BILL ANALYSIS

C.S.H.B. 1164
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Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Stakeholders have identified maternal hemorrhaging as responsible for many of the maternal deaths they have investigated and have listed it as one of the leading causes of maternal mortality in Texas. Massive obstetric hemorrhage is sometimes caused by a complex condition called placenta accreta spectrum disorder (PAS), in which the placenta grows into, and sometimes through, the uterus during pregnancy. This condition affects a significant number of births, and has increased in prevalence as the rate of caesarean delivery has also increased. Stakeholders argue that improved care for PAS will lower maternal mortality in Texas. C.S.H.B. 1164 seeks to create improved patient safety practices regarding PAS and require all hospitals with a maternal level of care designation to implement those practices.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 1 of this bill.

ANALYSIS

C.S.H.B. 1164 amends the Health and Safety Code to require the executive commissioner of the Health and Human Services Commission (HHSC), in consultation with the Department of State Health Services (DSHS), the Perinatal Advisory Council, and certain interested persons, to develop by rule patient safety practices for the evaluation, diagnosis, treatment, and management of placenta accreta spectrum disorder. The bill requires the council, using data collected by DSHS from available sources, to recommend rules on the patient safety practices for the evaluation, diagnosis, treatment, management, and reporting of the disorder and establishes the following deadlines:

- not later than December 1, 2021, DSHS must consult with the specified interested persons in collaboration with the council and must collect and provide the necessary data to the council; and
- not later than August 1, 2022, the executive commissioner of HHSC must adopt rules for the patient safety practices based on the council's recommendations.

C.S.H.B. 1164 requires the patient safety practices, at a minimum, to require a hospital with a maternal level of care designation to do the following:

- screen patients for placenta accreta spectrum disorder, if appropriate;
- manage patients with the disorder, including referring and transporting patients to a higher level of care when clinically indicated;

- foster telemedicine medical services, referral, and transport relationships with other hospitals with a maternal level of care designation for the treatment and management of the disorder;
- address inpatient postpartum care for patients diagnosed with the disorder; and
- develop a written hospital preparedness and management plan for patients with the disorder who are undiagnosed until delivery.

The bill requires the applicable hospitals to adopt these practices not later than October 1, 2022, but establishes that the hospitals are not required to comply with the bill's provisions before January 1, 2023. The bill requires a hospital with a level IV maternal designation, in addition to implementing the minimum required practices, to have available a multidisciplinary team of health professionals who may include specified types of specialists and who either have successfully completed certain team response training or have, as a team, appropriate treatment or management experience. The patient safety practices required for a hospital with a maternal level of care designation must include the HHSC rules adopted on the basis of the council's recommendations.

C.S.H.B. 1164 establishes that its provisions relating to patient safety practices and associated rules, including the use of or failure to use any such practices or other information or materials developed or disseminated under those provisions, do not create a civil, criminal, or administrative cause of action or liability or create a standard of care, obligation, or duty that provides a basis for a cause of action, and may not be referred to or used as evidence in a health care liability claim.

C.S.H.B. 1164 requires the council to consider the patient safety practices adopted under the bill's provisions in developing the criteria used to assign level of neonatal and maternal care designations to hospitals.

EFFECTIVE DATE

September 1, 2021.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 1164 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

Although the substitute, like the original, relates to improving and better coordinating the treatment of placenta accreta spectrum disorder, the substantive provisions of the substitute and the original do not share any common language.