TEXAS
Health and Human Services

Texas Department of State Health Services

Jennifer A. Shuford, M.D., M.P.H.
Interim Commissioner

December 14, 2022

The Honorable Greg Abbott
Governor of Texas
P.O. Box 12428
Austin, TX 78711-2428

Dear Governor Abbott:

Pursuant to Texas Health and Safety Code, Section 34.015, the Department of State Health Services (DSHS) and the Maternal Mortality and Morbidity Review Committee are required to submit a report on findings and recommendations of the review committee by September 1 of each even-numbered year. The report is submitted to the governor, lieutenant governor, speaker of the House of Representatives, and appropriate committees of the legislature.

Since September 2022, DSHS has finalized the number of 2019 maternal deaths needing committee review. 147 deaths occurred in 2019 in woman who were pregnant or had been pregnant in the last 365 days. Of these 147, the committee has now fully reviewed 140. The committee will review the remaining 7 cases in spring 2023 and finalize its 2019 cohort analysis in early summer.

Attached to this letter is more information about the committee's past and ongoing efforts, maternal health data indicators, and Texas efforts to address maternal morbidity and mortality. I hope you will find these additional materials a useful complement to the committee's findings and recommendations on the partially-completed 2019 cohort. DSHS will submit an update to this report when the committee finalizes review and analysis of the 2019 cohort. If you have questions, please email DSHS Director of External Relations, Rachael Hendrickson, at Rachael.Hendrickson@dshs.texas.gov.

Sincerely,

Jennifer A. Shuford, M.D., M.P.H.

DSHS Maternal Mortality and Morbidity Review Committee

Process and Operations

1. CASE IDENTIFICATION

DSHS confirms the pregnancy status from death certificates by checking Medicaid, hospital and other records.

(continual process)

2. RECORDS REQUEST

DSHS requests medical and other records that provide the basis for the committee's review of each maternal death.

(up to 3 months to receive)

3. REDACTION

DSHS contracts with Univ. North Texas Health Science Center to remove provider and facility names before nurse abstraction as required by state law.

(~45 hours per case)

Redaction time varies from 1 to 250 work hours per case

4. ABSTRACTION

A nurse summarizes the records for committee review and enters data about each case into a database.

(~20 hours per case)

5. SMALL GROUP REVIEW

A smaller group of committee members review each case and makes a preliminary assessment.

It may determine additional records are needed to complete case review.

6. FINAL DETERMINATIONS BY THE FULL COMMITTEE

The case is presented to committee for final review.

Committee members classify the death in several ways, including whether it was preventable.

7. COHORT ANALYSIS AND REPORT

Each cohort of cases is analyzed for overall findings and recommendations for the next biennial report.

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Texas Maternal Mortality and Morbidity

Data Snapshot

*as of December 2022

2019 COHORT OF MATERNAL DEATH CASES

● = 10 cases

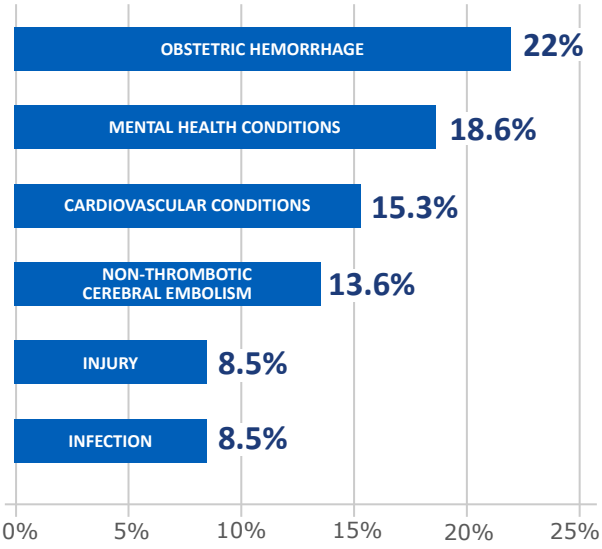
147 TOTAL CASES

140 REVIEWED CASES *(as of 12/22)*

59 DEATHS DUE TO PREGNANCY

52 OF THE 59 CASES WERE DETERMINED TO HAVE A CHANCE OF PREVENTABILITY

TOP CAUSES OF PREGNANCY RELATED DEATHS



12 WOMEN DIED PER MONTH ON AVERAGE WHILE PREGNANT OR WITHIN ONE YEAR OF PREGNANCY.

In 2020, Black women were 2x more likely to experience critical health issues –

1.7x more likely to have **hemorrhage-related** health issues.

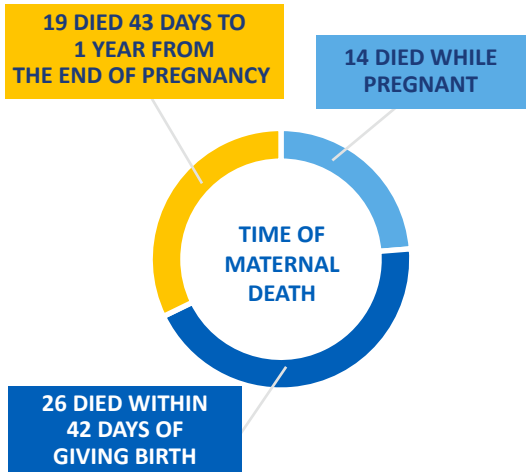
3.2x more likely to have **preeclampsia-related** health issues.

2.3x more likely to have **sepsis-related** health issues.

140 CASES OF PREGNANCY ASSOCIATED DEATHS RESULTED IN

7,034 YEARS OF POTENTIAL LIFE LOST BY THE WOMEN WHO DIED

291 LIVING CHILDREN WHO HAVE LOST THEIR MOTHER



WOMEN AGED 40 AND OLDER ARE 2.6x MORE LIKELY TO HAVE CRITICAL HEALTH ISSUES.

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DSHS Maternal Mortality and Morbidity Prevention Highlights

Texas Alliance for Innovation in Maternal Health (TexasAIM) Projects

TexasAIM provides the health care system "bundles" of education and resources to address 98.4% of preventable maternal deaths in Texas.

Obstetric Hemorrhage	Severe Hypertension	Opioid and Substance Use Disorder	Cardiac Conditions	Sepsis
Ongoing since November 2018	*Relaunch with hospitals in January 2023*	*Launches Spring 2023*	*Launch Expected December 2024*	*Launch Expected December 2026*
Rate of obstetric hemorrhage decreased 8.6% in hospital deliveries	94% of Texas hospitals (210) with obstetric services are expected to participate			

Overall rates of obstetric hemorrhage are decreasing but non-Hispanic Black women are still disproportionately impacted.

Black moms have higher risk for poor outcomes than any other race or ethnicity.

DSHS is incorporating national tools to help address disparities.

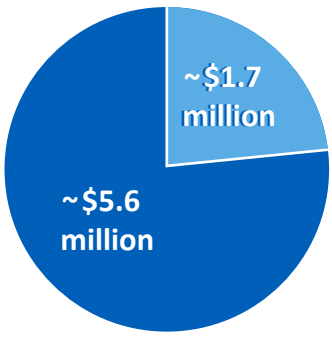
Hear Her Texas Public and Provider Awareness Campaign

- The DSHS Hear Her Texas campaign empowers women, their health care providers, and support networks to know the urgent maternal warning signs and seek care when they have concerns.
- See the campaign at **dshs.texas.gov/HearHerTX**

High-Risk Maternal Care Coordination Services Pilot

- Community-based high risk care coordination for moms in Northeast Texas.
- Courses supporting community health workers.
- Pilot to begin with at least **60 moms**

The 18-month pilot begins March 2023



Funding for Maternal Mortality and Morbidity Efforts

- **Texas Legislature State Funding: ~$5.6 million per year**
- **Federal Funding: ~$1.7 million per year**

~$7.3 million total

During the pandemic, TexasAIM redirected activities to support COVID-19 care for pregnant moms.

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