



Maternal Mortality and Morbidity Task Force and DSHS Joint Biennial Report

**Presentation to the Senate
Committee on Health & Human
Services**

**Lisa Hollier, MD, MPH
Chair, Texas Maternal Mortality
and Morbidity Task Force**

September 12, 2018



TEXAS
Health and Human
Services

Texas Department of State
Health Services

Presentation Overview



TEXAS
Health and Human Services

Texas Department of State
Health Services

- Joint Biennial Report Overview
- Findings
- Recommendations



TEXAS
Health and Human Services

Texas Department of State
Health Services

Joint Biennial Report Overview

Basis of Findings and Recommendations

- Individual Case Reviews for 2012 cohort (within 365 days following pregnancy)
 - 89 cases reviewed by Task Force
- Rates, trends, and disparities analysis by DSHS for years 2012-2015:
 - 382 deaths analyzed by DSHS
- Literature review of best practices in other states
- Collective experience of Task Force members



TEXAS
Health and Human Services

Texas Department of State
Health Services

Joint Biennial Report Overview

New Components in 2018 Report

- More in-depth analysis on whether contributing factors leading to maternal death could be prevented
- More in-depth demographic analysis to explore trends related to age, pre-pregnancy weight, individual behavior, geographic location, etc.
- Individual focus on risk factors affecting Black women



TEXAS
Health and Human Services

Texas Department of State
Health Services

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

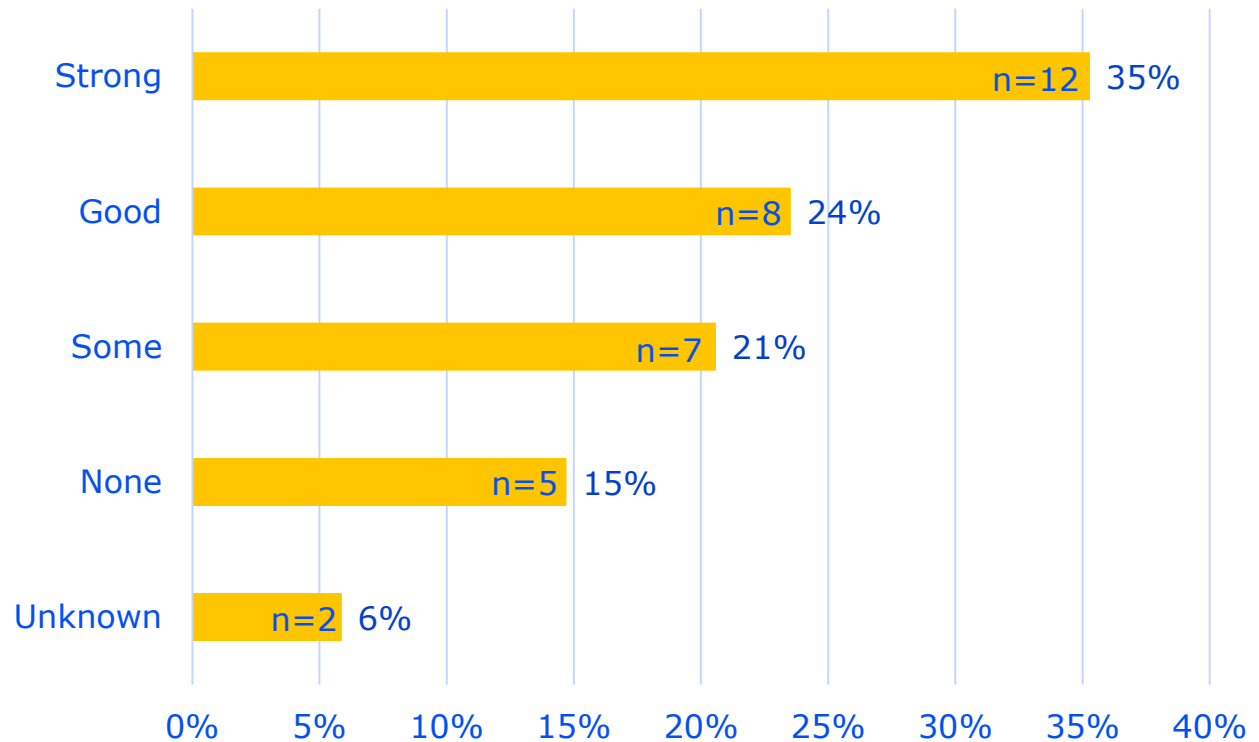


TEXAS
Health and Human Services

Texas Department of State
Health Services

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

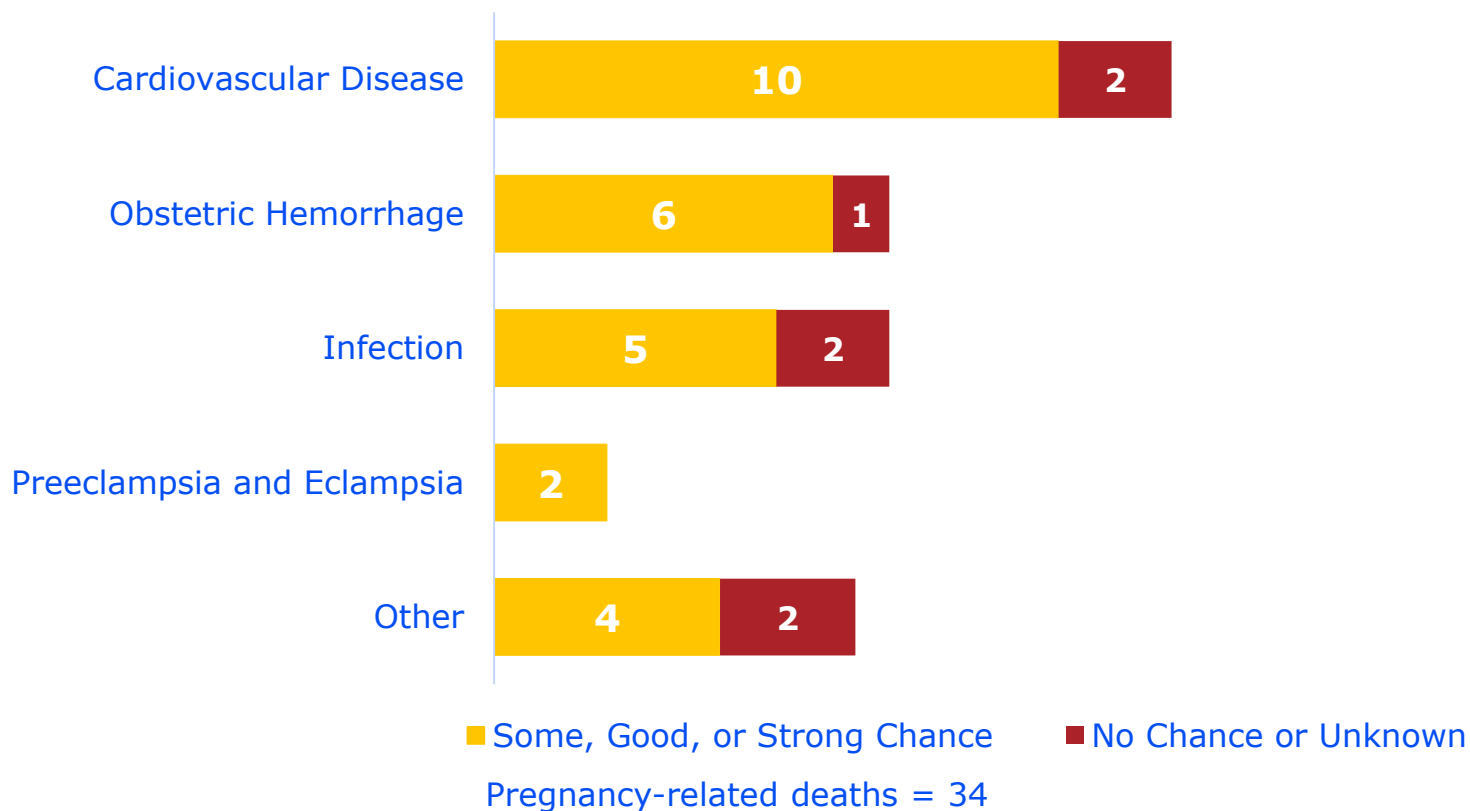


TEXAS
Health and Human Services

Texas Department of State
Health Services

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





TEXAS
Health and Human Services

Texas Department of State
Health Services

2018 Task Force & DSHS Joint Biennial Report

Findings

1. Nearly 40% of maternal deaths reviewed were identified as pregnancy-related.
2. The leading causes of pregnancy-related death in 2012 included cardiovascular and coronary conditions, obstetric hemorrhage, infection/sepsis, and cardiomyopathy.
3. Black women were more likely to experience pregnancy-related death in 2012.
4. The majority of maternal deaths in 2012 were to women enrolled in the Medicaid program at the time of delivery.



TEXAS
Health and Human Services

Texas Department of State
Health Services

2018 Task Force & DSHS Joint Biennial Report

Findings

5. Most pregnancy-related deaths were potentially preventable.
6. A complex interaction of personal, provider, facility, systems and community factors contributed to maternal death.
7. Delays in receiving case records and the redaction process slowed maternal death case review.
8. Hemorrhage and Cardiac Event were the two most common causes of death while pregnant or within 7 days postpartum.



TEXAS
Health and Human Services

Texas Department of State
Health Services

2018 Task Force & DSHS Joint Biennial Report

Findings

9. The majority of maternal deaths occurred more than 60 days postpartum.
10. In 2012 to 2015, drug overdose was the leading cause of maternal death from delivery to 365 days postpartum.
11. There is a complex set of factors associated with maternal death, underscoring the need for detailed review of maternal deaths.
12. Black women bear the greatest risk for maternal death.



2018 Task Force & DSHS Joint Biennial Report

Findings

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



TEXAS
Health and Human Services

Texas Department of State
Health Services

2018 Task Force & DSHS Joint Biennial Report

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.



TEXAS
Health and Human Services

Texas Department of State
Health Services

2018 Task Force & DSHS Joint Biennial Report

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.



TEXAS
Health and Human Services

Texas Department of State
Health Services

2018 Task Force & DSHS Joint Biennial Report

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.



TEXAS
Health and Human
Services

Thank You
