



Maternal Mortality and Morbidity Task Force and DSHS Joint Biennial Report

**Presentation to the House
Committee on Public Health**

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Presentation Overview



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- Joint Biennial Report Overview
 - At-Risk Population Focus
 - Contributing Factors
- Findings
- Recommendations
- Implementing Recommendations



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Joint Biennial Report Overview

Task Force Activities during FY2016-2017

- Completed multidisciplinary review of 2012 maternal deaths (89 cases)
 - Determined cause and contributing factors to death, pregnancy-relatedness, and preventability opportunities
- Met 8 times during Fiscal Years 2016-2017
 - Each member dedicated over 178 hours to discussing new data introduced by DSHS, conducting case reviews, and developing recommendations.
- Added 2 new members per Senate Bill 17
 - Physician specializing in critical care
 - Nurse specializing in labor and delivery



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Joint Biennial Report Overview

New Components in 2018 Report

- Risk factors affecting at-risk population
- More in-depth demographic analysis of trends related to age, pre-pregnancy weight, individual behavior, geographic location, etc.
- More in-depth analysis on whether contributing factors leading to maternal death could be prevented



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At-Risk Population Focus

Risk Persists for Black Mothers Regardless of:

- Socioeconomic status
- Marriage status
- Education level
- Possession of private insurance

Factors Affecting Risk Include:

- Late entry to prenatal care
- Pre-pregnancy obesity
- Maternal Hypertension
- Obstetric Hypertension
- Obstetric Hemorrhage



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Joint Biennial Report Overview: Contributing Factors

Pregnancy-Related Death Contributing Factors Analysis

- 2012 Analysis Covered
 - 89 maternal death cases reviewed
 - 34 determined as pregnancy-related
- Types/Percentages of Contributing Factors Present
 - Individual and Family Factors (42%)
 - Provider Factors (36%)
 - Facility Factors (16%)
 - System and Community Factors (6%)
- Pregnancy-Related Death Contributing Factors
 - Average of 5.2 factors present per case

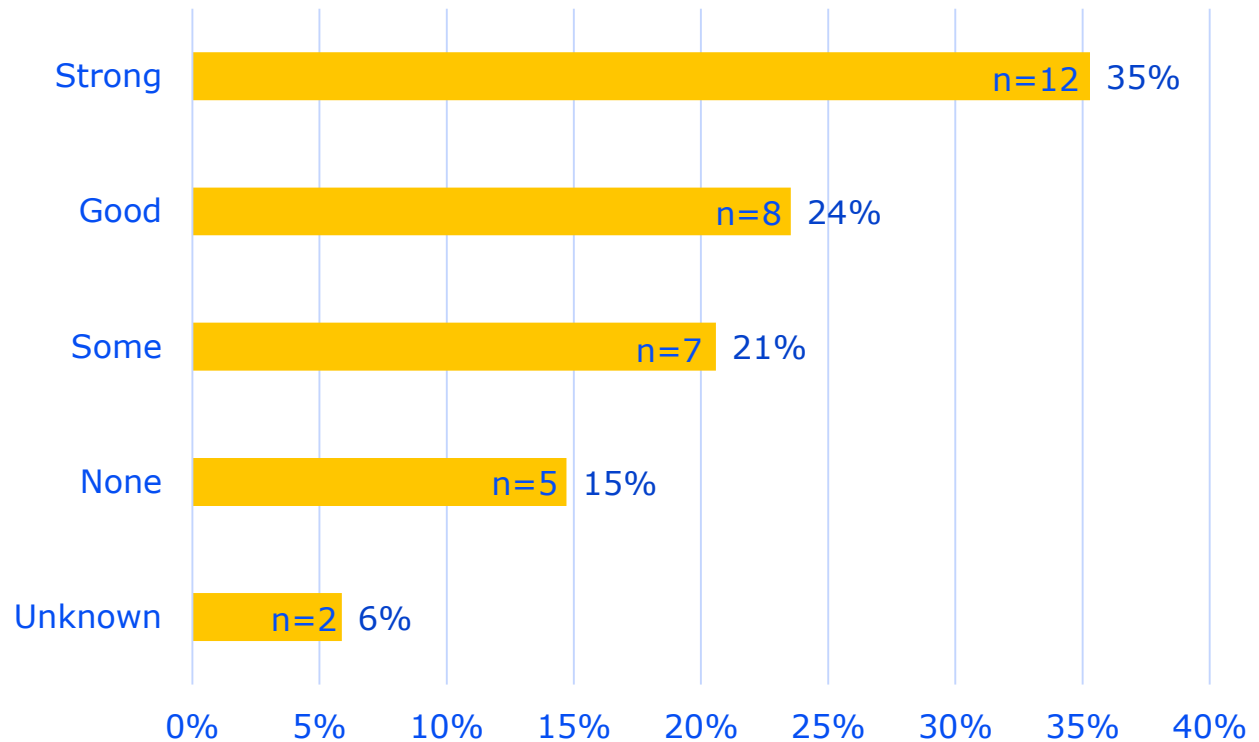


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Joint Biennial Report Overview: Care and Management

Task Force rating of chance of preventing pregnancy-related deaths through better care and/or management during/after pregnancy, Texas, 2012



■ Proportion of all pregnancy-related deaths (%)
n=number of deaths Pregnancy-related deaths = 34

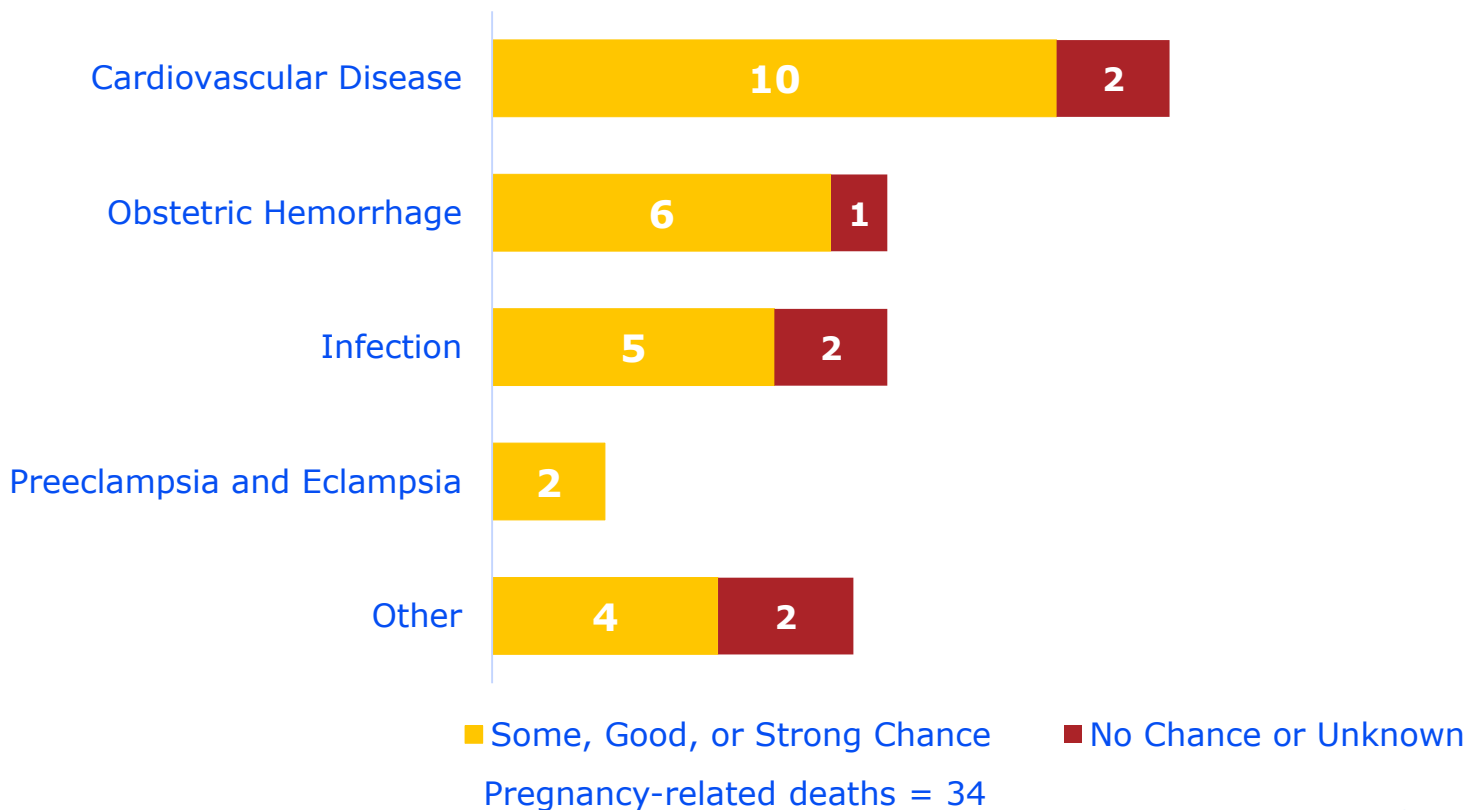


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Joint Biennial Report Overview: Care and Management

Task Force rating of chance of preventing pregnancy-related deaths through better care and/or management during/after pregnancy by cause of death, Texas, 2012





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Case Review Findings

- Nearly 40% of maternal deaths reviewed were identified as pregnancy-related.
- The leading causes of pregnancy-related death in 2012 included cardiovascular and coronary conditions, obstetric hemorrhage, infection/sepsis, and cardiomyopathy.
- Black women were more likely to experience pregnancy-related death in 2012.



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Case Review Findings

- The majority of maternal deaths in 2012 were to women enrolled in the Medicaid program at the time of delivery.
- Most pregnancy-related deaths were potentially preventable.
- A complex interaction of personal, provider, facility, systems and community factors contributed to maternal death.
- Delays in receiving case records and the redaction process slowed maternal death case review.



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Trend Analysis Findings

- Hemorrhage and Cardiac Event were the two most common causes of death while pregnant or within 7 days postpartum.
- The majority of maternal deaths occurred more than 60 days postpartum.
- In 2012 to 2015, drug overdose was the leading cause of maternal death from delivery to 365 days postpartum.
- There is a complex set of factors associated with maternal death, underscoring the need for detailed review of maternal deaths.



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Trend Analysis Findings

- Black women bear the greatest risk for maternal death.
- The increased risk for maternal death among Black women exists regardless of income, education, marital status, or other health factors.
- Obstetric hemorrhage was the leading cause of severe maternal morbidity.
- Black women are at a higher risk of severe maternal morbidity (SMM) involving obstetric hemorrhage.
- Rates of SMM due to obstetric hemorrhage disorders varied by county.



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Task Force Recommendations

1. Increase access to health services during the year after pregnancy and throughout the interconception period to improve the health of women, facilitate continuity of care, enable effective care transitions, and promote safe birth spacing.
2. Enhance screening and appropriate referral for maternal risk conditions.
3. Prioritize care coordination and management for pregnant and postpartum women.



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Task Force Recommendations

4. Promote a culture of safety and high reliability through implementation of best practices in birthing facilities.
5. Identify or develop and implement programs to reduce maternal mortality from cardiovascular and coronary conditions, cardiomyopathy and infection/sepsis.
6. Improve postpartum care management and discharge education for patients and families. Enhance screening and appropriate referral for maternal risk conditions.



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Task Force Recommendations

7. Increase maternal health programming to target high-risk populations, especially Black women.
8. Initiate public awareness campaigns to promote health enhancing behaviors
9. Champion integrated care models combining physical and behavioral health services for women and families.
10. Support strategies to improve the maternal death review process.



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Implementing Task Force Recommendations

DSHS Exceptional Item 3: Combat Maternal Mortality & Morbidity

- **Implement Maternal Safety Initiatives Statewide, \$2.7 M:** Promote and implement new TexasAIM maternal safety bundles statewide, including stipends for hospitals that may need additional resources to implement AIM.
- **Implement Care Coordination Pilots, \$1.0 M:** Create and implement training for CHWs to identify women with high risk factors, provide education on preventive measures, and facilitate appropriate referrals to care.
- **Develop and Train Providers on Use of Risk Assessment Tools, \$1.3 M:** Create and promote risk assessment tools for identification of maternal risk factors during routine prenatal care.
- **Increase Public Awareness and Prevention Activities, \$2.0 M:** Enhance provider and community understanding about maternal risk factors and related preventive measures.



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Implementing Task Force Recommendations

A care coordination pilot and new public awareness efforts can address certain recommendations through:

- Increased attention to high-risk populations, especially Black women
- Enhanced screening and referral for maternal risk conditions
- Prioritization of care coordination for pregnant and postpartum women, for both physical and behavioral health
- Public awareness campaigns to promote health-enhancing behaviors
- Education for patients and families around postpartum care management

Implementing Task Force Recommendations

- Continue implementation of maternal safety initiative using TexasAIM bundles:
 - Hemorrhage
 - Opioid Use Disorder Pilot
 - Hypertension/Preeclampsia
- Work with legislators and stakeholders to implement Task Force Recommendations



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Thank You
