) chapter at PC.06.01.01 and PC.06.01.03 for management of hemorrhage as well as hypertension and mirror much of our existing practices as described. Taken altogether, “access” to prenatal care is considered one component of a comprehensive and orchestrated public health care system that is community-based and extends to the inpatient care setting using evidenced-based, standardized practices that are monitored for quality assurance.

Turning now to the second theme, how do we then measure such quality? An obvious method is to track rates of maternal mortality. This unfortunately is easier said than done and putting our collective arms around maternal mortality data is only the beginning. At present, much of the data tracking for maternal mortality is limited to use of coded death data from maternal death certificates. The use of such coded data is fraught with potential error due to miscoding. As noted last year in this committee, half (50.3%) of obstetric-coded deaths in Texas during 2012 actually showed no evidence of pregnancy within 42 days. To be clear, this is not an indictment of the current processes involved in compiling such data, or of those that have dedicated their life to this important effort, but rather a point to emphasize that it is extremely difficult to confirm cases from afar. Moreover, this underscores the need for significant resources to accurately collect such critical information. Compare this effort to the existing infrastructure already used for other recognized significant public health issues. One example is tuberculosis (TB). For Dallas County alone, there are more than 50 dedicated staff within the Dallas County Health Department tracking, reporting, and actively managing cases of TB. These heroes within the DCHD provide follow-up, chart abstraction, reporting, and daily direct observed therapy located at a patient’s home, place of employment, or even under a bridge. The same level of infrastructure has not yet been put forward for maternal death. We need sustained support to actively identify these complex cases, and ultimately, provide good quality data to make well-informed decisions. Our hope is that the recent passing of the 2018 Preventing Maternal Deaths Act is a key step forward in this effort.

A second method of assessing “quality” of maternal care is measuring rates of severe maternal morbidity (SMM), or *near-misses*. These are unexpected outcomes that result in significant short- or long-term consequences to a woman’s health, such as hysterectomy and transfusion. These SMM rates are also almost universally derived from hospital billing codes—simply because no other data sources are available. Moreover, we must consider the potential unintended consequences of tracking such “SMM” metrics, especially transfusion of blood. Blood transfusion is the single greatest contributor to the SMM rate both at Parkland Hospital and nationally. In 2014, blood transfusion accounted for more than 80% of the SMM rate in the United States. We caution, however, that this can become a perverse surrogate of quality. If a provider hesitates, or worse, withholds a transfusion of blood to a patient to avoid the “label” of SMM, then there is an unintended risk of mortality. Indeed, the reason obstetric hemorrhage is deadly is because of failure to promptly restore a woman’s circulating blood volume. This can have far-reaching consequences in quality measurement across hospitals. For example, a hospital with a high rate of

transfusion could be considered inferior to a hospital with a low rate of transfusion. Is it possible that this evaluation is upside down? The hospital with the higher transfusion rate may actually be higher in quality than the hospital with a low rate of transfusion as measured by mortality. We must be careful to not inadvertently worsen mortality while trying to avoid a surrogate of morbidity by careful selection of quality metrics.

In closing, thank you again for this opportunity to share our experiences from Parkland Hospital and our efforts to establish prenatal care access. Also, thank you for your understanding of the importance of relevant quality data and reporting. To advance the national effort in improving both maternal mortality and morbidity, it is critical that accurate, relevant clinical data are reported and are used to guide decisions for healthcare policy. Ultimately, these efforts can lead to safer deliveries of mothers and their infants for the future generations of our country.

Thank you,

A handwritten signature in black ink, appearing to read "David B. Nelson". The signature is fluid and cursive, with a large initial "D" and "B".

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