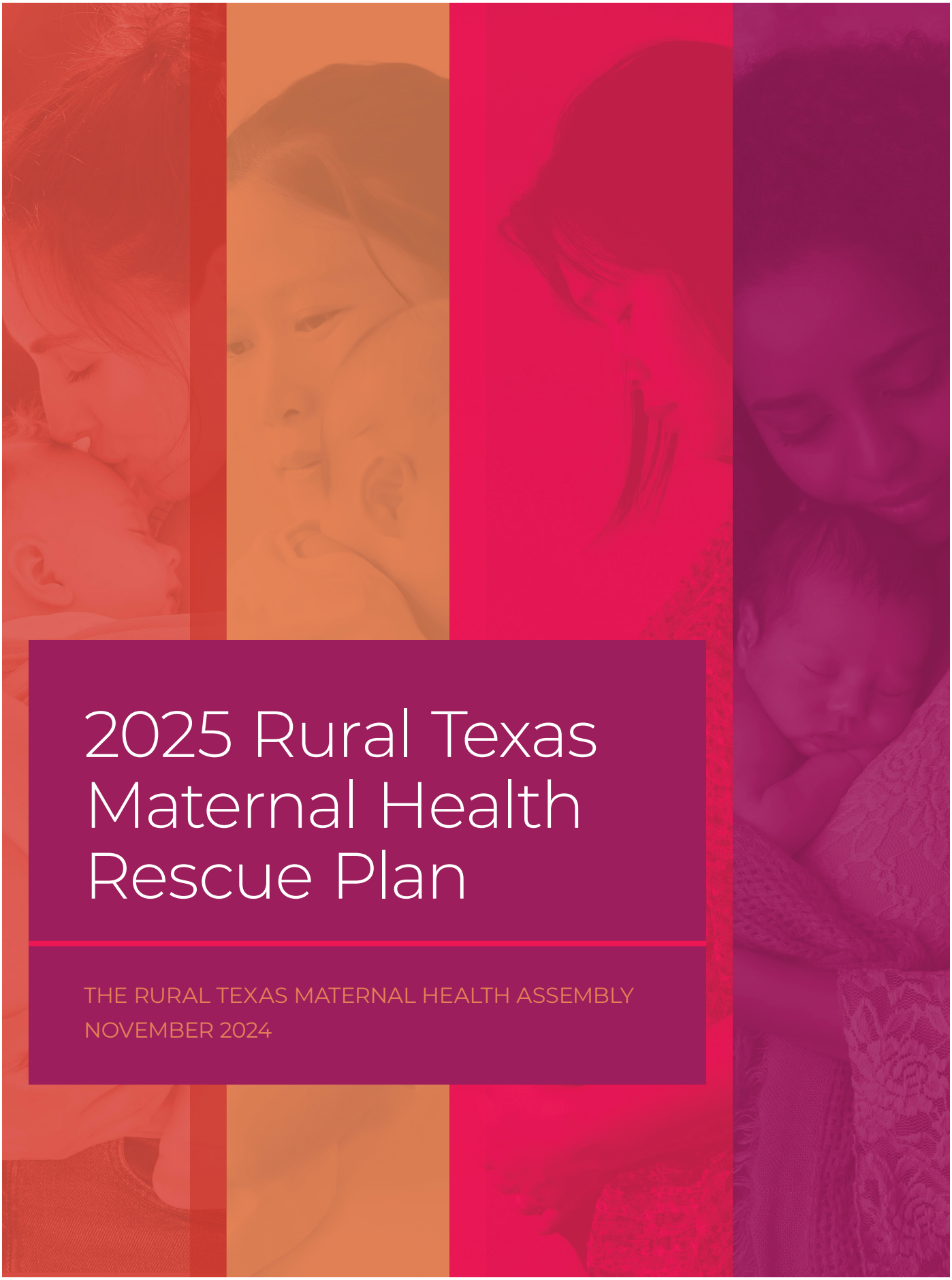

2025 Rural Texas Maternal Health Rescue Plan

THE RURAL TEXAS MATERNAL HEALTH ASSEMBLY

NOVEMBER 2024

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BY THE RURAL TEXAS MATERNAL HEALTH ASSEMBLY

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Scan to visit the Texas A&M Rural and Community Health Institute's Rural Texas Maternal Health Initiative.

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Executive Summary

Twenty-five years ago, the state's rural health system was in crisis, with hospitals closing, obstetrical (OB) care physicians limiting services or leaving, and nurses and allied health professionals being displaced. Thousands of rural Texans lost access to local, reliable, and safe health care services. **In response, lawmakers enacted House Bill 18, the Rural Health Rescue Act, a comprehensive package of reforms to stabilize and strengthen the rural maternal health system.**

As the saying goes, history doesn't repeat itself, but it does rhyme. And today, rural communities can see a clear pattern: **the state's rural maternal health care system teeters perilously close to another crisis.**

- 47% of Texas counties are "maternity care deserts," lacking OB care services entirely, compared to 33% nationally.[i]
    - 20% of Texas women received inadequate or no prenatal care, compared to 14.8% nationally. In rural counties, the rate is even higher.
    - 28% of rural mothers live 30 minutes or more from a maternity care facility.
- In 2021, out of the 214 Texas counties lacking sufficient primary care, 74% (159) were rural.[ii]
- Seventy-one rural Texas counties lack a hospital.[iii] Among hospitals still providing labor and delivery services, 59% report financial losses for each service.[iv]
- As many as 25% of rural women lack health insurance.[v,vi]

The lack of local services harms the health of mothers and babies. Women who must travel long distances for preventive care or labor and delivery have worse health outcomes, which is why rurality in and of itself is a factor in the maternal health crisis. In other words, rural women and their babies are more likely than their urban counterparts to suffer severe complications, or worse.[vii,viii]

Without access to local preventive and primary care, rural women are more likely to miss important cancer screenings, postpartum care, and contraceptive services, which are key to promoting appropriate birth spacing and better birth outcomes. Statewide, 25% of all maternal deaths — both rural and urban — occur up to 12 months following delivery, making regular postpartum visits critically important.

Aside from the health implications, **promoting better birth outcomes makes economic sense, boosting productivity and potential of a state's largest economic asset: half its workforce.[ix] Moreover, Texas' continued economic prowess is inextricably linked to the prosperity of its rural communities,** which generate more than $20 billion in annual revenue. However, the future of these communities depends upon their ability to attract young families, who are reluctant to live in a place lacking local maternal health care.

Given the condition of Texas' rural maternal health system, the Rural Texas Maternal Health Assembly (Assembly), described below, respectfully urges the 89th Legislature to enact a modern rural maternal health rescue initiative, centered on consensus-driven reforms that will promote a high-quality, enduring rural maternal health care system that fosters healthy families, sustains strong communities, and promotes economic prosperity today and for future generations.

Of utmost importance, our organizations implore lawmakers to address the urgent, entrenched "Code Red" issues that imperil the long-term viability of the state's rural maternal health system. Addressing these problems will lay a secure foundation on which to build other necessary changes that will improve the health outcomes of rural mothers and families.

The Rural Texas Maternal Health Assembly urges the 89th Legislature to enact a modern rural maternal health rescue initiative, centered on consensus-driven reforms that will promote a high-quality, enduring rural maternal health care system that fosters healthy families, sustains strong communities, and promotes economic prosperity today and for future generations.

Code Red Priorities

- ★ Retain and attract rural health care facilities, clinics, and health care professionals by ensuring their financial viability by providing competitive reimbursement, reducing uncompensated care, and cutting costly red tape.
- ★ Boost the rural maternal health workforce pipeline and capacity, with workforce defined to include medical, nursing, and non-clinical professionals.
- ★ Increase the availability of women's preventive health care before, during, and after pregnancy by fully funding the state's women's health programs and increasing their capacity and reach.
- ★ Alleviate non-clinical barriers to care, such as food insecurity, that undermine the well-being of mothers and babies and increase overall health care costs.

The rural maternal health crisis is complex, requiring a multifaceted strategy to heal it. In addition to the Code Red Priorities, we ask that lawmakers adopt a slate of interrelated and crucial strategies designed to address two categories: critical and essential. *Critical* strategies will bolster the viability of the rural maternal health system, while *essential* strategies will improve patient and family health outcomes by promoting innovative initiatives to heighten the quality of women's health services.

Critical Priorities

- ★ Fund rural community innovation grants that foster local ingenuity and innovation to improve women's access to vital clinical and non-clinical support services.
- ★ Align Medicaid pregnancy and postpartum clinical policy with best practices shown to improve perinatal health outcomes.
- ★ Reduce pregnancy-related complications and associated costs by enhancing access to pre-pregnancy specialty care for women at higher risk for pregnancy-related complications.
- ★ Modernize rural health care delivery through advancement of innovative rural maternal health care delivery and payment models.

Essential Priorities

- ★ Eliminate unnecessary red tape that delays timely receipt of preventive care before, during, and after pregnancy.
- ★ Establish innovative rural perinatal home visiting programs to address both clinical and non-clinical needs of expectant and new mothers.
- ★ Engage and support expectant mothers and new parents using safe and reliable digital care-management applications.
- ★ Improve rural perinatal quality and health outcomes by providing rural hospitals and health care professionals resources to successfully participate in the state's perinatal quality collaborative and training initiatives.

These recommendations did not emerge in a political vacuum. Each of the Assembly organizations recognizes that the 89th Legislature will be asked to sustain or increase funding for many other critical needs, including property tax reductions, border security, schools, water, and emergency preparedness. **Yet, failure to address the rural maternal health crisis now will cost taxpayers more later, while jeopardizing the safety and health of expectant and future mothers.**

We respectfully urge favorable consideration of these recommendations, thoughtfully developed to preserve safe and accessible rural maternal health care for this generation and those to come.

Background

Rural communities are the lifeblood of the state. When people envision Texas, it is rural Texas they see. In fact, visitors to **Texas' official website** are greeted with a photograph of an iconic mountain range in remote West Texas.

Yet, this way of life — and its profound benefits to all Texans — could be lost. The steady erosion of Texas' rural maternal health system makes it harder for rural communities to attract and retain employers, as well as the very people they need to ensure long term economic vitality — young people. While many factors determine where people choose to settle and raise families, health care access — or lack thereof — is paramount, particularly for young women, who tend to use health care services more frequently than men.

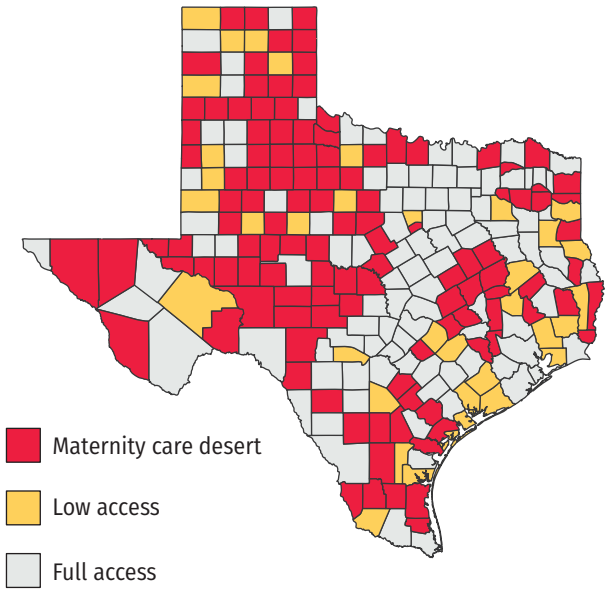
Already, rural women struggle to obtain even routine care, including checkups, cancer screenings, or prescription refills because they increasingly must travel to get the care they need, requiring more time spent away from home.[x] Access to maternity care in rural counties continues to decline. Forty-nine percent of rural counties had hospital-based obstetrics in 2010. By 2022, only 42% had hospital-based obstetrics and 58% of rural counties had no hospital-based obstetric services at all. For specialty maternal care or hospital services, many rural women must go farther afield.

These challenges result in adverse outcomes for rural mothers and babies in rural communities. Research shows that American women living in rural counties experience pregnancy-related mortality ratios up to three times higher than women living in large-metro counties.[xi]

Furthermore, the degradation of Texas' rural maternal health system harms the entire state. Urban obstetrical facilities and health care clinicians struggle to absorb patients from rural regions, leading to overcrowded clinics, longer wait times, and strained resources.

Preserving a strong rural maternal health system is not just about ensuring access to health care, but also sustaining Texas' economic prosperity and protecting the health of mothers and babies, who form the bedrock of any thriving community. Any rural civic or business leader will tell you that thriving rural communities are those where women want to live with their families. Erosion of those services will deter more from choosing a rural way of life.

Access to maternity care in Texas



Source: March of Dimes. Where You Live Matters: Maternity Care in Texas

47%

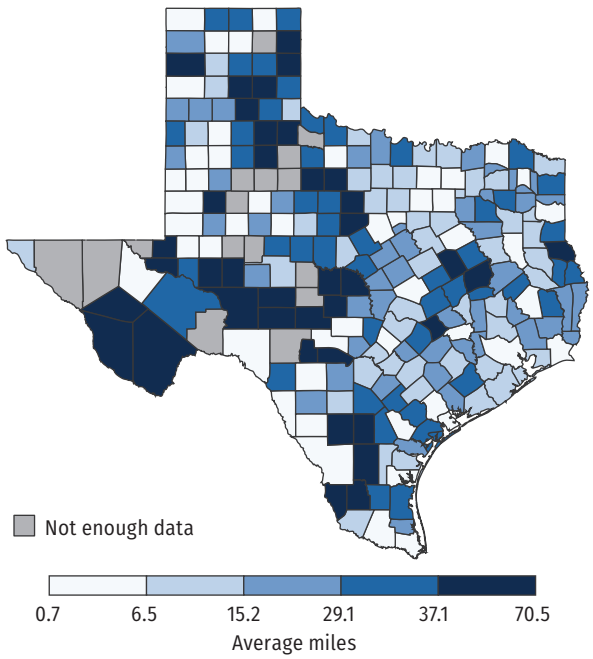
of Texas counties are defined as maternity care deserts.

During the 88th legislative session, lawmakers took action to improve statewide access to maternal health, measures that will profoundly benefit rural communities, including:

- Extending Medicaid postpartum coverage to a full year;
- Establishing standardized screening for non-clinical drivers that harm pregnant women;
- Increasing Medicaid funding for Medicaid physicians and professional obstetrical care services;
- Boosting rural hospital labor and delivery "add-on" payments;
- Funding new mobile rural preventive health centers for underserved communities; and
- Increased investments to expand broadband availability, a critical component of increasing use of virtual maternal health services in rural settings.

As important as these measures undoubtedly are, the scale and depth of the rural maternal health crisis requires more audacious action — enactment of a multipoint plan that will foster and sustain the ingenuity and innovation needed to tackle longstanding and deeply rooted issues that continue to destabilize rural maternal health.

Distance to birthing hospital by county



Source: March of Dimes. Where You Live Matters: Maternity Care in Texas

To that end, on July 25, 2024, Texas A&M University's Rural and Community Health Institute, together with the Texas Academy of Family Physicians, Texas Organization of Rural and Community Hospitals, and Texas Health Institute, convened a Rural Texas Maternal Health Assembly (Assembly) comprising 54 invited organizations that represent rural health care providers, academic institutions, advocates, and foundations, as well as senior officials from key state entities and advisory committees who served as advisors.

The Assembly's task was to identify a cohesive, consensus-driven Rural Maternal Health Rescue Plan modeled on the Rural Health Rescue Act enacted 25 years ago. A total of 35 Assembly members responded to a survey designed to identify key issues and potential solutions for Texas mothers living in rural communities. Working groups of Assembly members carefully studied the issues identified through the survey and information gathered through 22 key informant interviews. Assembly members discussed potential solutions and policy recommendations during an in-person Assembly meeting in Austin on September 6, 2024.

Assembly members considered dozens of initiatives, some new and others tested in other states. Twelve priorities emerged, which members ranked in terms of priority and the extent to which the reform could benefit most families, communities or health care providers and professionals, acknowledging the substantial overlap across categories.

Priority rankings:

Code Red: Urgent reforms needed to address pervasive, longstanding issues that threaten rural maternal health viability and on which the success of all other reforms will depend.

Critical: Strategies to bolster the long-term viability of a rural maternal health system.

Essential: Strategies that will improve patient and family health outcomes by promoting innovative ways to increase availability of high-quality preventive and maternity care services.

Assembly members also considered other potential recommendations, which despite their merits did not demand the same priority, as deemed by most Assembly participants. Nevertheless, given that most of these recommendations would help advance the state's efforts to improve maternal health, additional proposals are chronicled in Appendix (A).

Rural Texas Maternal Health Rescue Plan Discussion of 12 Priority Policy Proposals

Code Red Priorities

1. Ensure the financial solvency of the rural maternal health system by:

- Adopting a Medicaid payment modernization strategy to boost Medicaid payments for rural facilities and health care professionals,
- Sustaining incubator dollars for rural federally qualified health centers,
- Reducing uncompensated care, and
- Cutting excessive red tape.

RATIONALE: Rural health care practitioners, and the hospitals or clinics in which they practice, are foundational to the economic prosperity of any rural area providing jobs and undergirding rural communities' tax bases. **And, like any business, rural hospitals, clinics, and practices cannot operate if they cannot pay their staff and keep the lights on.**

Yet, the state's largest payer for maternal health services, Medicaid, pays woefully low rates, well below the cost of providing not only obstetrical care but also the primary care services women and their babies need after pregnancy. Statewide, Medicaid pays for 51% of all births.[xii] In rural counties, that figure is higher, ranging from 60% to 92%.

High operational costs and low patient volume make it difficult for hospitals to remain financially viable without cost-based reimbursement. As a result, there has been an alarming decline in rural hospital labor and delivery services as more rural hospitals make the difficult decision to eliminate or reduce them. Changing the payment formula would help more rural hospitals sustain labor and delivery services.

For physician and professional services, increasing payments for office-based care will boost availability of postpartum care for mothers and improve access to services before and between pregnancies, promoting early detection and management of chronic diseases that contribute to pregnancy-related complications.

For a routine office exam of a postpartum mother, Medicaid pays physicians $34, compared to $88 for a similar service provided to a Medicare patient. **Higher Medicaid physician payments are also an essential component of retaining and recruiting more rural health care providers.**[xiii]

Because rural health care facilities, clinics, and health care professionals are paid using different reimbursement methodologies, enhancing the financial viability of each will require solutions tailored to each provider class, as outlined below.

Additionally, the state must reduce the high rate of rural Texans without health insurance, which not only harms the health and financial security of patients, but also the financial stability of rural facilities and health care professionals. Roughly 25% of rural Texans lack health insurance compared to 21.7% statewide. In 2023, among all uninsured Texans, 56% to 71% are eligible for *existing* state or federal programs,[xiv] such as Medicaid or the ACA Marketplace. Far too many rural Texans remain uninsured because they do not realize they are eligible for an affordable option. Thus, it is vital that Texas enact robust outreach and education efforts to inform rural Texans of their health insurance options, while also making it easier to get insurance coverage by simplifying the enrollment and referral processes.

Compounding the above challenges is the volume of Medicaid red tape, which detracts from direct patient care — services that pay the bills. While overhead costs are inherent to any business, many Medicaid policies and processes could be streamlined or eliminated to help minimize these costs, including reducing Medicaid prior authorization requirements, expediting Medicaid managed care provider credentialing, improving timeliness of Medicaid patient enrollment, and improving continuity of care.

Recommendation 1.A. Establish competitive Medicaid reimbursement rates for rural maternal health providers.

Hospitals

- **Establish cost-based Medicaid[xv] obstetrical care payments for rural hospitals that provide maternity care services.**[xvi] Allowable cost will be defined as the costs specified on each rural hospital's cost report and updated (rebased) every other year.

To mitigate the upfront costs, lawmakers could phase in cost-based reimbursement over a specified period.

Short of this option, lawmakers should direct HHSC to conduct a study on the impact of implementing cost-based reimbursement for rural hospital maternity care services. The study should examine not only the impact of cost-based payments on access to and quality of care, but also the local economic impact of sustaining access to maternity care. Findings would be reported to the Legislature to inform future rural maternal health payment policy actions.

Physicians and health care professionals

- **Boost payments by increasing payment rates for rural adult office-based services (evaluation and management services) by at least 6% for qualified practitioners that provide women's and maternal health care,** matching the increase provided in 2023 for pediatric office services and obstetrical care. Medicaid adult E&M codes pay 40% to 60% of Medicare physician payment rates for the same types of services. Rural physicians and health care professionals bill these codes when providing preventive and primary care services, including for postpartum women.
- **Establish an endowed Rural Maternal Health Quality Improvement Fund** within the Office of the Comptroller, proceeds from which could be allocated to reward rural primary care and obstetrical care practices that meet specified access and quality measures.
- **Establish fixed Medicaid per member, per month sustainability payments for rural maternal care practitioners** to help cover the costs of services needed to holistically manage women's preventive, primary, and maternity care needs, including telephone consultations, chronic care management, and care coordination among other health care professionals.
- **Increase Medicaid payments for rural obstetrical anesthesia services** to help hospitals recruit and retain this crucial specialty.

Federally Qualified Health Centers (FQHCs)

- Increase incubator dollars to support rural or rural-serving FQHCs to expand rural maternal health services. From existing FQHC incubator dollars appropriated by lawmakers, 11 clinics are using funds to improve maternal health, of which seven projects encompass rural communities. Providers are using fuds to expand clinic capacity, hire more maternity care health professionals, and purchase crucial equipment, such as ultrasound machines.

Recommendation 1.B. Reduce the burden of uncompensated care by increasing the number of rural Texas women with meaningful health care coverage, focusing on those eligible for, but not enrolled in public or private health insurance, using a multipronged strategy.

- Expand the use of Outstation Eligibility Workers (OWP) by placing them in more FQHCs and hospitals as well as rural health clinics to provide additional assistance to enroll eligible Texans eligible for Medicaid, promoting not only timelier access to maternal care, but also health care coverage. Furthermore, the state should increase funding for the Community Partner Program (CPP) by providing grants to community-based organizations able to provide enhanced outreach, education and enrollment in Medicaid and related services, ultimately enhancing health care access for rural populations.
- Expand the use of outstation Medicaid eligibility workers and community partners.

Use more reliable and current data sources to conduct Medicaid administrative renewals, thereby reducing eligibility determination costs to the state, maintaining program integrity, and helping eligible women and children renew coverage more quickly. Under this process, states use electronic data sources to verify income and other eligibility criteria. About 11% of Texas Medicaid renewals are conducted this way compared to 79% for Louisiana and 70% for Arkansas.

Adopting best practices from these and other states could help Texas streamline Medicaid eligibility and prevent gaps in coverage.

- Improve eligibility and enrollment accuracy and timeliness by replicating eligibility best practices adopted in many other conservative states, which boost use of reliable electronic data to confirm a patient's eligibility for Medicaid.

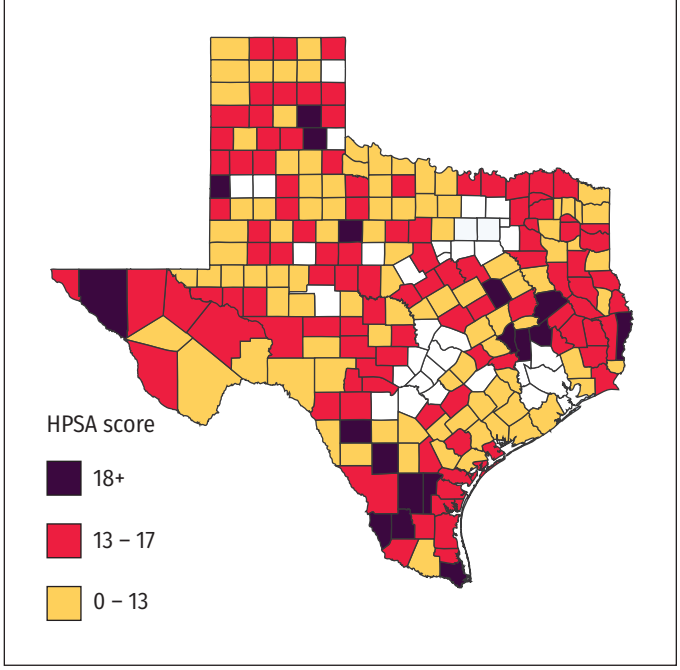
Reform Texas' presumptive eligibility (PE) policies to encourage more hospitals and FQHCs to participate as well as other provider types. PE is the process where "qualified entities" — hospitals, community health clinics, physician practices — screen patients for Medicaid eligibility. Those deemed reasonably likely to qualify can then initiate health care services right away, pending the state's review of their official application. For pregnant women, early entry prenatal care is essential to identifying and managing chronic conditions or non-medical factors that could put the pregnancy at higher risk. Increasing use of PE would help more women obtain these services, but Texas' excessively strict criteria for PE determinations deter qualified entities from participating. Similarly, Texas Medicaid should encourage more obstetrical care and primary care clinicians to become qualified PE entities to improve initiation of early prenatal care among rural mothers.

- Simplify presumptive eligibility.

Modernize the Texas Integrated Eligibility Redesign System (TIERS) and upgrade the state's 211 Information and Referral Network. For the 2026-27 biennium, HHSC requested $300 million in general revenue to ensure these systems work efficiently and effectively, without costly overtime hours to "work around" ongoing information technology issues common within TIERS that prevent it from timely enrolling people into Medicaid and the Supplemental Nutrition Assistance Program, SNAP.

- Modernize TIERS to improve Medicaid enrollment timeliness.
- Upgrade 211, the state's Information & Referral Network, to make it easier for working Texans to enroll themselves or their children in Medicaid or other public programs..

Primary Care Health Professional Shortage Areas (HPSAs)



Source: Texas Department of State Health Services Health Professional Shortage Area Dashboard

214

of Texas' 254 counties are Primary Care HPSAs. Of those, 159 are rural counties.

Recommendation 1.C. Minimize costly Medicaid red tape and administrative hassles.

Due to the number of rural women who benefit from pregnancy-related Medicaid, it is vital that obstetrical care health professionals be able to quickly and easily enroll in Medicaid and complete Medicaid managed care (MCO) credentialing. However, the state enrollment process and system providers use to complete enrollment, the Provider Enrollment and Management System (PEMS), can be slow and cumbersome. Obstetrical care clinicians report being unable to conduct even basic provider enrollment and reenrollment functions via PEMS, such as adding or removing clinicians working in their practices, delaying new enrollment and periodic revalidation.

In 2025, Texas Medicaid will roll out a streamlined process through which health care providers who apply to participate in Medicaid may initiate the provider enrollment and MCO credentialing processes simultaneously. Participating Medicaid health care providers and health care professionals have long sought this new approach, known as PEMS+. If smoothly implemented, it has the potential to streamline and accelerate the provider enrollment process, giving providers the ability to start seeing Medicaid patients and receiving associated payments sooner. **However, underlying and extensive problems with the current provider enrollment system (PEMS), including timelines and accuracy of application processing as well as data integrity issues, must be resolved for PEMS+ to succeed.**

The state and stakeholders should collaborate to identify and address any barriers or delays to provider enrollment and credentialing and explore potential solutions to ensure obstetrical care clinicians can begin delivering care as soon as possible. One such option could be exploring the feasibility of extending Medicaid expedited credentialing to FQHCs and RHCs. Current state law requires commercial and Medicaid MCOs to make available expedited credentialing, a mechanism by which new physicians joining a contracted group practice can be paid as a contracted provider while awaiting completion of the MCO credentialing review, provided they have already enrolled in Texas Medicaid and meet expedited credentialing requirements. Another consideration that should be explored is opportunities to improve the functionality, accuracy and timeliness of the Medicaid Provider Enrollment and Management System (PEMS).

- Improve the functionality, accuracy and timeliness of the Medicaid Provider Enrollment Management System (PEMS).
- Explore Medicaid expedited credentialing to FQHCs and RHCs.

Prior authorizations (PAs), when judiciously applied, are a necessary component of modern health care delivery, helping promote safe, appropriate services. According to a 2023 report by the federal Office of the Inspector General that compared Medicaid MCO denial rates among the top national Medicaid health plans to those of Medicare Advantage (MA) plans, *the Medicaid MCOs denied one out of every eight (12.5%) prior authorization requests in 2019 versus only 5.7% among MA plans.*[xvii] Several Texas health plans identified in the report had PA denial rates ranging from 10% to 34%.

While Medicare and Medicaid populations vary greatly in terms of health care services needed and used, the difference in denial rates among MA and MC plans raises questions about what is driving the variation. Texas Medicaid oversees MCOs' PA practices to ensure patients receive appropriate care, but the Assembly recommends that HHSC, working with stakeholders, conduct a deeper review to identify opportunities for improvement, with the goal of promoting best practices to reduce the number of PA requests that currently contribute to higher rural practice and MCO administrative costs.

The Assembly also recommends amending the Medicaid preferred drug list exception process to allow pregnant women with specific diagnoses that contribute to pregnancy-related complications, such as hypertension or diabetes, to continue using a non-preferred drug throughout pregnancy without continued PA if, at the time of Medicaid enrollment, the prescription medication on which the expectant mother is stable is not preferred.

- Using existing Medicaid managed care advisory committees, convene stakeholders to identify pragmatic strategies to curb the proliferation of prior authorizations; improve continuity of care protections for pregnant women taking prescription drugs for the treatment of chronic conditions that contribute to pregnancy-related complications.

2. Increase the rural maternal health workforce by:

- Increasing availability of all health care professionals who provide preventive, primary care and/or maternal health services to rural women by 1) enhancing rural education and training opportunities; and 2) establishing innovative recruitment and retention strategies, focusing specifically on the following:
  - obstetricians and gynecologists (OB-GYNs), full-spectrum family medicine physicians practicing obstetrics (FM-OBs), and certified nurse midwives (CNMs);
  - family medicine physicians (FMs) and advanced practice professionals (APPs) — nurse practitioners and physician assistants — who provide women's preventive health care;
  - anesthesiologists and certified registered nurse anesthetists (CRNAs); and
  - obstetrical care nurses (OB-nurses) and respiratory therapists (RT).
- Increasing the use of virtual health care services, and
- Augmenting availability of trained, nonclinical maternal health professionals to stretch capacity.

RATIONALE: A sustainable and well-supported rural maternal health care workforce is essential for delivering high-quality care to rural women throughout their reproductive life spans. This task requires thinking creatively and thoughtfully about how to attract and retain not only obstetrical and primary care health professionals, but also trained non-clinical professionals, whose services extend the reach of their clinical colleagues while improving health outcomes.

In the 88th legislative session, lawmakers invested significant new dollars in loan repayment programs to attract more physicians, nurses, and mental health professionals to rural and underserved areas. Given the high cost of education and the payment differential for rural maternal health professionals whose largest payer is Medicaid, which pays roughly half of commercial insurance rates, lawmakers should consider providing loan forgiveness for professionals who choose to practice in a rural community for more than five years.

Recommendation 2.A. Maintain investments in the state's existing physician and health professional loan repayment programs as part of a comprehensive strategy to recruit more practitioners to rural communities.

- Given the challenges to retain obstetrical care physicians, the Assembly recommends forgiveness of loans for obstetricians and FM-OBs who commit to practicing in rural communities for at least five years, as well as adding retention bonuses for further years of service.

Recommendation 2.B. Fully fund Senate Bill 25 (88th legislative session), to provide enhanced loan payments for nurses and nurse faculty, and to establish funding to expand clinical site rotations for new nurses.

- The Assembly recommends lawmakers also enact measures to specifically recruit and retain advanced practice professionals and CRNAs to rural communities, including targeted loan repayments and increased rural rotation opportunities. These professionals are critical to the rural maternal health workforce. For rural APRNs practicing midwifery or women's health services, the state also should provide loan forgiveness for those who practice in a rural community for at least five years or more, with retention bonuses for further years of service.

Recommendation 2.C. Expand the number of rural rotations available for medical students to gain firsthand experience in rural practice, including rural maternal health care.

- These rotations should include direct patient care, community health involvement, and clinical shadowing to inspire more professionals to pursue careers in rural maternal health.
- Likewise, certified nurse midwives and advanced practice registered nurses have limited opportunities to train in rural areas, whether through preceptorships during training or post-graduation residencies, and the state should provide funding to expand them.

Recommendation 2.D. Direct HHSC to perform a study to evaluate unnecessary regulations and restrictions that prevent all members of the rural maternal health workforce from more effectively and efficiently taking care of patients in a collaborative team-based practice environment.

Unlike many other states with large rural populations, including Colorado and Kansas, Texas has limited graduate medical education opportunities for family physician residents seeking additional maternity and women's health care training. Assembly members reported anecdotal data that out-of-state programs have been able to attract and retain Texas family medicine residents who wanted to practice as FM-OBs here but chose to leave and practice near their fellowship locations because of limited training opportunities in Texas.

Recommendation 2.E. Increase funding for graduate medical education (GME) grants through the Texas Higher Education Coordinating Board to establish and support more family medicine-obstetrics fellowships, helping Texas to train more family medicine physicians interested in providing obstetrical care in rural communities and better compete with states already offering such training.

For rural hospitals to safely provide labor and delivery services, funding also is needed to recruit anesthesia professionals, obstetrical care nurses, trained respiratory therapists.

Recommendation 2.F. Provide incentives for anesthesia fellows and nurses pursuing a certified registered nurse anesthetist (CRNA) degree to practice rurally through funded electives in rural settings.

Recommendation 2.G. Provide financial support, including stipends, educational loans, bonus payments, and so forth, to help hospitals hire and retain the clinical staff needed to offer labor and delivery services, including obstetrical care nurses and respiratory therapists.

Trained non-clinical health professionals, such as community health workers (CHWs) and community perinatal doulas, could also help address health disparities and improve rural maternity care capacity. These professionals do not provide clinical care, but assist physicians and APPs with important patient education, care coordination, and case management. In 2023, House Bill 1575 authorized doulas and CHWs as new Medicaid provider types that may provide case management services for high-risk pregnant women.

Research shows that access to community-based doulas during prenatal, labor and delivery, and postpartum periods can improve birth outcomes and reduce the need for surgical interventions, including C-sections. For these reasons, Texas' panel of maternal health experts recommended that lawmakers consider expanding doula services as a Medicaid benefit.[xviii]

Recommendation 2.H. Expand use of and enhance payment for trained non-clinical staff including community health workers (CHWs) and community-perinatal doulas.

Texas Medicaid recognizes CHWs as a provider type, but low payment rates discourage their broader use. Doulas are a new Medicaid provider type, enrolled to provide case management for high-risk pregnant women. The Assembly recommends broadening doula service to encompass perinatal care and replicating programs such as **Parents as Teacher Doula Training.** If enacted, the model would not only expand rural mothers' access to these professionals, but also provide important job opportunities for more rural Texans.

Advances in virtual care and digital technology allow virtual delivery of an array of clinical and social support services, which complement in-person visits while minimizing the need for long-distance travel. Texas Medicaid supports such services, but often with limited payment and flexibility. An innovative example comes from New Mexico, where obstetrical care clinicians caring for high-risk pregnant rural women to prescribe a "telehealth kit, which includes a tablet with embedded devices that monitor and report blood pressure, weight, oxygen level, glucose level, and fetal heart rates."[xix] By promoting similar innovation and streamlining use of virtual care, rural maternal health providers will be able to better leverage virtual care, which can be used not only to expand access to clinical services, including prenatal and postpartum care, home telemonitoring, and mental health care, but also to parenting support services.

20.4%

of Texas women received inadequate or no prenatal care, compared to 14.8% nationally. In rural counties, the rate is even higher.

For example, the American College of Obstetricians and Gynecologists supports using telemedicine consultations for some prenatal visits involving low-risk pregnancies.

Moreover, the technology can be a boon for enhancing clinician-to-clinician consults. For example, the University of Arkansas for Medical Sciences' Institute for Digital Health and Innovation offers a 24/7 program to provide clinical education to help improve patient safety, including clinician-to-clinician consults, obstetrical care triage, and obstetrical care training services.

Recommendation 2.I. Promote and support greater use of virtual care for direct patient care services by removing administrative, payment, and technological barriers that prevent widespread use of telemonitoring and other virtual services in rural areas.

FQHCs and RHCs can provide such services, but other provider types capable of providing telemonitoring, including physician practices, should be included too. The Assembly also recommends redefining telemonitoring policy to allow it to be used for a broader array of clinically indicated preventive health services, including remote ultrasounds, blood pressure and heart rate checks, and prenatal and postpartum care, in tandem with necessary in-person services, among other interventions.

Recommendation 2.J. Establish state funded regional Remote Consultative Services to provide rural obstetrical care clinicians 24/7 access to clinician-to-clinician consults to improve management of complex patients or OB emergencies.

3. Boost availability of women's preventive health care before and between pregnancies.

RATIONALE: Texas Medicaid provides comprehensive coverage to pregnant and postpartum women, with pregnancy-related Medicaid coverage beginning during the prenatal period and extending to a full 12 months following delivery. For pregnant women who qualify for Medicaid, the Children's Health Insurance Program – Perinatal Program (CHIP-P) provides preventive prenatal care to women with low incomes who do not qualify for Medicaid benefits.

25%

of all Texas' maternal deaths – both rural and urban – occur up to 12 months following delivery, making regular postpartum visits critically important.

However, women also need preventive health care before and between pregnancies, not only to protect their own health, but also to support a healthier pregnancy when they decide to start a family or have more children. Texas women can get such care through the Healthy Texas Women (HTW) program or the Family Planning Program (FPP), both of which provide critical preventive and basic primary care services, such as well-woman exams, contraceptive coverage, and cancer screenings. Moreover, women diagnosed with breast or cervical cancer also are eligible for full Medicaid coverage throughout the duration of their cancer treatment.

Texas funds FPP using state general revenue, whereas both the federal and state governments fund the Medicaid Breast and Cervical Cancer Treatment Program and HTW. HTW currently operates under a federal Medicaid 1115 waiver, which likely will end in 2025, along with the federal funds that accompany it. If that happens, it is imperative that the state replace this lost funding to preserve women's access to HTW's critical services.

Recommendation 3.A. Support funding to ensure women have access to comprehensive health care coverage before, during, and between pregnancies, including replacing any lost Healthy Texas Women Medicaid federal funds with state general revenue.

Recommendation 3.B. Maintain current state investments in the Family Planning Program and the Breast and Cervical Cancer Treatment Program.

Additionally, in 2023, lawmakers provided $10 million to expand use of mobile women's health clinics, which bring preventive care to rural areas. The clinics have been tremendously successful, leading HHSC to request additional funding in its 2026-27 Legislative Appropriations Request so the state can roll out the clinics in more rural areas. Lawmakers should approve the request, while also supporting other innovative means to bring preventive care to rural women, such as stationary satellite clinics and remote telehealth visits.

Recommendation 3.C. Expand availability of mobile or telehealth women's preventive health services (or similar) to bring these services to rural women.

> **"The low reimbursement rate, it's a huge factor, and the administrative burden of being in Medicaid is substantial. I talked to one OB group outside of Sweetwater that said they're the only birthing unit for hundreds of miles. And they couldn't get enrolled in Medicaid so they can't treat Medicaid patients."**
>
> **— Diana Forester, Director of Health Policy, Texas Care for Children**

4. Establish a comprehensive, holistic strategy to alleviate non-medical drivers that contribute to poor health outcomes and higher costs for rural mothers and families, specifically food insecurity, transportation barriers, and limited economic opportunities.

RATIONALE: Timely access to medical care is key to good health, but many other factors, including access to nutritious foods, economic opportunities, and transportation, play an even more important role. These factors, known as non-medical drivers of health (NMDOH), account for as much as 80% of a person's well-being and health outcomes, which can undermine the effectiveness of medical interventions when left unaddressed. Many NMDOH are more common in rural areas, where women and families often struggle to obtain healthy foods, find reliable transportation, or secure their economic future due to lack of local jobs.

For example, pregnant women taking insulin for the treatment of diabetes will nevertheless often experience more complications if they also lack access to nutritious foods needed to manage their blood sugar. Without access to reliable transportation, busy rural moms may postpone or skip needed care, harming their health and increasing overall costs.

In 2023, lawmakers took important steps to address NMDOH among pregnant women by enacting House Bill 1575, which enabled standardized voluntary screening for these factors, among other changes. MCOs connect women who screen positive to locally available services. Yet, given the magnitude of these challenges in rural Texas, and the uncoordinated approach to successful NMDOH interventions, the Assembly recommends that Texas pursue a comprehensive strategy to alleviate NMDOH.

Given the growing recognition among state policymakers and health care professionals about the role of NMDOH on the health of communities, nearly half of states have enacted a policy framework to address them, focusing on approaches that integrate screening, referral, and intervention into clinical practice. It remains challenging for any health care system to address NMDOH, in part due to lack of resources but also because medical and community professionals often lack a common understanding about the role of each in addressing NMDOH without duplicating work. Thus, any reform efforts must bring together the health and community systems to develop integrated NMDOH interventions.

Within Medicaid, states have two primary options to meaningfully address NMDOH — a Medicaid 1115 waiver or adopting an "in lieu of services" strategy — each with its own benefits and drawbacks.

1115 waiver

In 2015, under Republican Governor Pat McCrory, the North Carolina Legislature approved legislation that directed its state Medicaid agency to seek federal authority to test innovative strategies to mitigate NMDOH among Medicaid enrollees. The five-year initiative, known as the Healthy Opportunities Pilot (HOP), received federal approval in 2018, the first of its kind in the nation, to assess the "impact of providing select evidence-based, non-medical interventions related to housing, food, transportation" and other issues. For example, a high-risk pregnant mother who struggles to obtain healthy foods is eligible to receive a food box.

Like Texas, North Carolina has vast rural areas, with 80 of its 100 counties so designated. The state concentrated HOP pilots in these communities. Over the past five years, HOP served more than 20,000 Medicaid enrollees and their families statewide. An independent interim evaluation published in April 2024 found that HOP not only improved the well-being of pilot participants, but also reduced Medicaid costs by $85 per member, per month.[xx]

To date, 21 NMDOH-related Medicaid 1115 waivers have been approved,[xxi] including in Arkansas, Florida, and Utah, with another 16 waivers pending.

"In lieu of services"

Rather than pursue a waiver, states also can address NMDOH using an "in lieu of services" (ILOS) strategy, allowing Medicaid managed care plans to pay for alternative services instead of standard Medicaid benefits when it is medically appropriate and cost-effective. In 2016, CMS authorized states to use ILOS for medical services (and in 2019 Texas lawmakers directed HHSC to pursue such an option to improve mental health services), but CMS did not issue official guidance extending the ILOS flexibility to NMDOH until 2023, and now at least three states have exercised this option.

Regardless of the funding strategy, solutions to address medical and non-medical drivers of health for rural mothers must be community-based, community-led, and supported by a workforce that is employed in the community. One way to accomplish this is through Community Health Resource Centers (CHRC), tested originally in Texas' Brazos Valley Region and based on a comprehensive needs assessment and strategic planning. In conjunction with community partnerships, CHRCs offer a variety of medical and health and human services to help meet the needs of their communities.

Recommendation 4.A. Implement a cohesive, integrated strategy to address clinical and non-clinical drivers of health for rural mothers, using either federal Medicaid waiver authority or an ILOS model.

- For Texas' rural mothers and families, the Assembly recommends focusing on efforts to improve access to healthy foods, reliable transportation, and economic opportunities.

Recommendation 4.B. Embed the CHRC model into any NMDOH strategy to ensure initiatives meet the needs of rural mothers, families and communities.

In 2022, 58% of rural counties in Texas had no hospital-based obstetric services.

5. Fund community innovation grants to foster local ingenuity and innovation aimed at improving women's access to vital clinical and non-clinical support services.

RATIONALE: Texas' vast rural geography, regional variation in health care resources and capacity, and unique cultural and socioeconomic needs preclude designing cookie-cutter strategies to improve the access to and quality of rural maternal health. Dalhart, a small town in the Texas Panhandle, has very different needs than those of Newton, located 686 miles away in deep East Texas. Other states with large rural populations, including Alaska, Illinois, and New Mexico have implemented novel strategies to improve rural maternal health, some of which could be imported and tailored to Texas' unique communities.

For example, Assembly participants considered several "hub-and-spoke" models to improve access to clinical and non-clinical rural maternal health services. The model, tested in Texas, Missouri, New Mexico, and other states, promotes collaboration among a diverse mix of rural and urban regional health care entities, clinicians, health plans, and community services to improve access to and quality of care for rural mothers and babies.

Acute care hospitals typically anchor these programs, partnering with one or more FQHCs, private practices, rural health clinics, Medicaid health plans, and/or local social services. Regardless of the organization, research shows hub-and-spoke strategies improve rural obstetrical care. Strategies commonly deployed in these models include a mix of increased use of virtual care, activation of digital "hotlines" to connect rural health professionals to urban colleagues, expanded use of community health workers or doulas to support expectant and new mothers, establishment of satellite or "outpost" clinics to expand availability of prenatal and postpartum preventive care services, and increased opportunities for remote continuing clinical education for rural health care professionals. In some states, hub-and-spoke models also incorporate a "maternity care house" or hotel located near an urban maternity care facility. High-risk rural pregnant women stay in the house a couple weeks prior to a scheduled delivery so that if they go into labor early, they will still deliver safely at a facility equipped to manage any complications.

By definition, rural communities must be resourceful, and lawmakers should leverage this ingenuity by providing community innovation grant dollars to support the design and implementation of tailored rural maternal health access and safety interventions best suited to a rural community's own needs. Already, Texas provides similar dollars to rural hospitals. In 2023, lawmakers allotted $50 million in grant funds to HHSC for the purpose of financially stabilizing rural hospitals including maternal care operations.[xxii] Lawmakers should add community innovation grants to this current program.

To foster collaboration, the Assembly recommends that one criterion of any grant must be demonstration of regional or community stakeholder engagement on the proposed reform(s).

Recommendation 5.A. Allocate at least an additional $50 million greater than the 2024-25 biennial spending level to provide rural maternal health community innovation grants.

6. Reduce pregnancy-related complications and associated costs by augmenting Healthy Texas Women (HTW) benefits to improve specialty care treatment for conditions that contribute to pregnancy-related complications.

RATIONALE: Healthy pregnancies do not begin at conception, but in the months and years before. Once a woman gets pregnant, previously unmanaged chronic conditions lead to expensive and difficult to treat maternal care. Conditions such as diabetes and hypertension can result in serious pregnancy-related complications and birth defects, even if the mother received early prenatal care. For example, according to the state's panel of maternal health experts, 25% of all mothers who experienced pre-pregnancy obesity also experienced maternal hypertension and diabetes, both of which can seriously harm mother and baby.

Babies born to women with pre-gestational diabetes have higher rates of congenital birth defects and prematurity, while women with high blood pressure and hypertension before pregnancy also experience more adverse birth outcomes, including perinatal death. For women ineligible for Medicaid or comprehensive health care coverage, HTW is an important source of preventive and primary care, including prescriptions for the treatment of diabetes and hypertension. However, if HTW enrollees need to see a specialist to better manage their condition, specialty care is not a covered benefit. Furthermore, HTW does not cover nutritional counseling or FDA-approved obesity management medications.

Ensuring women have access to comprehensive health care throughout their reproductive lifetimes tops the list of recommendations to improve maternal health from the Department of State Health Services Maternal Mortality and Morbidity Review Committee (MMMRC). Along with the implementation of 12-months' postpartum coverage, enhancing HTW benefits to help women obtain needed care before pregnancy will help fulfill the state's goal of reducing maternal mortality and morbidity.

Recommendation 6.A. Enhance HTW benefits to cover specialty care services for the pre-pregnancy medical diagnoses or conditions that elevate risks of poor birth outcomes.

7. Modernize rural health care delivery by advancing the use of innovative rural maternal alternative payment models that reward the provision of timely, high quality, cost-effective health and social services.

RATIONALE: Texas Medicaid has been at the forefront of redesigning health care delivery, adopting its original value-based care payment framework more than a decade ago. Value-based care models reward health care systems and health care professionals for better health outcomes by paying for the quality of care rather than its quantity, while also improving cost effectiveness by promoting the right care at the right time in the right place. There are many payment models that promote such transformation, but at its essence, it involves replacing fee-for-service, wholly or partially, with payment for quality.

To that end, Texas Medicaid requires Medicaid MCOs to implement alternative payment models (APM) in which a portion of each health care provider's payment is based upon how well they perform on specified quality or performance measures. For women's health, these include measures such as timeliness of prenatal and postpartum care, access to contraceptive care, and rates of severe maternal complications. Many health plans have pilots underway.

In the past year, HHSC has emphasized increasing APMs for both maternal and rural health (though not necessarily a combined model). However, even within health systems with more resources, implementing APMs is no easy feat, requiring fundamental changes to how and where care is delivered, measured, evaluated, and paid. Moreover, the low volume of maternity care and women's health services within a rural facility or practice makes quality measurement more challenging. However, rural Texas communities could greatly benefit from a value-based care framework, particularly by giving providers a system to better manage and evaluate the care of small populations.

Rural health care organizations typically have smaller margins and higher relative fixed costs than their urban counterparts, making it more difficult to invest in the necessary tools and resources for managing total cost. That is why in 2021 the Texas Organization of Rural & Community Hospitals launched a clinically integrated network to create a high-performing network capable of sharing costs and risks among rural hospitals seeking to participate in value-based contracts with public and private payers.[xxiii] It includes more than 21 rural facilities statewide. While the model is not focused specifically on rural maternal health, it demonstrates the feasibility of a rural clinically integrated network that works on value-based care.

For the current biennium, lawmakers allocated state funding to provide technical assistance to rural hospitals transitioning to value-based care. A similar strategy is needed now for FQHCs and small physician practices. Value-based care requires substantial upfront costs for establishing data collection, reporting, creating analytical systems, redesigning workflow, reimagining care delivery, using a team-based approach, enhancing care coordination, and revising how practices engage and communicate with patients.

The steady erosion of Texas' rural maternal health system makes it harder for rural communities to attract and retain employers as well as the very people they need to ensure long term economic vitality — young people.

Recommendation 7.A. Provide technical and financial resources to help rural health care facilities, clinics and health professionals reengineer rural maternal health care delivery to focus on value, including grant funding to provide technical assistance to providers seeking to undergo such transformation.

Recommendation 7.B. Direct HHSC to collaborate with rural health care providers and MCOs to reform underlying data, quality measurement, and value-based designs to ensure such models are compatible with rural practice, including:

- Improving data accuracy, including ensuring clinics and practices have a correct list of patients attributed to them each month.
- Striving to align maternal health performance measures with commercial payers, while also streamlining and simplifying the measures that are reported; and
- Establishing core criteria for rural maternal health value-based payment strategies. Each MCO develops its own model, which increases complexity and costs.

Recommendation 7.C. Establish a technical assistance center focused on maternal and obstetrical care to help rural hospitals, FQHCs, and clinics improve financial performance, foster collaborative relationships among health care institutions, and increase the overall efficiency of health care delivery in rural areas, ensuring effective use of resources to improve maternal care.

Research shows that women living in rural counties in the U.S. can have pregnancy-related mortality ratios up to three times higher than women living in large metro counties.

8. Align Medicaid pregnancy and postpartum clinical policy with best practices that improve perinatal health outcomes, such as enhanced perinatal depression screenings.

RATIONALE: Medicaid is the largest payer of maternal health services in Texas, yet many of its clinical, procedural, and prescription drug policies inadvertently contribute to poor birth outcomes.

- Medicaid reimbursement policy does not align with new extended postpartum coverage. Providers receive a single payment for all the postpartum obstetrical care needed during the first six weeks, even though women typically require at least two or three visits before transitioning to more routine primary care.
- Perinatal mental health disorders are among the conditions most likely to contribute to maternal death from six weeks to one year postpartum — deaths that are almost entirely preventable.[xxiv] Yet, Texas Medicaid pays for only one postpartum depression screening as part of the newborn checkup. National specialty societies recommend as many as four postpartum perinatal depression screenings in addition to screening provided during pregnancy.
- Use of long-acting reversible contraceptives (LARC), the most effective form of contraception, remains low, even though LARCs help women better time and space pregnancies, a key element of healthier pregnancies. Many rural women who wish to obtain LARCs struggle to do so, not only because many face limited availability of local services, but also because rural obstetrical care practices stopped providing them due to payment and administrative hassles.
- Evidence shows that sound oral health before and during pregnancy also helps improve birth outcomes, including reducing the rate of preterm births. Texas Medicaid currently pays for emergency dental care during pregnancy, but not routine preventive care. While most Medicaid MCOs offer preventive dental care during pregnancy as a value-added service, dental care is not a covered benefit. Prior to pregnancy, HTW includes no preventive oral health services.
- For women who deliver twins, Medicaid pays the same rate as for a singleton delivery, even though the delivery of a multiparous pregnancy inherently carries more risk and takes more time.
- Gaps in the Medicaid and CHIP prescription drug formularies result in delayed treatment for pregnant and postpartum women. CHIP, for example, does not cover hypertensive medications, though pregnancy-related hypertension contributes to poor birth outcomes.
- Lactation support remains inadequate to help new mothers successfully breastfeed, which is associated with better health outcomes for mothers and babies.

Recommendation 8.A. Direct HHSC, together with rural maternal health stakeholders, to undertake a thorough review of clinical, administrative, and payment policies that inadvertently impede timely rural maternal health care services before, during, and after pregnancy.

Essential Priorities

9. Increase availability of patient navigators to connect women to crucial health and social services for which they are eligible, while also eliminating red tape that delays timely receipt of preventive care before, during, and after pregnancy.

RATIONALE: Patient navigation originated in oncology care during the 1990s to help cancer patients navigate the many health and social services necessary for successful treatment. Today, based on countless evaluations of its efficacy, the model has been exported to other health care services, including maternal health, where it is increasingly embraced as a means to improve care for pregnant and postpartum women by streamlining the transition from obstetric to primary care, enhancing visit effectiveness, creating personalized postpartum care, and providing patient- and clinician-focused education.[xxv] Additionally, its use can help women and families overcome financial, cultural, logistical, and educational obstacles to health care.

For example, patient navigators can help a new mother seeking postpartum care schedule needed appointments for herself and her newborn, coordinate transportation, refer her to needed parenting support or mental health resources, and provide basic education on potential warning signs related to maternal or newborn complications. Additionally, studies show patient navigators can promote patient self-efficacy, enhance access to care, and sustain engagement with care, including making health visits more productive.[xxvi] Additionally, patient navigators help facilitate referrals to services to address non-medical needs, including food pantries and childcare.

Assembly members noted that many hospital systems, faith-based organizations, and community entities have attempted to provide low-tech navigation systems by creating websites with resources women could access, but the systems are difficult to keep current and typically do not provide the vital in-person connection. When drawn from the community, studies show navigators can improve use of and compliance with medically necessary care and mitigate barriers to it.[xxvii] Establishing regional or local patient navigators, drawn from the communities they serve, would be much more useful.

In 2023, lawmakers appropriated $5.2 million for the current biennium to fund on-site patient navigators for women's health services. The Assembly recommends expanding such services to include maternity clinical and non-clinical services for expectant and postpartum mothers.

Recommendation 9.A. Expand patient navigation services to help expectant and new mothers obtain necessary clinical and non-clinical services. The Assembly recommends embedding patient navigators at the regional or community level to ensure the service is one to which providers can refer patients, regardless of their insurance status or plan type.

10. Establish innovative programs to address both clinical and non-clinical needs.

RATIONALE: Texas has long embraced home visiting programs, such as the Nurse Family Partnership (NFP) and the Texas Home Visiting (THV) program, to help promote positive child outcomes by addressing the health and welfare of new parents and families. While the programs vary in their approach, evidence shows they can help young families thrive by teaching parents-to-be about how to take care of their own and their child's physical, mental, and emotional well-being. NFP deploys trained nurses to serve as trusted advisors and resources, engaging young mothers during early pregnancy and remaining involved with a family through the child's second birthday. THV, on the other hand, relies on trained non-clinical volunteers who serve as mentors to parents at risk. Regardless of model, the goal is to improve pregnancy outcomes, child health and development, and families' economic self-sufficiency.

Similarly, **Parents as Teachers** (PAT) is an award-winning program for providing in-home visitation services. PAT is currently testing a hybrid in-person/virtual model to reach more families in Texas. Among its goals are to improve parent understanding of early childhood development, promote early identification of pediatric developmental delays, improve school readiness, and prevent child abuse.

The scale and depth of this crisis requires the enactment of a multipoint plan that will foster and sustain the ingenuity and innovation needed to tackle longstanding and deeply rooted issues that continue to destabilize rural maternal health.

In other states, communities recruit and train local volunteers, such as retirees, to serve as "aunties" or "grannies" to new mothers, acting as mentors who provide parenting education, help schedule health care visits, provide crisis referrals, and so forth. Vermont, for example, established **Postpartum Angels,** which matches families with trained volunteer home visitors who conduct up to 12 weekly home visits after the birth or adoption of a baby.

In addition to interventions provided by NFP or THV, perinatal home visiting programs also can provide a clinical bridge for high-risk pregnant or postpartum women, bringing services to them between scheduled in-person visits, which limits the need for travel.

For example, **Project Swaddle,** established in Indiana in 2018, trains community paramedics to provide non-emergency transportation, as well as telehealth and in-person "check-ins," for high-risk pregnant and postpartum women who have been referred to the program by a physician, case manager, or the Women, Infants and Children (WIC) program. Participants receive regular visits from the paramedic, who updates the patient's obstetrical care professional in addition to connecting women to local social services to address any non-medical drivers of health.

While it is more challenging to implement home visiting programs in rural areas due to large geographic distances home visitors must travel, by exploring implementation of more unconventional interventions, Texas can efficiently deliver these services to rural women.

Recommendation 10.A. Expand use of innovative perinatal home visiting programs for expectant and new rural mothers, including funding to support training of community paramedics and volunteers to expand availability of these programs.

11. Engage and support expectant mothers and new parents using safe and reliable digital care management tools and applications.

RATIONALE: Social isolation among pregnant and postpartum women can contribute to higher rates of perinatal depression and substance abuse disorders.[xxviii] Among rural women, geographic isolation can fuel feelings of loneliness.[xxix] Perinatal mood disorders and other behavioral health conditions are associated with higher rates of maternal mortality and morbidity.

Engaging with supportive social networks and personal connections is critical to reducing social isolation, but such engagement may not be possible for residents of remote Texas counties or those who lack reliable transportation. New digital care applications can help connect rural women not only to health care professionals, but also to other expectant or existing mothers who can provide a virtual community.

With the expansion of broadband throughout rural Texas, digital strategies to improve maternal health are now more feasible. Depending on the application, expectant mothers can receive a wide range of education and support during the prenatal and postpartum periods, eliminating some of the challenges due to geographical and transportation barriers in rural communities.

Recommendation 11.A. Pilot use of smartphone apps among rural expectant and new mothers to assess effectiveness in ameliorating perinatal mood disorders.

12. Improve perinatal quality and health outcomes by supporting the ability of rural hospitals and health professionals to participate in the state's perinatal quality collaborative and training programs.

RATIONALE: Texas' statewide Perinatal Quality Improvement Network (PQIN) seeks to improve maternal and child health. The framework has evolved over time, but today consists of multiple components that work collaboratively to improve the quality and safety of maternal and neonatal health. Entities within the PQIN include the MMMRC, the Texas Alliance for Innovation in Maternal Health (TexasAIM), and the Texas Collaborative for Healthy Mothers and Babies, among others. Diverse geographic members, including rural ones, comprise the membership of each. Additionally, in 2013, lawmakers established the Perinatal Advisory Council to advise the state on criteria it should use to designate hospital neonatal and maternal levels of care.

The individual and combined work of the PQIN and PAC have resulted in implementation of many important patient safety and clinical improvement initiatives, such as developing maternal (and neonatal) level of care designations to distinguish hospitals based on the types of maternal care they care capable of providing routinely; inpatient hospital safety "bundles" to help improve early intervention for common maternal health emergencies, such as hemorrhage; and assessment of factors that contribute to maternal deaths and severe complications to help design life-saving interventions.

Assembly members strongly support these perinatal improvement efforts, while also acknowledging that implementation can be challenging in rural communities, which may lack the financial, technical, workforce, or continuing education capacity to do so.

Recommendation 12.A. Provide funding to strengthen Texas' Perinatal Quality Improvement Network, including dollars to establish a statewide perinatal data collection and reporting system, information from which could be used to guide more effective rural-focused quality and safety interventions.

Recommendation 12. B. Provide stipends to offset rural hospitals' costs to implement and comply with quality improvement and patient safety initiatives, including funds to help rural hospitals obtain and comply with maternal level of care designation criteria and participate in Texas AIM, a multidisciplinary initiative to help hospitals and communities implement maternal health safety best practices, such as training to prevent maternal hemorrhage.

Recommendation 12.C. Provide funding to the Department of State Health Services (DSHS) to develop targeted training for rural non-obstetrical and non-clinical professionals to help improve identification of maternal early warning signs and risk factors, focusing on primary care clinicians and emergency medical professionals who do not frequently encounter such events.[xxx]

Given that rural health systems have fewer resources and higher staff turnover, it will be important to devise training to their specific needs. Training also should be developed for non-clinical professionals, such as community health workers (CHWs), doulas, and peer support specialists, who regularly work with pregnant women and thus would benefit from enhanced training on how to recognize potential pregnancy-related complications.

Recommendation 12.D. Provide funding for rural continuing education (CE) programs, such as Project ECHO, a virtual mentorship and learning network.

Unlike traditional telemedicine or telehealth models, in which the specialist assumes care of the patient, Project ECHO provides rural clinicians with "telementoring," a guided practice model where the participating clinician retains responsibility for managing the patients to improve local care delivery."[xxxi] Given the low volume of maternal health services in many rural communities, obstetrical nurses and physicians must have opportunities to hone and sustain clinical skills through CE. Furthermore, supporting mobile simulation units and remote training programs as part of rural physician and nurse CE will also enhance skills and confidence in managing maternal health cases, especially in areas with limited traditional training opportunities. This approach will help ensure that health care providers are well-prepared to manage maternal health in settings with limited resources and low volumes of maternal care.

Recommendation 12.E. Provide funding to DSHS to establish obstetric-related rural "refresher" courses for general anesthesiologists and CRNAs to help maintain the knowledge and skills necessary to promote anesthesia safety during obstetrical care emergencies.

Rural hospitals with low OB volume do not have dedicated OB anesthesia teams. Instead, the anesthesiologist or CRNA provides care for any surgical service or emergency. Without the volume of obstetrical cases needed to maintain vital clinical skills, rural hospitals must find other means to preserve them. Given that OB anesthesia carries unique risks, continuing education on this service is especially important.

Likewise, hospitals that do not provide labor-and-delivery services nevertheless must treat periodic OB emergencies, providing stabilization services prior to transfer to a maternal-level-of-care facility. Small hospitals struggle with the costs of providing such training. Refresher courses, including simulations, are a critical and cost-effective tool to maintain important OB-anesthesia clinical expertise.

Recommendation 12.F. Provide funding to the state's Regional Advisory Councils to develop and provide training modules, including simulations or refresher courses, to maintain or enhance the ability of rural emergency medical physicians and professionals to safely manage obstetrical care emergencies.

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Appendix A: Additional Beneficial Reforms

- ★ Direct HHSC to study implementation of bundled payments for OB services. The study would examine the long-term cost and benefits of a value-based framework similar to models of care coordination and monitoring used by commercial payers.
- ★ Increase Medicaid dental reimbursement rates for pregnant women and postpartum mothers.
- ★ Provide loan repayment funding to attract dentists willing to practice in rural communities.
- ★ Address liability insurance costs – create a funding mechanism to cover malpractice liability insurance for family medicine physicians moving to rural communities to provide labor-and-delivery services.
- ★ Establish a Medicaid payment mechanism for community health workers and doulas employed at Health Resource Centers to help improve health literacy and health outcomes for rural mothers and babies.

Appendix B: The Process

Texas A&M University's Rural and Community Health Institute, in collaboration with the Texas Academy of Family Physicians, Texas Health Institute, and the Texas Organization of Rural and Community Hospitals — collectively known as "the conveners" — initiated the Rural Texas Maternal Health Assembly in June 2024, with the goal of gaining greater understanding about the day-to-day obstacles rural communities face trying to preserve access to critical women's health services before, during and after pregnancy and to use that insight to develop pragmatic interventions and recommendations for lawmakers to consider during the 89th Texas Legislature.

Conveners invited more than 50 organizations, along with individual experts in rural health and maternal health, to participate, including representatives from medicine, nursing, community clinics, consumer groups, health plan organizations, teaching and research institutions, and foundations.

The Assembly acknowledges that it did not interview mothers themselves, not out of lack of interest but time. However, the Assembly attempted to rectify this by interviewing participants who work directly with women of reproductive age.

Forty-seven Assembly members participated in the kick-off meeting in July, and 35 members contributed to an online survey designed to identify key challenges for rural Texas mothers and providers. This survey focused on non-clinical challenges, key social determinants of health, and potential models of maternal care suitable for rural areas. To further explore potential solutions, consultants conducted 22 key informant interviews with representatives from 13 organizations.

Following the in-person meeting, Assembly conveners organized work groups to delve deeper into the identified issues and develop policy recommendations. This group convened in person on September 6, 2024, and continued to communicate weekly thereafter to refine these recommendations. The work groups were tasked with finalizing a comprehensive position paper by mid-October 2024, outlining the solutions and recommendations developed during the Assembly process, with the plan to widely disseminated and accessible online at **Rural Texas Maternal Health Rescue Plan.**

Scan to visit the Texas A&M Rural and Community Health Institute's Rural Texas Maternal Health Initiative.

Assembly Participants

The Assembly comprised a diverse group of stakeholders, including rural maternal health experts, rural health care providers, senior officials from key state entities, and representatives from advisory committees. The conveners invited all entities with a known interest in improving rural maternal health. Several were unable to participate, others declined. A total of 54 organizations were invited to the Rural Texas Maternal Health Assembly. A list of invited organizations and their representatives appears in Appendix C.

Work group members began with an extensive list of potential solutions and initiatives, some new, others tested in other states. Potential solutions were grouped into three themes that emerged from the survey and interview results: 1) Foster Healthy Families, 2) Sustain Strong Communities, and 3) Promote Economic Viability. After lengthy discussions and weekly work group meetings to prioritize the list of potential solutions, 12 priorities emerged, which were ranked in terms of priority and whether the reform would benefit most families, communities, or health care providers and professionals, acknowledging the substantial overlap across categories. As shown in the following table, the 12 priorities cover all three categories of solutions identified from survey and interview results.

Timeline

1. Online survey completion: July 30, 2024
2. Virtual assembly kick-off meeting: July 25, 2024
3. Key informant interviews: August 2024
4. Work group drafted recommendations: August 2024
5. In-person work group and Assembly meeting: September 6, 2024, in Austin
6. Circulate position paper draft before finalizing: September 2024
7. Publication of the position paper: November 2024

Impact of proposed reforms by family, community, and economic viability

CODE RED PRIORITIES

Foster healthy families: Boost the availability of women's preventive health care, before, during, and after pregnancy by fully funding the state's women's health programs and increasing their reach.

Sustain strong communities: Alleviate non-clinical barriers, such as food insecurity, which undermine positive health outcomes for mothers and babies and increase overall health care costs.

Promote economic viability: Ensure the financial solvency of rural health care facilities, clinics, and health care professionals alike by:

a) Increasing payments to reflect costs,
b) Reducing uncompensated care, and
c) Reducing the red tape that increases providers' costs.

Increase the rural maternal health workforce pipeline and capacity, with workforce defined to include medical, nursing, and non-clinical professionals.

CRITICAL PRIORITIES

Foster healthy families: Foster local ingenuity to develop innovative approaches to improving access to care by funding community-level innovation grants.

Reduce pregnancy-related complications and associated costs by improving specialty treatment for common chronic conditions, such as diabetes, prior to pregnancy.

Provide resources to align Medicaid pregnancy and postpartum benefits with best practices shown to address common perinatal medical and behavioral health conditions.

Sustain strong communities: Support innovative rural maternal health care delivery models that reward provision of timely, high- quality, cost-effective health and social services.

ESSENTIAL PRIORITIES

Foster healthy families: Eliminate unnecessary red tape that delays timely receipt of preventive care before, during and after pregnancy.

Expand availability of innovative rural perinatal home visiting programs that address both clinical and non-clinical needs, including leveraging emergency medical personnel to fill gaps in care.

Sustain strong communities: Engage and support expectant mothers and new parents by expanding use of reliable and safe digital care management resources.

Improve perinatal quality and health outcomes by supporting the ability of rural hospitals and health professionals to participate in the state's perinatal quality collaborative and training programs.

Appendix C: Supporters, Contributors and Informational Resources

Rural Texas Maternal Health Rescue Plan Supporters

American College of Nurse-Midwives, TX Affiliate (CTCNM)
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Emily Rocha, RN

Texas State Office of Rural Health
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Advisory Entity Informational Resources

Perinatal Advisory Council
Patrick S. Ramsey, MD, MSPH

Texas Maternal Mortality and Morbidity Review Committee
Carla Ortique, MD, chair

The conveners invited all entities with a known interest in improving rural maternal health. Several were unable to participate, others declined.

Appendix D: List of Resources

BACKGROUND MATERIALS & DATA RESOURCES

Texas Health Data - Maternal Health

2022-MMMRC-DSHS-Joint-Biennial-Report.pdf (texas.gov)

Maternal Health: Availability of Hospital-Based Obstetric Care in Rural Areas | U.S. GAO

TCHMB

2024 State Scorecard on Women's Health and Reproductive Care | Commonwealth Fund

State Policy Lever Checklists - Prenatal-to-3 Policy Impact Center (pn3policy.org)

A Worsening Crisis: Obstetric Care in Rural America (harvard.edu)

U.S. maternal health: State shares of rural hospitals without maternity care (axios.com)

HRSA Invests Nearly $90 Million to Address Maternal Health Crisis | HRSA

Creating Health Care Models to Improve Maternal Health | MCHB (hrsa.gov) (Bexar County Hospital District received funding.)

Task Force on Maternal Mental Health National Strategy to Improve Maternal Mental Health Care (samhsa.gov)

America's Health Rankings Maternal and Infant Health Disparities Data Brief

MATERNITY CARE ACCESS

Can Family Doctors Deliver Rural America From its Maternal Health Crisis? - KFF Health News

2023 March Of Dimes Report Card For United States | PeriStats | March of Dimes

Where You Live Matters: Maternity Care Deserts and the Crisis of Access and Equity | March of Dimes

Maternal Health in Rural Communities

Rural Obstetric Unit Closures - The University of Minnesota Rural Health Research Center (umn.edu)

Restoring Access to Maternity Care in Rural America | Commonwealth Fund

Postpartum Morbidity and Mortality and Health Care Utilization in Rural vs. Urban Communities - The University of Minnesota Rural Health Research Center (umn.edu)

Microsoft PowerPoint - Hospital Webinar FINAL (nationalacademies.org)

Rural resilience: The role of birth centers in the United States - Jolles - 2020 - Birth - Wiley Online Library

Promoting Safety in Community-Based Birth Settings | AAFP

Assessment of interprofessional collaboration at free-standing birth centers: Does collaboration influence outcomes? - ScienceDirect

Postpartum Newborn Home Visits | SCDHEC

Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them | KFF

Texas Maternal Mortality and Morbidity Review Committee Maternal Mortality Case Review Terms

INNOVATION

HRSA Administrator Carole Johnson, Joined by Rep. Lauren Underwood, Launches New National Maternal Health Initiative | HRSA

Rural Maternal Health Toolkit - RHIhub (ruralhealthinfo.org)

HRSA Rural Maternal Health Initiatives - RHIhub Webinar (ruralhealthinfo.org)

Rural Maternal Health – Models and Innovations - Rural Health Information Hub

Expanding Telehealth for Improved Maternal Outcomes - Maternal Health Learning and Innovation Center

Maternal Opioid Misuse (MOM) Model | CMS

rural-case-study-meeting-essential-health-services-and-reimagining-obstetrics-in-a-rural-community-rural-case-study-april-2024.pdf (aha.org)

Postpartum Primary Care Engagement Using Default

Scheduling and Tailored Messaging: A Randomized Clinical Trial | Public Health | JAMA Network Open | JAMA Network

Maternity Care Payment Reform | National Partnership for Women & Families

Blueprint for Advancing High-Value Maternity Care Through Physiologic Childbearing | National Partnership for Women & Families

Postpartum Discharge Transition Staging | AIM (saferbirth.org)

Community-Based Models Improve Maternal Outcomes and Equity | Commonwealth Fund

Navigating geographical disparities: access to obstetric hospitals in maternity care deserts and across the United States | BMC Pregnancy and Childbirth | Full Text (biomedcentral.com)

Improving access to maternal care in rural communities | AHA News

Mapped: Over half of rural hospitals don't offer maternity care (advisory.com)

Proposed Solutions for Improving Maternal Health Care in Rural America - PubMed (nih.gov)

The Role of the Family Physician in Rural Maternity Care

CNM/CMs Fill the Gap in Rural Maternal Care

The Need for Reliable Robust Maternal Transport Program to Improve Maternal Outcomes in Rural America

Text And Telephone Screening And Referral Improved Detection And Treatment Of Maternal Mental Health Conditions | Health Affairs

Mental Health Conditions Increase Severe Maternal Morbidity By 50 Percent And Cost $102 Million Yearly In The United States | Health Affairs

Centering Healthcare Institute | CenteringPregnancy

Medicaid-Payment-Initiatives-to-Improve-Maternal-and-Birth-Outcomes.pdf (macpac.gov)

Chapter 4: Maternity Care (hcp-lan.org)

PREVENTIVE/PRIMARY CARE

Access to and Use of Midwifery Care for Rural Residents - The University of Minnesota Rural Health Research Center (umn.edu)

New Recommendations for Number of Required Prenatal Visits - The ObG Project

A Toolkit for Implementing Two-Generation Postpartum Care - I PROMOTE-IL (ipromoteil.org)

UMN-Case-Series_Postpartum-Support_8.4-final.pdf

MiPath Infographic for Providers (acog.org)

Telemedicine in Low-Risk Obstetrics - ScienceDirect

Obstetrics & Gynecology (lww.com)

Postpartum care needs assessment: women's understanding of postpartum care, practices, barriers, and educational needs | BMC Pregnancy and Childbirth | Full Text (biomedcentral.com)

Provider Perspectives on Barriers and Facilitators to Postpartum Care for Low-Income Individuals - PMC (nih.gov)

NMDOH

Food Insecurity, Chronic Disease, and Health Among Working-Age Adults (usda.gov)

Getting around rural America without a car is hard. These communities developed solutions | KCUR - Kansas City news and NPR

Rural Hunger and Access to Healthy Food Overview - Rural Health Information Hub

Food Insecurity in the Rural United States: An Examination of Struggles and Coping Mechanisms to Feed a Family among Households with a Low-Income - PMC (nih.gov)

Systematic Review of Interventions Addressing Food Insecurity in Pregnant Women and New Mothers - PMC (nih.gov)

Food Insecurity and Cardiovascular Health in Pregnant Women: Results From the Food for Families Program, Chelsea, Massachusetts, 2013–2015 (cdc.gov)

Pregnant and hungry: addressing food insecurity in pregnant women during the COVID-19 pandemic in the United States - PMC (nih.gov)

Food insecurity among pregnant women living in high-income countries: a systematic review - The Lancet

RELEVANT PEER-REVIEWED PAPERS PUBLISHED SINCE 2020

Ahn, R., Gonzalez, G. P., Anderson, B., Vladutiu, C. J., Fowler, E. R., & Manning, L. (2020). Initiatives to reduce maternal mortality and severe maternal morbidity in the United States: A narrative review. Annals of Internal Medicine, 173(11_Supplement), S3-S10. https://www.acpjournals.org/doi/full/10.7326/M19-3258

Singh, G. K. (2021). Trends and social inequalities in maternal mortality in the United States, 1969-2018. International Journal of Maternal and Child Health and AIDS, 10(1), 29. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7792749/

Chinn, J. J., Eisenberg, E., Dickerson, S. A., King, R. B., Chakhtoura, N., Lim, I. A. L., ... & Bianchi, D. W. (2020). Maternal mortality in the United States: research gaps, opportunities, and priorities. American journal of obstetrics and gynecology, 223(4), 486-492. https://www.sciencedirect.com/science/article/abs/pii/S0002937820307420

Ziller, E., & Milkowski, C. (2020). A century later: Rural public health's enduring challenges and opportunities. American journal of public health, 110(11), 1678-1686. https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2020.305868

Kozhimannil, K. B., Interrante, J. D., Tuttle, M. K., & Henning-Smith, C. (2020). Changes in hospital-based obstetric services in rural US counties, 2014-2018. Jama, 324(2), 197-199. https://jamanetwork.com/journals/jama/article-abstract/2768124

Leider, J. P., Meit, M., McCullough, J. M., Resnick, B., Dekker, D., Alfonso, Y. N., & Bishai, D. (2020). The state of rural public health: enduring needs in a new decade. American journal of public health, 110(9), 1283-1290. https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2020.305728

Mehta, L. S., Sharma, G., Creanga, A. A., Hameed, A. B., Hollier, L. M., Johnson, J. C., ... & American Heart Association Advocacy Coordinating Committee. (2021). Call to action: maternal health and saving mothers: a policy statement from the American Heart Association. Circulation, 144(15), e251-e269. https://www.ahajournals.org/doi/full/10.1161/CIR.0000000000001000

Shah, L. M., Varma, B., Nasir, K., Walsh, M. N., Blumenthal, R. S., Mehta, L. S., & Sharma, G. (2021). Reducing disparities in adverse pregnancy outcomes in the United States. American heart journal, 242, 92-102. https://www.sciencedirect.com/science/article/abs/pii/S0002870321002258?via%3Dihub

Merkt, P. T., Kramer, M. R., Goodman, D. A., Brantley, M. D., Barrera, C. M., Eckhaus, L., & Petersen, E. E. (2021). Urban-rural differences in pregnancy-related deaths, United States, 2011–2016. American journal of obstetrics and gynecology, 225(2), 183-e1. https://www.ajog.org/article/S0002-9378(21)00144-7/abstract

Appendix E: Legislative and Funding Strategies in Other States

Tennessee

Regional Obstetrical Consultants — Chattanooga's Solutions to Obstetrics in Rural Counties (STORC) program increases prenatal services for high-risk pregnancies in rural communities.

Mississippi

Mississippi WIC program allows breastfeeding mothers to access lactation support 24/7 via a downloadable app. (Mississippi has a higher maternal mortality rate than Texas so I'm not sure if this is working).

Kansas

Kansas Connecting Communities (KCC) — Using a centralized referral system, this program increases providers' capacity to screen, assess, treat, and refer perinatal women for depression, anxiety, and substance use disorders.

Washington State

The Parent-Child Assistance Program (PCAP) targets mothers with substance use disorders in the state of Washington and helps them access recovery resources, build healthy family lives, and maintain sobriety.

Vermont

Good Beginnings of Central Vermont/Postpartum Angel Family Support Program matches families with trained volunteer home visitors who conduct weekly visits to families in the home for up to three months (up to 12 visits) after the birth or adoption of a baby.

Arkansas

The University of Arkansas for Medical Sciences (UAMS) created the UAMS Institute for Digital Health & Innovation (IDHI) High-Risk Pregnancy Program, which utilizes telehealth to improve access to care and maternal/infant health care outcomes.

Assembly Conveners

TEXAS A&M HEALTH
A&M Rural and Community Health Institute

TEXAS HEALTH INSTITUTE

TORCH
Texas Organization of Rural & Community Hospitals

TEXAS ACADEMY OF FAMILY PHYSICIANS

Assembly Supporters

CTCNM
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AWHONN
TEXAS
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

CookChildren's

DHRHealth
Family Medicine Residency Program

Driscoll Health Plan

Global Family Practice
Advanced Rural-Global Medicine & Surgery

Lakeland Medical Associates

MARCH OF DIMES

MEDINA HEALTHCARE SYSTEM
In Partnership with Methodist HEALTHCARE | SAN ANTONIO

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OLNEY HAMILTON HOSPITAL
Three Times Recognized as a National Top Performing Hospital
OlneyHamiltonHospital.com
THE CHARTIS GROUP

RPMH
Our Family, Caring For Yours.

Rolling Plains Memorial Hospital

Society for Maternal-Fetal Medicine

TACHC
TEXAS ASSOCIATION OF COMMUNITY HEALTH CENTERS

TACHP Texas Association of Community Health Plans

TAHP
The Texas Association of Health Plans

TEXANS CARE for CHILDREN

TDA | TEXASDENTAL association

Texas Hospital Association

TNP
Texas Nurse Practitioners

TPS Texas Pediatric Society

Texas Rural Funders

TEXAS RURAL HEALTH ASSOCIATION

T.L.L. TEMPLE FOUNDATION
EST 1962
BUILDING A THRIVING DEEP EAST TEXAS

TEXAS Women's Healthcare COALITION

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College of Nursing

TEXAS A&M UNIVERSITY
College of Nursing
PROGRAM OF EXCELLENCE FOR MOTHERS, CHILDREN AND FAMILIES

UTA
Center for Rural Health and Nursing
COLLEGE OF NURSING AND HEALTH INNOVATION

THE UNIVERSITY OF TEXAS AT TYLER

hsc College of Nursing

hsc Texas College of Osteopathic Medicine

tcmhcc
Texas Child Mental Health Care Consortium
PeriPAN
Perinatal Psychiatry Access Network

State Agency Informational Resources

DSHS

TEXAS
Health and Human Services

Texas State Office of Rural Health

Advisory Entity Informational Resources

TEXAS
Health and Human Services
Perinatal Advisory Council (PAC)

Texas Department of State Health Services Maternal Mortality and Morbidity Review Committee