Healthy Moms Raising Healthy Babies

Central Texas and Statewide Challenges and Opportunities to Support Maternal Behavioral Health During the First Year After Childbirth

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TEXANS CARE for CHILDREN

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About This Report

This report focuses on the health of Texas mothers during the year after childbirth, with specific attention to improving new mothers' behavioral health, including support for both mental health and substance use challenges. Our research for this report included data, programs, and policies at the national, state, and local levels, but it particularly focused on the Central Texas region. While we focused on the Central Texas counties of Travis, Hays, Bastrop, Williamson, and Caldwell, the state health data we used for Central Texas includes the 30 counties in Health and Human Services Region 7.

Our goal was to understand the behavioral health needs of new mothers, the services and supports available, and barriers to accessing services that improve maternal health and well-being. Our report shines a light on a sample of innovative practices and programs that are working well to serve mothers and babies. We also identify action steps to help guide Central Texas communities and leaders in making changes that meaningfully improve the health and well-being of mothers, children, and families.

Texans Care for Children reviewed publicly available data, researched maternal health efforts in other states, analyzed state data, researched current programs and practices, and reviewed the network of health and behavioral health providers available to new mothers. We participated in two large listening sessions with Central Texas mothers and gathered information through 38 individual interviews with mothers, clinicians (including obstetrician/gynecologists, pediatricians, mental health therapists, and family planning providers), substance use treatment providers, community health workers, case managers, lactation consultants, doulas, postpartum support group leaders, and other maternal health professionals. Early in the project we set up an advisory committee made up of local providers and experts in maternal and infant health to inform the research.

This report is not intended to provide an exhaustive review of programs, challenges, or solutions. Every day we continue to learn more about innovative projects and programs that support maternal health in Central Texas.

Summary of Key Findings

Healthy children and families start with healthy births and healthy mothers. The year after the birth of a new baby can be a mix of celebration and challenges. Mothers may face pregnancy-related health issues that crop up unexpectedly or behavioral health challenges like substance use or maternal depression (also referred to as postpartum depression or perinatal mood and anxiety disorders). When communities provide effective support, parents can often manage these challenges, stay healthy, support their baby's development, and provide a strong foundation for the rest of a child's life.

Part 1 of this report describes the landscape of maternal health challenges in the postpartum year, including the impact of maternal depression and substance use, Texas data on maternal mortality and morbidity, and racial disparities in maternal health outcomes. Key health programs and behavioral health services are available to Texas mothers, but program capacity and reach may be limited, as described in Part 2.

Key findings from our research in Central Texas, which are explained in greater detail in Part 3 of this report, include the following:

Central Texas has significant maternal health challenges:

- Central Texas has the fourth highest maternal death rate in the state and high rates of other concerning birth outcomes.
- In Central Texas, overdose is a relatively less common cause of maternal deaths compared to other regions, but postpartum behavioral health challenges affect many new mothers and undermine their health and their babies' health.

Central Texas must address the particular challenges that the region's Black women and other women of color face as a result of the current and historical factors described in this report:

- Central Texas has the state's worst maternal death rate among Black women and high rates of disproportionality in other adverse birth outcomes, underscoring the need to address disparities in the region.
- The fear of Child Protective Services (CPS) prevents some mothers in the region, particularly women of color, from seeking and receiving the postpartum care they need.

Key barriers limit access to maternal health support in Central Texas:

- Lack of insurance coverage is a significant barrier to postpartum behavioral health care for mothers in Central Texas.
- Behavioral health providers for uninsured mothers in Central Texas often lack capacity both in terms of available slots and adequate staff training.
- Transportation to medical appointments is a significant barrier in Central Texas, and may lead to new mothers missing appointments or forgoing health care during a critical time.

There are underutilized opportunities to support maternal health in the region:

- Mothers and maternal health professionals in Central Texas have limited knowledge regarding the Healthy Texas Women program.
- Health professionals in Central Texas often lack the expertise and confidence to screen and refer clients for behavioral health challenges.
- Co-location of medical and behavioral health services for mothers is effective but rarely implemented in Central Texas.
- Doulas, community health workers, and other labor and postpartum supports are beneficial for new mothers, especially women of color, but availability in Central Texas is limited due to limited funding.

Action steps and opportunities to address some of these challenges are listed in Part 4 of the report.

Part 1: Landscape of Maternal Health Challenges in the Year After Childbirth

Healthy children start with healthy pregnancies, healthy births, and healthy mothers. Decades of research tell us that early life experiences affect a child's long-term health, development, and success. Research also shows that, during these formative years, a child's health is inextricably linked to the health of his or her mother. In many ways, the health of mothers can affect entire families, workplaces, communities, and economies.

The year following the birth of a child is a mix of celebration and challenges. These are times when parents bond with their newborn, watch their baby smile for the first time, and play together during "tummy time." Yet, as any parent can attest, the first year with a new baby is also a time of extreme fatigue, moments of concern about the baby's health, and expected or unexpected stressors facing the new parents or relatives.

For mothers, the year after childbirth may include pregnancy complications, medical issues that crop up unexpectedly, or behavioral health challenges like maternal depression or substance use. Pregnancy-related health issues may not present themselves right away, instead coming weeks or months into the postpartum period. Stressors and physical changes in a woman's body can lead to or exacerbate mental health issues, such as maternal depression, which is one of the most common complications of pregnancy. In other cases, fatigue, pain, and other health issues can contribute to alcohol, drug, or opioid use, perhaps exacerbating a prior substance use challenge or leading to a new one. Without needed supports, there can be significant — and even tragic — consequences for the mother, baby, and the entire family. When communities provide effective support, parents can often manage these challenges, stay healthy, support their baby's health, and enjoy moments of wonder and bonding with their little one.

During our research, we spoke with mothers, grandparents, health professionals, and others about the trials and tribulations — as well as perseverance and success — of pregnancy and the postpartum year. One mother told us about how substance use treatment helped her combat addiction, helping her find healing and recovery and be a better mother for her children. We also heard from grandmothers who lost their daughters due to pregnancy complications and are now raising their grandchildren on their own. And another mother shared her near-death experience after childbirth, how the hospital kicked into gear to stop a dangerous obstetric hemorrhage, and how lucky she is to be alive to see her children grow up.

Because of the many complex issues during the postpartum year, improving maternal health will require comprehensive, multi-system approaches to ensure all Texas mothers have the services they need to be healthy and raise healthy families.

Maternal depression is one of the most common complications of pregnancy.

Maternal depression — also referred to as perinatal mood and anxiety disorders, pregnancy-related depression, or postpartum depression — is one of the most common complications of pregnancy, affecting 1 in 7 women.[1] Maternal depression is a range of mood and anxiety disorders and depressive conditions that may begin during pregnancy, in the weeks and months after delivery, or up to a year after childbirth.[2] In fact, about half of women who are later diagnosed with maternal depression began experiencing symptoms during pregnancy.[3] Maternal depression is more than what's often called the "baby blues," which is a temporary state that usually occurs within a few days of a baby's birth and can last up to two weeks. Maternal depression is more severe and lasts longer. A new mother may face crippling anxiety or extreme depression as she tries to bond with her newborn. She may struggle to engage, feeling disconnected from her child and unable to respond to her baby's needs.

While all women are at risk, maternal depression disproportionately affects certain groups. For instance, women from low-income households, teen parents, and women with personal or family histories of depression face higher rates of maternal depression.[4] In fact, around half of parenting teens and mothers with low incomes experience depressive symptoms.[5] Additionally, women who struggle with substance use prior to pregnancy or during pregnancy are at high risk of postpartum depression.[6]

If untreated, maternal depression can have harmful effects on mothers, children, and communities across the state.

Timely screening and treatment of maternal depression are critical for a mother's health and a child's health, brain development, and school readiness. When maternal depression is untreated:

- Mothers may be less likely to implement injury prevention measures such as putting a baby on her back to sleep.[7]
- Infants are more likely to be diagnosed with "failure to thrive," which can be seen in babies as early as two months old.[8]
- It can interfere with early bonding and parent-child interaction, which can lead to delayed language and cognitive development.[9]
- It can disrupt a child's stress response system, increasing risks of behavioral problems, attention deficit disorder, social disorders, depression, and learning disabilities down the road.[10]

In addition to the health and emotional consequences, untreated maternal depression can adversely affect a family's financial stability. If untreated, mothers suffering from depression are more likely to become unemployed and less likely to be employed full time compared to non-depressed mothers.[11]

Recent research found that the societal costs of not treating maternal depression is substantial — about $14.2 billion in 2017 — when taking into account lower productivity, absenteeism, and higher health care costs attributable to worse maternal and child health. Most of these costs are borne by employers and health care payers, including Medicaid, and affect communities and state budgets. In fact, looking at societal costs of untreated maternal depression from pregnancy through age five, researchers found that the average cost per mother-child pair is $32,000. This total is more than five times the cost of other pregnancy-related conditions, such as gestational diabetes and postpartum hemorrhage, which each cost up to $3,300 per mother.[12]

Given the effects of untreated maternal depression on mothers, children, the workforce, and communities across the state, early detection and treatment are critical to catch symptoms before they get worse. As discussed further below, while evidence-based treatments exist, including cognitive therapies, medication, and peer supports, many new mothers in Texas are not getting the help they need.

Substance use disorders are chronic illnesses affecting nearly one in ten Texans. With treatment and supports, recovery is possible.

Alcohol and substance use occur along a continuum. While many people may engage in unhealthy use of alcohol or other substances at some point in their lives, some will develop substance use disorders or become dependent due to a variety of complex biological, behavioral, and environmental factors. A substance use disorder is diagnosed when the recurrent use of alcohol and/or other drugs, including opioids, causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet responsibilities at work, school, or home.[13]

Substance use disorder is a chronic illness affecting nearly one in ten Texans.[14] National data demonstrate that gender is an important factor when examining patterns of substance use and prevalence. While substance use disorders are more prevalent among men, women are physiologically more susceptible to the toxic effects of substance use and more likely to use prescription drugs for non-medical purposes.[15] Women are also less likely to seek treatment services despite having better treatment outcomes than men.[16] However, with sufficient treatment and targeted support, a substance use disorder is manageable and recovery is possible. Relapse rates are comparable to other chronic conditions such as diabetes, asthma, and hypertension.[17]

Substance use, if left unmanaged or untreated, has harmful effects on mothers, a child's health and well-being, and entire communities.

The Texas Maternal Mortality and Morbidity Task Force found that, between 2012 and 2015, drug overdose was the leading cause of maternal death up to one year postpartum.[18] Most of these deaths involved licit or illicit use of opioids. As explained in greater detail below, most overdose maternal deaths — 80 percent — occurred more than 60 days postpartum.[19] While we do not know the circumstances for each case, these grim data show a critical need to focus on identifying signs of substance use disorder and providing mothers early treatment in an effort to prevent overdose.

During a pregnancy, substance exposure increases health risks to mothers and their babies. Prenatal substance exposure could lead to miscarriage, pregnancy complications, fetal death, preterm birth, or developmental delays or disorders such as Fetal Alcohol Spectrum Disorders (FASD).[20]

These challenges appear to be getting worse, not better. New estimates from the Centers for Disease Control (CDC) show that drinking alcohol during pregnancy is on the rise — more than one in nine pregnant women in the U.S. drink alcohol while pregnant, and about four percent binge drink.[21] Moreover, opioid use among pregnant women in the U.S. increased fivefold between 2000 and 2009.[22] There has been a parallel increase in the incidence of neonatal abstinence syndrome (NAS) among newborns — a neonatal drug withdrawal condition primarily caused by maternal opioid use.[23] Between 2010 and 2014, rates of NAS in Texas increased by 51.3 percent.[24]

Newborns with NAS are more likely to have longer, medically complex hospitalizations. In Texas, average hospital charges related to NAS infants were nine times higher than that of nonaffected newborns. In 2012, Medicaid was the primary payer for 81 percent of hospital charges associated with NAS across the country — underscoring the state's critical interest in preventing and treating opioid use, especially during pregnancy.[25]

Beyond prenatal exposure, a parent's substance use disorder can harm a child's health and well-being. Parental substance use is a contributing factor in two-thirds of child removals in Texas (68 percent), according to 2017 data from the Texas Department of Family and Protective Services (DFPS).[26] Substance use itself is not child abuse or neglect, but it can be a risk factor. Recurrent substance use could mean a child is left in unsafe care, either with an inappropriate caretaker or unattended. A parent may neglect or sporadically address a child's needs for regular meals, clothing, cleanliness, and medical care. While the circumstances of each DFPS investigation and child removal is different, and other risk factors exacerbate the need for child removal, it is clear that untreated parental substance use is one of the main factors behind children entering foster care. It is in the state's critical interest to ensure parents have access to substance use treatment and recovery supports so children can stay safely with their families.

Research shows that women with substance use disorder are far more likely to relapse in the postpartum period than during pregnancy, underscoring the importance of maintaining access to substance use treatment during the year after childbirth.

The year after childbirth includes many challenges and stressors that increase the likelihood of relapse and overdose for women with substance use disorders.

In some cases, women are able to receive treatment during pregnancy and start on a path to recovery. Unfortunately, however, relapse after periods of abstinence is common for people with substance use disorder and can be deadly for mothers who relapse in the year after pregnancy.[27]

The first year after delivery is filled with many common triggers for relapse, including sleep deprivation, physical and hormonal changes, the stressors and demands of parenting, and, in some cases, the threat of loss of child custody.[28] Access to substance use treatment, recovery supports, and relapse prevention programs are critical during the postpartum year when women are at high risk of relapse. In fact, research shows that women with substance use disorder are far more likely to relapse in the postpartum period than during pregnancy.[29] Recognizing this challenge, SAMHSA's Treatment Improvement Protocol on treatment for women with substance use disorder recommends that services be continued, if not intensified, during the year following pregnancy.[30]

Yet in Texas, Medicaid health insurance, which covers about half of pregnancies and births in the state, ends approximately 60 days after childbirth. As a result, new mothers may lose insurance and substance use treatment they received during pregnancy.

Uninsured women are not the only ones with limited access to these services. Even if a woman has Medicaid, she may not be able to access substance use treatment because of waitlists or limited capacity in her local area. For instance, as described further below, low Medicaid payment rates for residential treatment care are crippling the ability of substance use treatment

providers to cover the cost of treatment services. Losing insurance and/or losing substance use treatment in the postpartum period may have dangerous consequences for mothers and their families.[31]

In Texas in particular, many new mothers are uninsured and do not have access to affordable health insurance before or after pregnancy.

One in four (25.5 percent) women of childbearing age (18 to 44) is uninsured in Texas, the worst rate in the nation.[32] Medicaid for Pregnant Women is available from the start of pregnancy and ends about two months after delivery (specifically, the last day of the month in which the 60-day postpartum period ends). When Medicaid coverage ends, new mothers are auto-enrolled from Medicaid into the state's Healthy Texas Women (HTW) program. HTW is not full-scope health insurance, but covers essential preventive care, family planning, and screening and treatment for hypertension and diabetes. Other than HTW's benefits, if a woman does not receive insurance through her job or spouse's job, she likely becomes uninsured after Medicaid cuts off. The sudden plunge into uninsured status when a new baby is just two months old can mean mothers discontinue medications or other ongoing treatment they need.

One in four women of childbearing age is uninsured in Texas, the worst rate in the nation.

The 2019 Texas Legislature took some targeted steps on maternal health but did not extend health coverage to 12 months after childbirth.

During the 2019 Texas legislative session, the Texas House passed House Bill 744 to extend Medicaid coverage to one year postpartum, but the Texas Senate did not take up the legislation. The bill reflected the first recommendation in the 2018 report by the Texas Maternal Mortality and Morbidity Task Force. Additionally, numerous legislators filed bills to accept the Medicaid expansion funding that the federal government offers to states to provide health coverage to low-income adults, including mothers, but those bills were not voted out of House or Senate committees.

The Legislature did pass other important, limited maternal health measures. House Bill 1111, which passed as an amendment to Senate Bill 748, establishes a pregnancy medical home pilot program to coordinate maternity care; creates a pilot program to improve care coordination services for women at higher risk of poor pregnancy, birth, or postpartum outcomes; and directs HHSC to develop a program to deliver prenatal and postpartum care through telehealth services, among other provisions. Senate Bill 750 and its accompanying $15 million in the state budget has the potential to support additional postpartum health services for a portion of the women enrolled in the state's Healthy Texas Women program. House Bill 25 establishes a pilot program to ensure more Texas mothers can use the state's Medicaid transportation program to attend prenatal and postpartum care appointments. Prior to this step, mothers who needed to take their newborn babies or other young children with them were unable to use the program.

The Texas budget also includes an additional $7 million requested by the Department of State Health Services (DSHS) for maternal health initiatives and a small overall increase in funding for substance use prevention and treatment, with a notable boost for pregnant women and mothers.

Texas' Maternal Mortality and Morbidity Task Force report shed additional light on maternal deaths and harmful pregnancy complications, including behavioral health challenges and the need for increased access to health coverage.

For their 2018 report, DSHS and the Texas Maternal Mortality and Morbidity Task Force, created by the Texas Legislature in 2013, conducted an in-depth review of maternal deaths that occurred in 2012. They also analyzed state trends in maternal deaths from 2012 to 2015, identifying 382 Texas mothers who died while

pregnant or up to one year after the end of pregnancy. For the first time, the Task Force's report also included regional trends and a specific exploration of populations at greatest risk of death or pregnancy complications.

The data presented in the Task Force report reveal the following, among other conclusions:

Most maternal deaths were potentially preventable.

The Task Force found that in 80 percent of the maternal deaths in 2012, there was some chance of preventability. Reinforcing the complexity of this issue, several factors contributed to a maternal death, including individual, provider, community, and facility factors:

- Individual factors contributing to death included underlying medical issues such as cardiovascular disease, chronic hypertension, and depression.
- Provider and facility-level factors contributing to preventable deaths included inadequate or delayed response to diagnosis and treatment during pregnancy, delivery, and the postpartum period; delay or lack of bedside clinical presence; failure to recognize high-risk patients and refer patients to appropriate specialists; and a lack of appropriate hand-off of patients between hospital staff and outpatient providers.
- Community- and system-level factors contributing to preventable deaths included lack of access to health care between pregnancies as well as poor care coordination between inpatient and outpatient settings.[33]

Certain populations of Texas women face greater risk of maternal death and harmful pregnancy complications.

Black mothers bear the greatest risk of maternal death or serious pregnancy complications compared to other Texas mothers, according to the Task Force analysis as well as other reports. The increased risk of maternal death among Black women cuts across all socioeconomic levels — regardless of income, education, marital status, or other health factors.[34] The Task Force found that in 2012, Black mothers were 2.3 times more likely to die compared to non-Hispanic White women.[35]

Black mothers in Texas were also at highest risk of severe morbidity (i.e., severe pregnancy complication) involving obstetric hemorrhage. Obstetric hemorrhage — which is excessive bleeding before, during, or after childbirth — was the leading cause of severe maternal morbidity in 2014 for all women based on Texas hospital discharge records.[36]

Low-income women of any race faced a higher risk of maternal death from 2012 to 2015. The majority of maternal deaths in between 2012 and 2015 (57 percent) were to women enrolled in Medicaid at the time of delivery.[37] While insurance status at the time of death is unknown, it is likely that many of these women lost Medicaid about 60 days after childbirth and lost access to comprehensive health care. Their enrollment in Medicaid during pregnancy also means they were likely uninsured before their pregnancy, a common experience considering that Texas has the nation's highest uninsured rate for women of childbearing age.[38] Lack of access to insurance before

or between pregnancy means it is harder to manage and treat underlying health issues, such as diabetes or heart disease that increase the risk of pregnancy complications or maternal death.

Behavioral health challenges, particularly between 60 days and one year postpartum, led to many maternal deaths in Texas.

Drug overdose was the leading cause of maternal death up to one year postpartum between 2012 and 2015, and almost 80 percent of overdose deaths occurred more than 60 days postpartum.[39] Two-thirds of overdose cases involved a combination of drugs (66 percent). Opioids were detected in a majority of overdose cases (58 percent).[40] Other causes of maternal death from 2012 to 2015 were cardiac event, homicide, infection/sepsis, and suicide.[41]

Suicide was the fifth leading cause of maternal death in Texas between 2012 and 2015, with the vast majority occurring between 60 days and one year postpartum.[42] Beyond Texas, a 2013 study of over ten thousand new mothers found that one in five women who screened positive for depression after delivery had thoughts of harming themselves.[43] Early screening and follow-up care could save lives.

Since the vast majority of drug overdoses and suicides occur more than 60 days postpartum, prevention and health interventions throughout the year after delivery are critical for preventing tragic maternal deaths.

The majority of all maternal deaths in Texas occurred between 60 days and one year postpartum. From 2012 to 2015, 56 percent of all maternal deaths occurred during that critical time after Texas mothers' Medicaid coverage ends two months following childbirth.

Maternal deaths are only one part of the story, with many more mothers facing severe pregnancy complications.[44]

Pregnancy complications are much more common than maternal deaths. They often threaten mothers' health and/or the health and development of their baby. Pregnancy complications include serious events like obstetric hemorrhage, eclampsia, sepsis/infection, and cardiac event, which often lead to emergency cesarean sections or urgent hospital stays. Pregnancy complications can increase the risk of a baby being born too early or too small, which can lead to long neonatal hospital stays and long-term health problems for a child such as asthma, developmental delays, or disabilities. As noted above, obstetric hemorrhage was the leading cause of severe maternal morbidity in 2014 (among delivery hospitalizations) and Black women in Texas were at a higher risk of severe maternal morbidity involving obstetric hemorrhage.[45]

To improve maternal health, Texas should increase access to health services during the year after pregnancy and between pregnancies.

The first recommendation in the Task Force's report was to increase access to health services during the year after pregnancy and throughout the interconception period to improve the health of women and enable effective care transitions. Specifically, the Task Force recommends extending health coverage to Texas women for a full year

The Texas Maternal Mortality and Morbidity Task Force made 10 recommendations to improve maternal health, many of which directly relate to behavioral health of new mothers. Select Task Force recommendations include:

- Increase access to health services before and during the year after pregnancy to improve the health of women, facilitate continuity of care, enable effective care transitions, and promote safe birth spacing. Specifically, the Task Force recommended "extending access to healthcare coverage for 12 months following delivery to ensure that medical and behavioral health conditions can be managed and treated before becoming progressively severe."
- Enhance screening and appropriate referral for maternal risk conditions, including screening and support for chronic health conditions, mental health challenges, and substance use disorders.
- Champion integrated care models combining physical and behavioral health services for women and families.[60]

postpartum. Access to primary, behavioral, and specialty care to manage health conditions before and after pregnancy is the most effective way to address issues before they get worse or harm the mother and baby.

The Task Force's recommendation is in line with research on the link between health coverage and maternal mortality. An analysis of data from 1999 to 2016 from the National Center for Health Statistics found that states offering health coverage to low-wage workers before, during, and after pregnancy was associated with lower maternal mortality rates, reflecting 1.6 fewer maternal deaths per 100,000 women.[46]

A range of policies and structural factors — both past and present — contribute to racial disparities and disproportionality in maternal health outcomes, both in Texas and nationwide.

Health and health care do not exist in a vacuum. The health of families and whole populations are shaped by a combination of individual, health system, community, and structural variables, many of which are interrelated. These factors affect mothers of all backgrounds and from all communities in Texas.

However, the data make clear that the health risks to Black mothers and infants are particularly high. While an in-depth examination of these causes is beyond the scope of this report, this section provides an introduction to some causes of racial disparities and disproportionality in maternal and infant health.

Implicit biases in our health care system can affect the quality of health care provided, decision making, and how health programs are carried out.

Research shows that implicit biases — subconscious, involuntary assumptions — affect our "feelings and attitudes about other people based on characteristics such as race, ethnicity, age, and appearance."[47] Those biases include implicit racial biases, the unintentional negative assumptions about Black people, resulting from centuries of racist ideas, that can affect the actions of even well-intentioned people.

As health care professionals evaluate and communicate with Black patients, those invisible biases can affect decision making and the quality of health care. Four out of five studies on the subject "found evidence of implicit race bias among clinicians," according to analysis by the Institute for Urban Policy Research & Analysis (IUPRA) at the University of Texas at Austin.[48] Beyond individual interactions between health care professionals and patients, implicit biases can also affect the systems-level decision making of policymakers and program officials.

The first step to addressing implicit biases and their consequences is for individual health care providers and leaders to recognize that they exist. It is also important to address implicit bias through training, collection and analysis of data, and efforts to directly counteract the effect of biases.

Chronic stress, including the physical toll of stress related to structural racism, increases health risks for mothers and babies.

In recent years, researchers have identified a closer link between chronic stress and physical health than previously known.[49] The persistent, constant coping with acute and chronic stressors impact the body on a physiological level and can have a profound effect on health. The link between stress exposure and physical health has been referred to as "weathering" and allostatic load. Allostatic load describes the cumulative physiological impact of chronic stressors experienced over a person's lifetime.[50] Research on weathering reveals chronic stress during pregnancy and exposure to stress hormones over the life course has a "wear and tear" effect on mothers and can cause physical harm and health risks to mother and baby.[51] Research shows that the effects of weathering or allostatic load affect Black Americans — regardless of socioeconomic or educational background — more than any group in the form of negative health outcomes.[52]

Reflecting this and other research, many experts now believe that the physical toll of stress related to structural racism provides part of the explanation for racial disparities in birth outcomes.[53] For instance, an atmosphere of societal and systemic racism can create a kind of toxic physiological stress over time, increasing the risk of conditions like hypertension and preeclampsia, which contribute to pregnancy complications or maternal and infant death.[54]

Discrimination, both past and present, negatively affects social determinants of health — such as housing, food scarcity, and education, among others.

Health care experts are increasingly focused on "social determinants" of health. The CDC, for example, notes that social determinants — such as unstable housing, low income, unsafe neighborhoods, or substandard education — negatively affect health outcomes.[55]

While social determinants of health are influenced by income, they are also influenced by race in a way that can place higher income Black families at greater risk of poor health, particularly when combined with implicit bias and the other factors discussed in this section of our report.

For many Black people today, social determinants of health have been affected by multiple generations of discriminatory policies and practices regarding housing, employment, criminal justice, education, and other areas. The staggering wealth gap between Black and White families today,[56] which in part reflects the way parents and grandparents are able to accumulate and pass financial assets down to their children, underscores the way discriminatory policies and practices of recent generations continue to affect current generations.

Lack of access to health insurance disproportionately affects people of color and limits the ability to manage health conditions before and after pregnancy.

As the Texas Maternal Mortality and Morbidity Task Force's recommendation highlights, access to primary, behavioral, and specialty care before and after pregnancy is the most effective way to manage health conditions (such as high blood pressure or diabetes) before they get worse or become harmful for mother and baby. However, access to health care is limited for women who are uninsured.

In Texas, Black and Hispanic women are more likely to be uninsured than White women. Seventeen percent of nonelderly Black adults in Texas, 29 percent of nonelderly Hispanic adults, and 12 percent of nonelderly White adults in the state were uninsured in 2017.[57]

Recent research found that states that offer Medicaid insurance to cover low-wage adults who do not have insurance through their job experienced a decrease in disparities for Black families with respect to maternal mortality, infant death, preterm birth, and low birth weight babies. Specifically:

- Analysis of data from 2010 to 2016 found that infant deaths have declined across most states, but the decline was more than 50 percent greater in states that offer health coverage before, during, and after pregnancy — with the decline in infant deaths greatest among Black infants.[58]
- Research found that coverage for low-wage workers before, during, and after pregnancy was associated with "significant improvements in disparities for black infants relative to white infants for the four outcomes studied: preterm birth, very preterm birth, low birth weight, and very low birth weight."[59]

Part 2: Key Health Programs and Services Available to Texas Mothers

This section outlines the variety of programs implemented in Texas that seek to keep new mothers healthy, including medical and behavioral health options, with some examples from Central Texas.

Important but limited maternal health services are available when women's Medicaid coverage ends.

Medicaid for Pregnant Women is available to women with low incomes during pregnancy and about 60 days following the birth of their baby. This coverage is much-needed for low-wage women who do not receive insurance through their job. Medicaid covers comprehensive medical and behavioral health, including mental health counseling, peer supports, medications, substance use treatment, and case management throughout pregnancy. When their Medicaid coverage ends, new mothers are then auto-enrolled from Medicaid into the state's Healthy Texas Women program.

Healthy Texas Women (HTW) is available to non-pregnant women between age 15 and 44 who have an income at or below 200 percent Federal Poverty Level (FPL) (i.e., about $4,000 monthly income for a family of four). HTW covers a narrower set of health services than Medicaid or other health insurance. It focuses on preventive care, including family planning, cervical cancer screenings, and well-woman exams, as well as some screening and treatment for hypertension, diabetes, high cholesterol, and maternal depression in the primary care setting. For instance, HTW covers maternal depression screening, some antidepressant medications, and consultation with a primary care provider. But, if a woman needs to see a cardiologist for a heart condition, an endocrinologist to help with diabetes, or a therapist or psychiatrist for mental health counseling, it is unlikely that she would find a provider who participates in HTW. Technically, HTW is open to these and other specialty providers as well as primary care providers. However, specialty providers offer an array of services that are not covered by HTW and very few participate in the program in its current form.

CHIP Perinatal is available to pregnant women who do not qualify for Medicaid for Pregnant Women because of income or immigration status. Health benefits are for the baby, which means prenatal care and two postpartum visits are covered, but family planning and mental health care are not covered. Most new mothers in CHIP Perinatal are not eligible for HTW but can qualify for Texas' Family Planning Program (FPP) after pregnancy.

The Family Planning Program is available to women up to age 64 who do not qualify for HTW because of income or immigration status. For instance, FPP has a slightly higher income threshold compared to HTW, at 250 percent FPL, which represents about a $5,000 monthly income for a family of four. The focus of FPP is family planning and preventive health, including contraception, cervical cancer screening, and well-woman exams. FPP covers screening for diabetes, hypertension, and maternal depression screening, but not treatment for these health conditions. While fewer Texas providers participate in FPP, this program offers critical preventive care for many Texas women.

Community health centers — also called **Federally Qualified Health Centers** — accept patients regardless of insurance or ability to pay. Many of these health centers in Central Texas participate in Medicaid, HTW, and FPP. Many individual obstetrician/gynecology (OB/GYN) practices participate in both Medicaid and HTW, supporting continuity of care by allowing a mother to stay with her same provider for prenatal care, postpartum visits, and well-woman care after pregnancy.

Access to behavioral health services provided by private practices is limited and costly.

Behavioral health supports are available to new mothers through a few different avenues in Texas and may depend on the type or intensity of services needed. Some mothers find a mental health counselor, psychologist, or psychiatrist at a private practice. However, many of these providers do not take Medicaid insurance and accept limited private insurance. **For low-income mothers, after Medicaid coverage ends about 60 days following childbirth, mental health visits become virtually unaffordable at an individual practice.**

The Texas Health and Human Services Commission (HHSC) contracts with several mental and behavioral health providers to serve Texans in need on their path towards recovery, but the shortage of mental health professionals and the waitlists for substance use treatment services continue to be a challenge.

HHSC contracts with 37 providers to serve as Local Mental Health Authorities (LMHAs) and deliver mental health services in a region.[61] Mental health services can include medication management, one-on-one mental health counseling and case management, mental health rehabilitative services, and crisis care, among other services. LMHAs can be an option for uninsured, low-income mothers depending on diagnosis and level of functioning. Examples in Central Texas include:

- **Integral Care** (serving Travis county);
- **Bluebonnet Trails Community Services** (serving Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee, and Williamson); and
- **Hill Country Mental Health & Developmental Disability Center** (serving Bandera, Blanco, Comal, Edwards, Gillespie, Hays, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde, and Val Verde).

Since each community mental health provider is responsible for serving many Texas counties, depending on the LMHA's locations, mothers may have to travel long distances to find a site offering mental health services they need. While many LMHAs offer telehealth options, Texas continues to face a severe shortage of mental health professionals. About 73 percent of Texas counties are designated as Mental Health Professional Shortage Areas (186 out of 254 counties), which means the county has more than 30,000 residents per clinician.[62] In Central Texas, Bastrop and Williamson counties are designated as Mental Health Professional Shortage Areas and Caldwell and Travis counties have a partial shortage of mental health professionals.[63]

In addition, HHSC contracts with state-licensed behavioral health providers to deliver substance use treatment and recovery supports.* Community-based providers may be the only option for Texans who cannot afford private, for-profit substance use treatment programs that are self-pay or only accept private insurance. Some providers offer substance use treatment and serve as an LMHA; some providers focus on substance use treatment and recovery only. Examples of community-based substance use providers in Central Texas include: **Bluebonnet Trails Community Services; Austin Recovery** (one of 10 Women and Children residential treatment providers in the state); **Integral Care**; and **Cenikor**.

HHSC-contracted substance use providers offer evidence-based services, such as outpatient or residential care, designed to support a client's recovery and health. Services can include individual, peer, and family counseling; detoxification treatment; medication-assisted treatment (MAT); case management; and recovery after-care services.

Notably, some substance use providers offer female-specialized services, which can include outpatient services, detoxification, and female residential care. These providers use gender-specific, trauma-informed models that are proven to help pregnant and parenting women move towards stable recovery, prevent child abuse and neglect, reduce the number of infants born affected by drugs or alcohol, and promote family stability.[64]

HHSC contracts with ten specialized Women and Children residential treatment providers that allow pregnant women and mothers to stay together with their children during the course of treatment. These programs help build parenting skills, reduce child abuse/neglect, and promote strong maternal-child attachment, which is a key element of recovery and critical for both infant health and parental success.

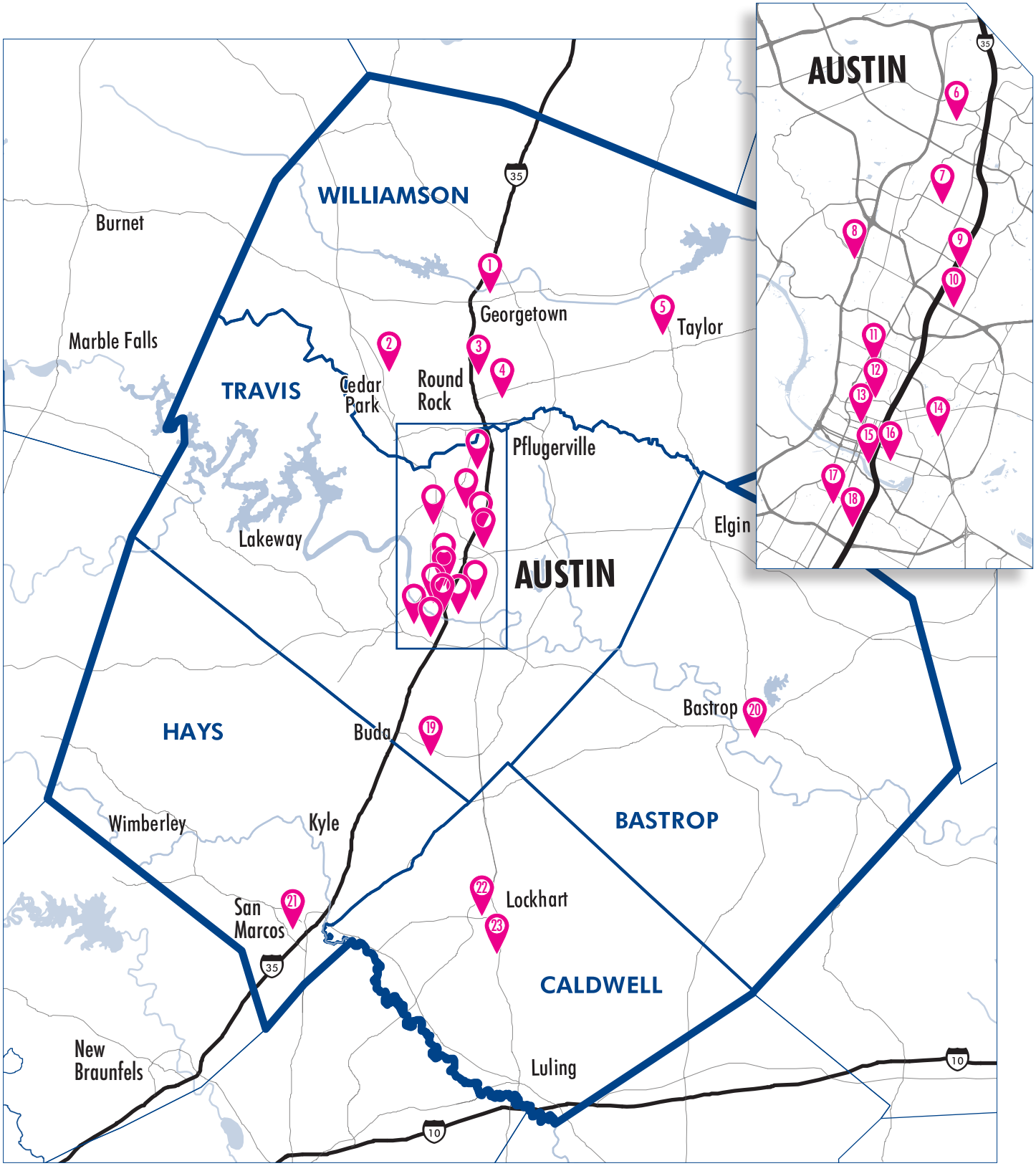
Under federal and state rules, Texas has identified "priority populations" to expedite entry into substance use treatment:

1. Pregnant women with substance use disorders who inject drugs;
2. Pregnant women with substance use disorders;
3. Men and women with substance use disorders who inject drugs;
4. Men and women at high risk of overdose;
5. Men and women with substance use disorders who have been referred by the Texas Department of Family and Protective Services (DFPS).[65]

* The majority of funding for substance use prevention, treatment, and recovery comes from Texas' federal Substance Abuse Prevention and Treatment Block Grant. In addition to Texas' federal block grant, Medicaid, 1115 Waiver project federal funds, and other federal SAMHSA grants, such as the Texas Targeted Opioid Response (TTOR) project, help substance use treatment providers deliver services to Texans in need. Under Texas' Substance Abuse Prevention and Treatment Block Grant, substance use providers that contract with HHSC for block grant funds must also participate in Medicaid, with Medicaid as the first payor and then block grant funding as the payor of last resort.

A Range of Substance Use Intervention and Treatment Providers Serve Central Texas

See Table 1 for Names of Providers and the Services They Offer



Source: Based on Texas Health and Human Services data. See http://txdshs.maps.arcgis.com/apps/webappviewer/index.html?id=0ebf2016e97243cb8aa665b01818cf4c.

Table 1: Providers Offer Different Levels of Services. Some Offer Both Mental Health and Substance Use Treatment (See Table 2).

	Agency	Services Provided	City	County
1	**Bluebonnet Trails**	COPSD, OI-SF	Georgetown	Williamson
2	**Bluebonnet Trails**	COPSD, O-A, OI-SF	Cedar Park	Williamson
3	**LifeSteps Council on Alcohol and Drugs**	PADRE, PPI	Georgetown	Williamson
4	**Bluebonnet Trails**	LMHA, OSAR, COPSD, O-A, OI-SF	Round Rock	Williamson
5	**Bluebonnet Trails**	COPSD, O-A, OI-SF	Taylor	Williamson
6	**Cenikor**	IR-A	Austin	Travis
7	**Bluebonnet Trails – CommUnity Care Clinic**	LMHA, OSAR	Austin	Travis
8	**Austin Recovery**	O-A	Austin	Travis
9	**Bluebonnet Trails – CommUnity Care Clinic**	LMHA, OSAR	Austin	Travis
10	**Clean Investments, Inc. Counseling Center**	O-A	Austin	Travis
11	**Bluebonnet Trails – Austin State Hospital Communities for Recovery**	LMHA, OSAR, RSS	Austin	Travis
12	**Austin Recovery**	O-A	Austin	Travis
13	**Austin Recovery**	O-A, OI-SP	Austin	Travis
14	**Integral Care**	COPSD	Austin	Travis
15	**Integral Care**	AD, AD-SF	Austin	Travis
16	**Integral Care**	COPSD, NAS-OTS, OTS	Austin	Travis
17	**Bluebonnet Trails – CommUnity Care Clinic**	LMHA, OSAR	Austin	Travis
18	**Phoenix House**	O-A, OI-SF	Austin	Travis
19	**Austin Recovery**	WCIR-SF, WCSR-SF	Buda	Travis
20	**Bluebonnet Trails**	LMHA, OSAR , COPSD, O-A, OI-SF	Bastrop	Bastrop
21	**Bluebonnet Trails – Hays Caldwell Council on Drug and Alcohol Abuse**	LMHA, OSAR	San Marcos	Hays
22	**Bluebonnet Trails**	COPSD, OI-SF	Lockhart	Caldwell
23	**Cenikor**	O-A, OI-SF	Lockhart	Caldwell

Table 2: Behavioral Health Services Range From Outpatient to Residential. Some are Specialized for Women and Mothers.

Full Name of Program/Service	Abbreviation
Co-Occurring Psychiatric and Substance Abuse Disorders	COPSD
Outpatient Individual – Specialized Female	OI-SF
Outreach, Screening, Assessment, and Referral Services	OSAR
Local Mental Health Authority	LMHA
Outpatient – Adult	O-A
Intensive Residential – Adult	IR-A
Recovery Support Services	RSS
Neonatal Abstinence Syndrome– Opioid Treatment Services	NAS-OTS
Opioid Treatment Services	OTS
Women & Children Intensive Residential – Specialized Female	WCIR-SF
Women & Children Supportive Residential – Specialized Female	WCSR-SF
Ambulatory Detoxification	AD
Ambulatory Detoxification – Specialized Female	AD-SF
Pregnant Postpartum Intervention Program	PPI
Parenting Awareness & Drug Risk Education	PADRE

While priority criteria help, waitlists are an ongoing challenge, and there is a significant unmet need for substance use treatment and recovery services in Texas. **Only 5.8 percent of low-income Texas adults with a substance use disorder are able to receive treatment services through a community-based treatment provider.**[66] An average of 100 Texas pregnant women and new mothers were on a waitlist for a Women and Children residential program in 2017, waiting an average of 18 days for a spot.[67] In the Central Texas area, Austin Recovery is the only provider offering Women and Children residential care at this time.

Outreach, Screening, Assessment, and Referral Centers (OSARs) often serve as the entry point into substance use treatment and a person's path towards recovery. The OSAR for Central Texas is **Bluebonnet Trails Community Services**, which is responsible for 30 counties in Health and Human Services Region 7.[68]

OSAR staff are trained to conduct screenings and assessments to determine whether a person needs substance use treatment and what kind of treatment is most appropriate — such as detoxification, intensive residential, or outpatient care. OSAR staff can help identify which providers have waitlists and help find a treatment provider that might have a spot. An OSAR is co-located at an LMHA in each of the 11 Health and Human Service Regions. OSAR staff also travel to other settings, such as community health centers, or may conduct screenings by phone to cover the many Texas counties they serve.

Texas has local programs to reach parents at risk of substance use disorder and reduce the impact of substance use on children and families.

HHSC contracts with local organizations to offer the **Pregnant and Postpartum Intervention (PPI)** program. An example of a PPI program in Central Texas is **Lifesteps Council on Alcohol and Drugs**.

PPI provides targeted outreach, screening, referrals, and intervention services — including counseling, home visits, case management, and transportation assistance — to help pregnant women and new mothers who have or are at risk of a substance use disorder. The program seeks to reduce prenatal substance exposure by providing earlier entry into prenatal care, substance use disorder treatment, and increased access to community resources.

PPI programs work to serve the most vulnerable local populations by conducting outreach efforts at homeless shelters, county jails, community health agencies, anti-human trafficking agencies, pregnancy resource centers, LMHAs, churches, crisis centers, and methadone clinics, among other locations.

Part 3: Central Texas Research Findings

Texans Care for Children analyzed Central Texas data to understand maternal health in the region and gathered information through interviews and listening sessions with families and maternal health professionals. The interviews were limited to the Central Texas counties of Travis, Hays, Bastrop, Williamson, and Caldwell. The state health data we used for Central Texas includes the 30 counties in Health and Human Services Region 7.

Our findings below include potential opportunities or action steps for health professionals, local leaders, and communities. Because of the many complex issues during the year after childbirth, action steps to address these challenges will require multi-system approaches at the health system, community, and statewide levels to ensure all Texas mothers have the supports they need to be healthy and raise healthy families.

Central Texas has significant maternal health challenges.

Central Texas has the fourth highest maternal death rate in the state and high rates of other concerning birth outcomes.

Reviewing Texas maternal deaths from 2012 to 2015, the Texas Maternal Mortality and Morbidity Task Force calculated maternal death rates to understand demographic characteristics and other factors associated with increased risk of death or pregnancy complications.** Central Texas (Region 7) has the state's fourth highest maternal death rate following the Texas Panhandle, San Antonio region, and Dallas/Fort Worth region. In Central Texas, there were 45 maternal deaths out of 177,643 live births between 2012 and 2015, a maternal death rate of 25.3 per 100,000 live births. From 2012 to 2015, Central Texas accounted for 12 percent of maternal deaths in Texas.[69]

Pregnancy complications can lead to babies being born too early (i.e., preterm birth, meaning less than 37 weeks gestation) or born too small (i.e., low birth weight), which can have long-term health consequences for children. Fortunately, the rates of babies born too early or too small in Central Texas are better than state averages.[70] Additionally, Central Texas has seen improvements in certain outcomes, such as the steady decline in the rate of teen births that occurred in the region and nationwide.[71]

Yet, other pregnancy and infant health measures in Central Texas are more concerning. Based on 2011 to 2015 state data, **Central Texas and North Texas had the highest prevalence of women who reported drinking during the last three months of pregnancy** (8.9 percent of women in Region 7 compared to 7.8 percent statewide).[72] **In addition, women were more likely to smoke during pregnancy in Central Texas compared to the state overall** (4.3 percent of women who gave birth in 2015 in Region 7 compared to 3.6 percent statewide). In particular, Bastrop and Caldwell counties had higher rates of smoking during pregnancy compared to the overall state rates.[73]

The higher prevalence of drinking and smoking during pregnancy in Central Texas highlights a potential need for early screenings, appropriate referrals for substance use issues, and discussions between health professionals and clients about the harmful effect of substances on the health of mothers and children.

In Central Texas, overdose is a relatively less common cause of maternal death compared to other regions, but postpartum behavioral health challenges affect many new mothers and undermine their health and their babies' health.

While drug overdose was the leading cause of maternal deaths in Texas up to one year postpartum, the rate of maternal deaths caused by drug overdose in Central Texas is lower than the rate in five of the seven other regions in the state. The majority of the state's maternal overdoses occurred in the Dallas/Fort Worth and Houston regions.[74]

Additionally, the prevalence of mothers who reported having maternal depression symptoms is lower in Central Texas compared to statewide (10.7 percent of women in Region 7 reported maternal depression compared to 13.8 percent statewide), according to 2012 to 2015 state data. In fact, Central Texas saw the lowest

**The Task Force's regional analysis refers to Health and Human Service Regions. Central Texas is Region 7, comprised of a 30-county area, with over half of the region's population residing in Travis County and Williamson County.

rate of self-reported maternal depression compared to all other Texas regions.[75]

Notably, however, Black women in Central Texas were much more likely to report maternal depression symptoms compared to White and Hispanic women. In Central Texas, 16.7 percent of Black women reported maternal depression symptoms, compared to 10.1 percent of White/Other women and 9.8 percent of Hispanic women.[76] The higher rate of maternal depression among Black mothers is also seen in Texas as a whole.[77]

Central Texas must address the particular challenges that the region's Black women and other women of color face as a result of the current and historical factors described in Part 1 of this report.

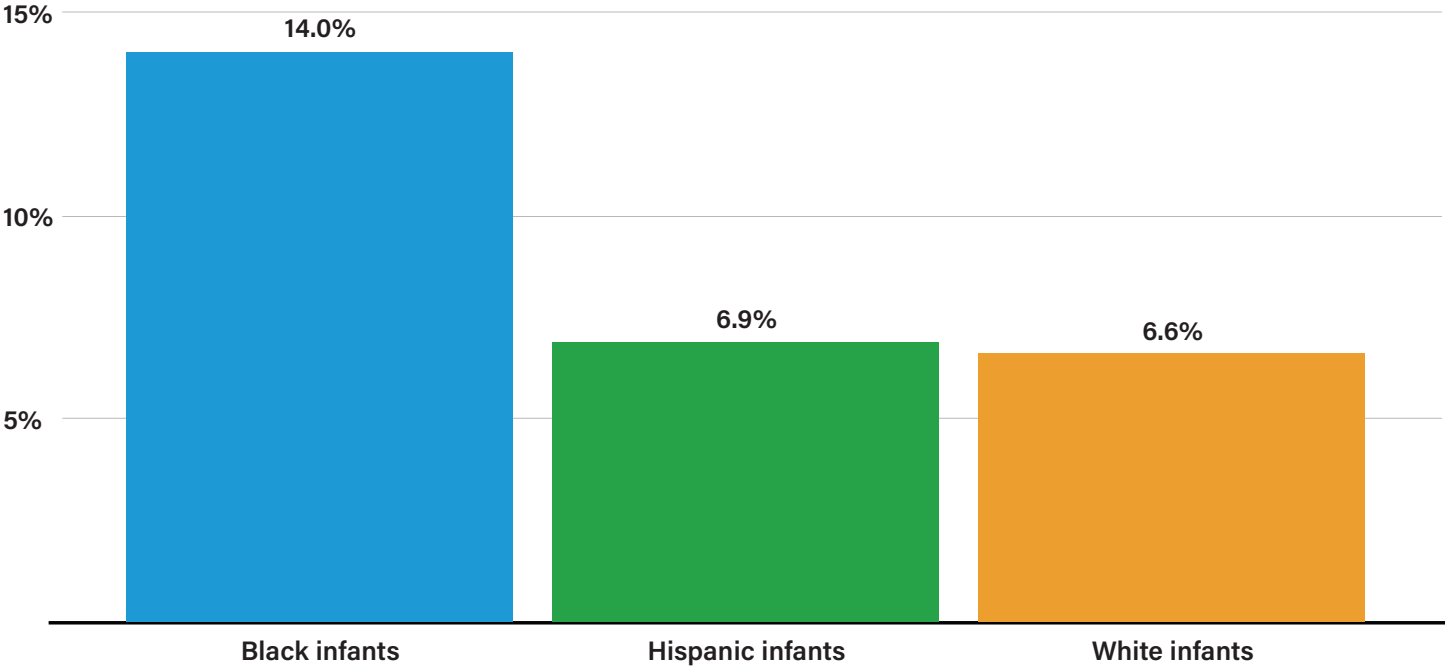
Central Texas has the state's worst maternal death rate among Black women and high rates of disproportionality in other birth outcomes, underscoring the need to address disparities in the region.

Out of the state's eight health regions, from 2012 to 2015, Black women in the Central Texas region had the highest maternal death rate up to one year postpartum at 61.6 per 100,000 live births.[78] The regions with the next highest rates were Dallas/Fort Worth at 48.3 and East Texas at 41.6. In Central Texas there were a total of 11 maternal deaths among Black women during that time period. The regions with the highest total number of maternal deaths among Black women from 2012 to 2015 were Dallas/Fort Worth with 31 and Houston with 26. But considering the number of live births to Black women in each region, Black women were more likely to die during pregnancy and up to a year postpartum in Central Texas than in other regions of the state.[79]

Moreover, racial disparities in infant health outcomes also persist in Central Texas. While the rates of babies born too early or too small in Central Texas are better than statewide averages, over the past decade, rates of preterm birth and low birth weight births for Black infants in Central Texas have consistently been 1.4 to 2.2 times higher than the rates among infants of all other races/ethnicities.[80] In fact, Black infants (14.0 percent) were more than twice as likely as Hispanic infants (6.9 percent) and White infants (6.6 percent) to be born with low birth weight in 2015 in Central Texas.[81]

Central Texas Has Significantly Worse Birth Outcomes for Black Infants Compared to Other Infants

Percentage of infants born with low birth weight in Central Texas in 2015*



* Central Texas refers to the 30 counties in Texas Health and Human Services Region 7
Source: Texas Department of State Health Services. Regional Analysis of Maternal and Infant Health in Texas, Public Health Region 7. p.53 (Apr 2018).

Additionally, while the infant mortality rate in Central Texas has been lower than the state average,[82] the rate of fetal and infant deaths among Black mothers in Central Texas is much worse compared to other Texas mothers.[83] In particular, state data show that 58 percent of all Black fetal and infant deaths in Central Texas were potentially preventable, underscoring how targeted maternal care and infant health interventions can help reduce disparities.[84]

The fear of Child Protective Services (CPS) prevents some mothers in the region from seeking and receiving the postpartum care they need, particularly in light of the disproportionate number of Black families in Central Texas and Hispanic families in Travis county involved in CPS cases.

Several mothers, clinicians, and maternal health professionals noted that many mothers are hesitant to reach out for help because of mental health stigma and the fear of being reported to DFPS (Department of Family and Protective Services, the state agency in which CPS is housed). This challenge was even more apparent for women of color. The vast majority of interviewees suggested that many mothers fear being seen as "unfit" to take care of their infant if they struggle with mental health or substance use. A peer specialist told us that the fear of being interrogated by a DFPS investigator in the hospital after giving birth, is "very real and very scary." In her experience, "for women of color who are more likely to be referred to DFPS, the fear is much more real."

Fears about a child's removal may be especially strong among women of color because Black children are disproportionately represented in Texas foster care. Both statewide and in Central Texas, Black children are much more likely to be represented at every stage of CPS involvement — including investigations of child abuse/neglect; child removals; and children in foster care awaiting adoption.[85] For instance, Black children are 11 percent of the statewide child population and make up 21 percent of children removed into foster care in Texas. Statewide, Black children are 1.7 times more likely to be reported to CPS, nearly twice as likely (1.9 times) to be investigated, and nearly twice as likely (1.9 times) to be removed by CPS compared to White children, according to fiscal year 2018 data.[86]

The overrepresentation of Black children in foster care is even worse in Central Texas, particularly in Travis county where Black and Hispanic children are much more likely to be involved in CPS cases. Black children make up less than 10 percent of the general child population in Central Texas but represent over 23 percent of children removed from their families. In contrast, White children make up 42 percent of the general child population in Central Texas and represent 36 percent of children removed from their home.[87] Certain counties have even more dramatic disproportionality. **DFPS analysis found that the disparities in Travis county are the highest out of the state's seven largest urban Texas counties.** Black children in Travis county are 4.6 times more likely than White children to have an allegation of child abuse/neglect, 5.1 times more likely to be investigated, and 7.8 times more likely to be removed in Travis county.[88] Notably, even though Hispanic children on average across Texas are less likely to be reported, investigated, or removed by CPS compared to White children, Hispanic children in Travis county are twice as likely to be reported (1.9 times), investigated (2.2 times), or removed (2.3 times) versus their White peers.[89]

Additionally, for new mothers with behavioral health challenges, fears of CPS involvement may reflect the high number of removals in Texas that include parental substance use. While substance use in itself is not child abuse or neglect, it is a risk factor that could lead to a child abuse/neglect investigation. Parental substance use is a contributing factor in 68 percent of CPS child removals in Texas.[90]

If a report of child abuse or neglect is made to DFPS Statewide Intake, several steps take place before a child is removed. In situations involving prenatal substance use, the investigation and subsequent steps taken may depend on whether drug or alcohol tests are positive, whether a newborn shows signs of effects, whether there is concern about the mother's ability to provide a safe environment for the baby, and what types of supports are available to the parent.[91]

DFPS and HHSC have worked together to bring a public health approach to child welfare reports, investigations, and decision making. There is growing recognition of the benefits to a new mother and her baby if they are able to stay together, especially during the first weeks and months when maternal-infant attachment, breastfeeding, and skin-to-skin contact are key.[92]

The Texas Attorney General has made it clear that physicians are not required to report to DFPS all pregnant patients who have used controlled substances during pregnancy.[93] HHSC has issued guidance to ensure health providers know they are not required to

report individuals taking medications as prescribed, such as methadone or other medication assisted treatment.***, [94]

During our interviews, professionals who work with mothers noted that practices by DFPS investigators can vary. The role of DFPS Child Protective Investigations is to assess whether a child is safe in her home. Interviewees saw cases in which, after a hospital made a report to DFPS, state investigators did not explain why they came to the hospital and what steps would be taken. That led to significant confusion, conflict, and stress for everyone involved. Yet, interviewees saw more success when DFPS investigators explained their role and the purpose of their visit. Interviewees noted that talking through questionnaires and developing a Safety Plan of Care together with mothers helps promote agreed-upon goals and may increase the chances of keeping families together safely.[95]

Coordination between hospital staff, labor support, case managers, and DFPS helps improve health for mother and baby. A case manager who works with women at a substance use treatment center spoke to us about the importance of a case manager or other labor support (such as a doula) during and after pregnancy to help mothers. In her experience, case managers build trusted relationships with women during the course of treatment, and they can help explain what may happen at the hospital if a DFPS report is made after the baby is born. Likewise, another interviewee noted that, given mothers' fears about being seen as "unfit" or having their child taken away, case managers or labor support can help "bring defenses down" and help improve the process, flow, and quality of a family's experience at the hospital.

While policies and practices are moving in the right direction, it is clear that more work is needed to ensure more mothers, especially women of color, do not fear asking for help or seeking behavioral health services because of fears about child removal. To address these complex challenges, opportunities include:

- Further disseminating guidance and promoting trainings to clinicians on best practices regarding reporting to DFPS when parental substance use is involved.
- Increasing investment in case managers who work with women in substance use treatment and recovery.
- Increasing investment in labor and postpartum support, such as doulas, to help mothers with behavioral health challenges.
- Investing in trainings for clinicians and non-clinicians at hospitals and birthing facilities to increase understanding of health disparities, inequities, and implicit bias that unintentionally impact decision making.
- Promoting implementation of the Alliance for Innovation on Maternal Health (AIM) maternal health and safety bundle, "Reduction of Peripartum Racial/Ethnic Disparities," designed to help health systems understand the impact of implicit bias, take steps to respond to disparities, and monitor process and outcome metrics stratified by race and ethnicity. "Bundles" are a collection of evidence-informed best practices for improving maternal health. Each bundle focuses on a specific maternal health issue. In partnership with DSHS, about 210 Texas hospitals participate in TexasAIM, with current efforts underway to implement the AIM Obstetric Hemorrhage Bundle and the AIM Obstetric Care for Women with Opioid Use Bundle in Texas hospitals.[96] Health systems could consider adding the Racial/Ethnic Disparities bundle as a targeted way to monitor and reduce disparities and build a culture of equity.[97]

Key barriers limit access to maternal health support in Central Texas.

Lack of insurance coverage is a significant barrier to postpartum behavioral health care for mothers in Central Texas.

Lack of insurance coverage to obtain health care in the year after childbirth was a constant theme raised by Central Texas health providers, mothers, and maternal health experts we interviewed. One OB/GYN emphasized that the biggest mental health issue affecting new mothers is "access, access, access." A health provider and medical director said, "it's hard to know which mental health provider to refer new mothers to, especially if she is without insurance." Several experts noted that many mental health therapists do not take insurance (or take limited private insurance), and paying the per-session out-of-pocket cost is a significant barrier for mothers with low incomes.

Likewise, interviewees noted that fragmented programs and funding sources make it difficult for providers and mothers to know what services are covered — and where to access them. For instance, a mother may receive prenatal care through Medicaid at one health practice. Then, after her Medicaid coverage ends 60 days following childbirth, she may receive well-woman

***For more information on policies and practices in child welfare cases involving parental substance use, please see Texans Care for Children's 2019 report, "Parental Substance Use in Texas CPS Cases and Opportunities to Keep Families Safely Together".]

exams through Healthy Texas Women at a different provider or health center. She may also have to take separate trips to a community mental health center (LMHA) for mental health counseling. Fragmented programs and funding make it more difficult for health professionals to focus on a woman's health over the course of her life.

One way to address this challenge is to optimize Medicaid by extending coverage for new mothers from 60 days to one year postpartum so new mothers can access the care they need to stay healthy. Coverage should include a range of behavioral health services, including medication, counseling and peer support, and other postpartum support options.

Behavioral health providers for low-income mothers in Central Texas often lack capacity, both in terms of available slots and adequate staff training.

Mental health

When it comes to mental health care for mothers with maternal depression, maternal health professionals said that providers either do not take the clients without insurance, are booked for weeks or months, or have out-of-pocket costs that are too high. One postpartum doula said "we might go through 4 or 5 different providers before finding a counselor that can take them…this is discouraging and heartbreaking for the family." She noted that, depending on the severity of the situation, mothers might be forced to go to the emergency room to get help.

Community mental health centers, such as LMHAs, accept Texans regardless of insurance or ability to pay. Staff at mental health centers told us they do have capacity to serve adults and do not have a waitlist, especially when it comes to outpatient counseling. They indicated that their counselors have training to treat a range of major depressive disorders, which can include maternal depression.

However, some doctors and maternal health professionals we interviewed noted that, even if a mental health center has the capacity to take on a client, it is unclear to them whether counselors or staff have expertise in maternal depression. Interviewees noted, for example, that mental health center staff must be able to answer questions about whether medications are safe to take while breastfeeding and how maternal depression affects their babies.

One opportunity to address these challenges is to promote trainings specific to maternal depression in order to build expertise and capacity at mental health centers to serve new mothers. Maternal depression trainings for clinicians and non-clinicians have already been developed by organizations like Pregnancy and Postpartum Health Alliance of Texas and Postpartum Support International, but wider dissemination may be needed.

Substance use

Substance use treatment providers who contract with HHSC for federal funding provide services to many Texans without insurance or ability to pay, based on clinical and financial eligibility. **However, there are often waitlists and limited treatment availability near where a mother lives.** Several experts told us that, in their experience, waitlists in Central Texas are not as big an issue for outpatient services (e.g., counseling and 12 step programs), but are much longer for residential treatment, detoxification, and opioid treatment services (e.g. medication-assisted treatment, like methadone, that is administered daily by a licensed professional).

One OSAR staff told us "the waitlist is the biggest issue." Staff said waitlists in the local area can be as long as eight weeks, which means the OSAR staff start looking for treatment availability outside of Central Texas. As a result, new mothers may have to move away from their family and uproot themselves from their community and support system. **If the facility is not one of the ten Women and Children residential treatment centers that allow mothers and children to stay together, mothers must leave their infant for weeks or months in order to get treatment towards recovery.**

These local observations of waitlists and limited capacity are consistent with statewide data. Only 5.8 percent of low-income Texas adults with a substance use disorder are able to receive treatment and recovery services through a community-based provider.[98] **Statewide data also show that many Texans are on waitlists for substance use treatment:**

- In 2017, there were 13,338 low-income Texans, including approximately 5,000 females, on a waitlist for a spot at a community-based substance use provider. Over 6,600 of those Texas adults were on a waitlist for intensive residential treatment.
- In 2017, Texas adults waited more than two weeks (15 days) on average for a spot in substance use treatment, but waitlists vary by type of service. Texas adults waited an average of 16 days for intensive residential treatment, over four weeks (31.9 days)

for outpatient treatment, and nearly four weeks (26.1 days) for medication-assisted treatment.
- Over 100 Texas mothers were on a waitlist in 2017 for a spot at a Women and Children intensive residential treatment center, waiting an average of 18 days before a spot became available.
- The number of pregnant women on a waitlist for treatment services more than doubled from 2011 to 2017.[99]

The waitlist data for Central Texas reveal:

- In 2017, there were 2,146 individuals on a waitlist for community-based substance use treatment in Central Texas, which is nearly double the number who were on a waitlist in the region in 2010.
- Residents of Central Texas were on a waitlist an average of nine days for a spot in substance use treatment in 2017, which is shorter than the statewide average that year.[100]

Several professionals we interviewed said that the established "priority populations" have helped expedite a client's entry into substance use treatment, especially for pregnant women. (Priority populations are: pregnant females with substance use disorders who inject drugs; pregnant females with substance use disorders; males and females with substance use disorders who inject drugs; males and females at high risk of overdose; and males and females with substance use disorders who have been referred by DFPS). But interviewees noted that, if a mother relapses after pregnancy, she may not fit a priority category and may have to wait weeks before a spot opens for medication-assisted treatment, detoxification services, or residential treatment. In many instances, according to our interviews, the substance use provider tries its best to find an opening for new mothers to avoid adverse effects on mothers and their infants.

Nearly double the number of Central Texans were on a waitlist for substance use treatment in 2017 compared to 2010.

A consistent challenge raised during our interviews is that low Medicaid reimbursement rates and HHSC-contracted payment rates do not cover the full costs of delivering quality substance use treatment services — a challenge that is crippling providers' ability to serve Texans in need. For example, a Medicaid plan pays less than $100 per day for residential treatment care and the HHSC contracted payment rate is around $100 per day, but the cost of providing quality residential care is more than $250 per day — including medical care, room and board, and counseling staff. Insufficient funding drives capacity challenges and limits non-profit providers' ability to serve pregnant women and new mothers with Medicaid as well as uninsured Texans. One professional noted that non-profit providers increasingly must focus on fundraising to cover costs and are unable to consider staff growth or service expansions that are much-needed in the region.

Reinforcing this funding challenge, interviewees noted that waitlists for substance use treatment become longer in the spring and summer as funding from HHSC runs out. Longer waitlists in the spring and summer are primarily the case for residential treatment, but can cut across all service types. HHSC-contracted treatment providers generally receive state and federal funds around the state fiscal year, starting September 1st. When contracted rates do not cover the full costs of delivering residential care, providers are running out of funds by late spring or summer. While mid-year adjustments may be available in some cases, when funding depletes before the next contract year, it affects providers' ability to accept low-income Texans with substance use disorders.

Moving forward, it is essential to maximize existing community programs through increased investment in community-based substance use treatment providers and recovery supports in Central Texas. Greater investment is needed to reduce waitlists and support recovery, including options that allow parents and children to stay together during treatment.

There may be future opportunities to add capacity for substance use treatment. Under the Family First Prevention Services Act (FFPSA), states will be able to use federal Title IV-E funding for substance use treatment services for up to 12 months for parents at risk of losing their children to CPS custody. As mentioned above, untreated parental substance use is one of the main reasons children enter foster care instead of staying with their family. Federal funding

under this new law is intended to prevent entry into foster care and keep families safe. Funding may be used to reimburse up to 50 percent of the amount states spend on substance use services for parents or caregivers when the services are directly related to the safety, permanency, or well-being of a child. Although Texas does not have immediate access to the new funding because of a delayed implementation until 2021, communities should start making plans around how to best leverage new federal funds to increase access to substance use treatment and prevent more children from coming into foster care.[101]

Transportation to medical appointments is a significant barrier in Central Texas, and may lead to new mothers missing visits or forgoing health care during a critical time.

Transportation barriers were a constant theme raised by families and health professionals in both urban and rural areas of Central Texas during our research. Many mothers with young children not only lack transportation but also child care options, meaning mothers must take their children with them to prenatal, postpartum, or behavioral health visits. If a woman does not have a car, she is at the mercy of public transportation, neighbors, or ridesharing in order to get from one place to another. Many women live in areas where public transportation is not accessible and ridesharing services are unavailable or too costly. This can be particularly challenging for mothers with high-risk pregnancies who have to see their OB/GYN and several other specialists in different parts of town.

Identifying another transportation obstacle, interviewees emphasized the limited access to child car seats. Hospitals typically require an infant car seat before a mother leaves the hospital with a newborn; yet many women without a vehicle also do not have a child car seat. While some nonprofits offer free or discounted car seats, many only provide infant seats if the parent owns a vehicle.

Transportation barriers lead to missed appointments and delayed care, which not only disrupts the provider-patient relationship and increases emergency room visits, but also increases costs to the health care system. Every year, 3.6 million Americans miss medical appointments due to a lack of reliable transportation,[102] with missed appointments costing the U.S. health system about $150 billion per year.[103]

Recognizing the link between transportation and health, Medicaid includes a medical transportation program that helps Medicaid clients get to appointments when they have no means of transportation. Options can include bus or rail tickets, taxi vouchers, or demand response services that typically take the form of a

dispatched vehicle. Unfortunately, many mothers cannot utilize the service because the medical transportation program does not permit pregnant women or new mothers to travel with their children to appointments.[104] A frequently-used option is a dispatched vehicle, which stops at multiple locations to pick up passengers and take them to their appointments. Mothers cannot travel with their children in this multi-passenger vehicle because Medicaid funds cover transportation for the Medicaid enrollee only (not children traveling with the mother).

Fortunately, legislation passed during the 2019 legislative session seeks to reduce these transportation obstacles. The Legislature passed House Bill 25 to direct HHSC to create a pilot program in the medical transportation program so more mothers can get to prenatal and postpartum care. The pilot enables mothers to travel with their children to appointments and to set up rides quickly, as opposed to the current system that requires clients to request rides more than two working days in advance. Furthermore, House Bill 1576, which passed the 2019 legislative session, significantly transforms the medical transportation program by requiring Medicaid health plans to manage and coordinate the transportation benefit. Health plans may arrange ridesharing for a client or use existing medical transportation providers that offer handicap accessible vehicles. Medicaid health plan management of the transportation benefit will begin rolling out in 2020, depending on new contract procurements and readiness.

Additionally, Central Texas organizations have pursued initiatives to address transportation needs. Many Medicaid health plans offer bus tickets, taxi rides, or rideshare vouchers to ensure clients can get to needed health care quickly. However, our interviews revealed confusion and limited knowledge about how mothers or health professionals should request rides through their Medicaid health plan. In addition, United Way of Greater Austin, the Central Texas nonprofit that operates 2-1-1 (the helpline that connects Texans with resources in their communities), partnered with ridesharing to help low-income and uninsured clients get to health appointments and job interviews.[105] Finally, outside of Central Texas, community health centers in Houston and East Texas have partnered with ridesharing to offer patients free rides to health appointments.

Although improving transportation infrastructure is a multi-system effort, potential opportunities to increase access to health appointments and improve maternal health include:

- Supporting partnerships between health systems, local organizations, health plans, and transportation providers to implement creative ways to get Texans to needed health care.
- Promoting telehealth visits and initiatives where possible, especially for mothers without transportation or child care options. Telehealth initiatives should be coupled with efforts to ensure parity between in-person and telehealth visits so that Medicaid coverage and insurance reimbursement of behavioral health services are equitable for virtual and in-person visits.
- Promoting outreach activities and educational materials so more mothers and maternal health professionals know how to request rides through the medical transportation program or through a woman's Medicaid health plan.
- Expanding child car seat donation programs so more families without their own vehicle can get child safety seats.
- Increasing outreach activities so more mothers and health professionals know about car seat programs offered by Medicaid health plans.

There are underutilized opportunities to support maternal health in the region.

Mothers and maternal health professionals in Central Texas have limited knowledge regarding the Healthy Texas Women program.

Most interviewees were either unaware of or reported that most of their colleagues were unaware of Healthy Texas Women and the Family Planning Program. Health professionals and Texas mothers reported limited knowledge regarding eligibility, covered benefits, and participating providers in the programs.

A recent statewide survey of Texas women also found a limited familiarity with HTW. According to a survey of almost six hundred Texas women of reproductive age (ages 18 to 44), three out of four (73 percent) uninsured women who would be income-eligible for HTW (non-pregnant and income under 200 percent federal poverty level) had not heard of HTW.[106] Uninsured women who did not have children were more likely to be unaware of the program compared to those with children. There were no other differences in familiarity with HTW according to age, race/ethnicity, or level of education.[107]

New mothers are auto-enrolled into HTW when their Medicaid coverage ends, meaning that a HTW provider may be the only source of preventive care for mothers after pregnancy. Given that HTW covers maternal depression screening and some antidepressant

medications, this program is a critical option for uninsured mothers facing maternal depression.

Opportunities for improvement include additional education and awareness campaigns so more Texas women and health professionals know about HTW's benefits and eligibility and know where to find a provider.

Health professionals in Central Texas often lack the expertise and confidence to screen and refer clients for behavioral health challenges.

A variety of health professionals — including OB/GYNs, family planning providers, and pediatricians — expressed a need to feel more confident screening for maternal depression and explaining next steps to their clients. Others mentioned hesitation or discomfort talking about drug or alcohol use or addiction with clients. For both mental health and substance use issues, providers identified a need for more resources and guidelines on how to carry out a successful "warm hand-off" to a behavioral health provider.

Mental health

Starting in July 2018, Children's Medicaid and Children's Health Insurance Program (CHIP) insurance began reimbursing pediatric providers for maternal depression screenings conducted during infant well-check visits. Interviewees expressed support for this benefit and noted that, since this benefit has recently rolled out, it may take time for more pediatric providers to feel comfortable incorporating maternal depression questionnaires into their routine practice. For instance, one pediatrician noted that parents frequently focus on their baby during well-check visits and seem surprised when a doctor offers a questionnaire asking about the parent's mental health and well-being.

During our interviews, the majority of Central Texas providers that screen new mothers for mental health issues said they use the Edinburgh Postnatal Depression Scale (EPDS) screening tool, which is one of several validated screening tools available to identify maternal depression.[108] One reason for the Edinburgh tool's popularity in Central Texas was the availability of a Spanish version.

During our interviews, health professionals noted both a limited knowledge around maternal depression — such as the signs, symptoms, and treatment options — as well as limited training on screening tools and how to refer to local services. Notably, training on pregnancy-related or postpartum behavioral health are not required in either Obstetrics and Gynecology or Psychiatry residency training programs.[109] One local expert noted that, in her experience, "providers were nervous to screen because they don't know where to refer." They are not sure they have the "bandwidth, time, or knowledge to do the warm hand-off" to follow-up care.

Family planning providers, who focus on contraception and well-woman care, expressed a desire for more training on maternal depression screening and treatment. Since Healthy Texas Women covers some limited antidepressant medications and brief consultation in the primary care setting, these providers said that they can be a "critical bridge" for new mothers as they wait to access mental health counseling or psychiatric services, if needed.

One way to address this challenge is to offer trainings on maternal depression screening to a broad range of maternal health professionals — including OB/GYNs, pediatricians, family planning providers, community health workers, doulas, home visitors, and Women Infants Children (WIC) staff. Trainings should include background on maternal depression, effective steps for a successful referral to behavioral health provider in Central Texas, and how to discuss mental health options with new mothers.

Substance use

According to our interviews, the approach to substance use screening and follow-up referrals varies in Central Texas. **Maternal health professionals we interviewed — including postpartum doulas, family planning providers, OB/GYNs, and lactation consultants — noted limited knowledge and comfort about how to initiate conversations around substance use with mothers, identify risks, and refer to an OSAR.**

Many providers said they routinely speak with their patients about the effects of alcohol and drug use during and after pregnancy, including risks with breastfeeding. A few providers mentioned they follow "Screening, Brief Intervention, and Referral to Treatment" (SBIRT), which is an evidence-based approach to identify, reduce, and prevent problematic use and addiction to alcohol or drugs. SBIRT is not a screening tool or patient questionnaire; rather it is a best practice approach for initiating conversations with a client, identifying risks, and using motivational interviewing to refer to follow-up care.[110]

A variety of screening tools or questionnaires have been studied and validated to identify substance use challenges. A few providers and OSAR staff told us they use the CAGE tool,[111] which is a four-question test originally developed for alcohol use that has been modified for drug use generally.[112] Of note, according to the American College of Obstetricians and Gynecologists (ACOG), the CAGE questionnaire is the most frequently-taught screening tool in U.S. medical schools, but it has not been proven to be appropriate for women, pregnant or postpartum women specifically, or clients of color.[113]

Additionally, during our interviews, Central Texas health professionals noted a disturbing practice — that some medical providers selectively screen pregnant women for substance use based on certain assumptions or suspicions, such as being enrolled in Medicaid or starting prenatal care late. These activities contradict ACOG's best practice recommendations:

> *"Substance use disorders affect women across all racial and ethnic groups and all socioeconomic groups, and affect women in rural, urban, and suburban populations. Screening based only on factors such as poor adherence to prenatal care or prior adverse pregnancy outcomes can lead to missed cases, and may add to stereotyping and stigma. Therefore it is essential that screening be universal."*

> *"Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman."*[114]

Moreover, many maternal health professionals — such as doulas, community health workers, and family planning providers — were not familiar with Texas OSARs. OSARs can be the first entry point into substance use treatment and a mother's path to recovery. OSAR staff are trained to conduct screenings and assessments to determine whether a person needs substance use treatment and what kind of treatment is most appropriate, such as detoxification, intensive residential treatment, or outpatient care. OSAR staff also can help navigate waitlists and identify a treatment provider that might have space for a new client. OSARs each serve several Texas counties, which means they may be available to screen clients by phone or they may travel to other settings, such as community health centers, certain days of the week.

Opportunities to address these issues include:

- Implementing a public awareness campaign about OSARs (i.e., their role, expertise, and availability in each county) and promoting partnerships between health professionals and local OSARs so that more maternal health professionals know where they can refer mothers with substance use challenges.
- Utilizing local addiction and recovery experts to offer trainings to a range of maternal health experts in Central Texas — including doctors, nurses, community health workers, doulas, and home visitors — about best practices for screenings, conversations about substance use, and follow-up referrals.

Co-location of medical and behavioral health services for mothers is effective but rarely implemented in Central Texas.

One of the Maternal Mortality and Morbidity Task Force's recommendations is to champion integrated care models that combine physical and behavioral health services for women and families. Some Central Texas health centers are making great strides integrating behavioral health into primary and well-woman care. A larger health center told us they have a handful of behavioral health specialists on site. They found their OB/GYNs and pediatricians feel more comfortable referring clients to a counselor down the hall. Another health center reported utilizing community health workers as part of pediatric well-child visits. The community health worker helps with screenings, such as a maternal depression screen, referrals to follow-up care or specialist, and other social supports for new parents. Based on our interviews, it appears that co-location of medical and behavioral services is limited in Central Texas.

Opportunities exist to leverage peer supports to better integrate physical and behavioral health care for new mothers. Certified through the state, peer support specialists and recovery coaches use formal training and their lived experience of recovery from mental health or substance use conditions to help guide individuals through recovery from their condition(s). Peer services are cost effective and an integral part of mental health and substance use service delivery.[115] However, both statewide and in Central Texas, peer specialists are typically located at LMHAs or state hospitals, and rarely based in community health centers or other health practices. Peer services were added as a covered Medicaid benefit in recent years, making it possible for additional health settings beyond LMHAs to utilize peer specialists. For instance, community health centers can consider integrating peer support services into care for pregnant women and new mothers or even coupling the services with a child's well-check visit. Co-location of peer supports in settings where mothers already go for their health care or their baby's care not only would integrate physical and behavioral health, but also offer behavioral health services at the right time and place.

With respect to recovery from substance use, we learned about one health center (CommUnity Care) that partners with a local substance use provider (Integral Care) to improve the delivery of medication-assisted treatment. While methadone must be administered daily at certain facilities licensed by the state, other MAT options like buprenorphine and suboxone can be prescribed by a licensed professional in other health settings. In this case, the health center doctors prescribe MAT medication to their clients and the substance use provider delivers the wrap-around support, counseling, and case management. Through this partnership, more clients can get MAT quickly and successfully move towards recovery.

To champion integrated care and incorporate behavioral health into well-woman care, potential opportunities include:

- Creating a pilot initiative that places peer support specialists and recovery coaches at community health centers or other settings where mothers already go.
- Supporting partnerships between substance use providers and clinicians who can prescribe medication-assisted treatment.
- Supporting and investing in more community health workers or behavioral health specialists on-site in health practices or community settings.

Doulas, community health workers, and other labor and postpartum supports are beneficial for new mothers, especially women of color, but availability in Central Texas is limited due to limited funding.

The Texas Maternal Mortality and Morbidity Task Force recommends increasing maternal health programming to address disparities and target high risk populations. The strategies recommended include: support for community health workers and other programs to bridge gaps in care and provide family-centered support and referrals, as well as reimbursement for continuous labor support, such as doulas and birth attendants.[116] Implementation of these strategies would support maternal health in Central Texas.

Community Health Workers (CHWs) or *promotoras* are trusted members of the local community who help clients gain access to needed services, provide informal counseling and social support, and increase health education through a range of activities such as outreach, patient navigation, and follow-up. DSHS operates a strong training and certification program to ensure CHWs and *promotoras* have skills and expertise to improve health in their local communities.[117]

Based on our interviews, there is a need for more CHWs, especially for pregnant women and new mothers, but greater use of CHWs is limited by a lack of funding. In Central Texas, some health centers and health systems employ CHWs to help with care coordination and other social service supports. The region also has a handful of local- or state-funded programs that support CHWs in the community, often linked to the local public health department such as Maternal Infant Outreach Program (MIOP) in Travis county. Community-based CHWs carry out outreach, health education, and home visits and can transport clients to health appointments. Some hospitals and health systems fund CHWs through private grants or through federal Delivery System Reform Incentive Payment (DSRIP) funding for innovative local health programs. But DSRIP federal funds are already declining and will expire in October 2021, which may further limit the availability of CHWs in the future.

Moreover, increasing access to trained doula services during and after pregnancy is a critical step for reducing disparities and improving maternal and infant health in Central Texas. Trained birth and postpartum doulas offer emotional, physical, and informational support during pregnancy, labor, and in the transition to parenthood. Studies show doula care reduces preterm births, delivery room costs, and risk of maternal depression while improving mother-child bonding, among other benefits.[118] Doulas can also help reduce the impact of implicit biases in health care by providing culturally appropriate, patient-centered care and by empowering mothers to communicate their needs and concerns during or after birth.[119]

While some insurance plans cover doula services, the majority of doula services are paid for by parents themselves. This leaves uninsured and low-income women with very limited access to birth or postpartum doula supports. In Central Texas, small non-profit organizations raise money to offer free or discounted doula services to women in need. Some birth and postpartum doulas volunteer their time and are paired up with families. This patchwork helps, but it may not be sustainable. Additionally, it does not reach all Central Texas communities, especially those in rural counties.

The Centers for Medicare and Medicaid Services (CMS) allows states to cover doula services through Medicaid and five states have adopted this option: Indiana, New Jersey, Minnesota, Oregon, and New York.

Moving forward, Texas should leverage Medicaid to increase access to labor and other postpartum support, such as doulas, and increase local investment in Central Texas doula programs. Additionally, Central Texas leaders and community partners should consider increasing investment in CHWs and promotoras at health centers, hospitals, and in the community.

Part 4: Action Steps

The year after childbirth presents an opportunity for communities to help parents stay healthy, support their baby's health, and provide a strong foundation for the rest of a child's life. The following action steps seek to guide Central Texas communities, health professionals, and leaders in making changes that meaningfully improve the health and wellbeing of mothers, children, and families.

There is no "silver bullet" for improving maternal health. Addressing challenges of the postpartum year will require comprehensive, multi-system reforms at the health system, community, and statewide levels to ensure all Texas mothers have the supports they need to stay healthy and raise healthy families.

Maximize Existing State Programs by Improving Access to Care

1. Implement the first recommendation of the Texas Maternal Mortality and Morbidity Task Force 2018 report by increasing access to health services before and during the year after pregnancy to improve women's health and facilitate continuity of care. Steps include extending Medicaid coverage for new mothers from 60 days to one year postpartum to ensure new mothers can access medical and behavioral health services to stay healthy. Legislative action is needed to authorize this step.

2. Increase access to community-based mental health and substance use providers that serve low-income Texans. Greater investment is needed to reduce waitlists and increase capacity for community-based providers to serve the number of Texans in need, including access to specialized female services and treatment where parents and children can stay together.

3. Identify ways to best utilize new federal funding under the Family First Prevention Services Act when it takes effect in Texas in 2021 to increase access to substance use treatment and prevent more children from entering foster care.

4. Leverage Medicaid to increase access to labor and other postpartum support, such as trained doulas, which help reduce delivery room costs and are beneficial for new mothers, especially women of color, but are not accessible to low-income mothers in Central Texas.

5. Promote implementation of initiatives that remove obstacles in the Medicaid medical transportation program so more mothers can travel with their children and get to needed health care quickly.

Improve Training Opportunities and Support Awareness Campaigns

1. Support public awareness campaigns in Central Texas — including online modules or trainings on eligibility and covered benefits in Healthy Texas Women and the Family Planning Program — to increase awareness of the programs and increase the number of mothers accessing care before and after pregnancy.

2. Promote trainings for mental health professionals regarding maternal depression in order to build expertise and capacity at mental health centers to serve new mothers. Maternal depression trainings for clinicians and non-clinicians have already been developed by organizations like Pregnancy and Postpartum Health Alliance of Texas and Postpartum Support International, but wider dissemination may be needed.

3. Offer additional trainings on maternal depression screening tools to a broad range of maternal health professionals — including pediatricians, family planning providers, nurses, community health workers, doulas, home visitors, WIC staff, and lactation consultants. Trainings should include effective steps for a successful referral in Central Texas and how to discuss mental health treatment options with new mothers.

4. Utilizing local expertise, promote and invest in trainings for maternal health professionals regarding best practices for substance use screenings, conversations about substance use, and follow-up referrals to an OSAR or behavioral health provider.

5. Implement outreach activities and an awareness campaign about OSARs (i.e., their role, expertise, and availability in each county) so that more Central Texas professionals know where they can refer mothers with substance use challenges. Awareness activities would benefit clinicians and health centers, but also other community organizations, like home visiting programs and local postpartum support groups.

6. Further disseminate guidance and promote trainings for clinicians and non-clinicians regarding best practices for reporting to DFPS when parental substance use is involved. This step is important for improving maternal and infant health, addressing disparities, and mitigating mothers' fears about CPS involvement.

7. Invest in race equity trainings for a range of professionals — from clinical staff to hospital administrators — to increase understanding of health disparities, inequities, and implicit bias that unintentionally affect decision making and health systems.

8. Support outreach and education activities so more mothers and maternal health professionals know how to request rides to health appointments through the medical transportation program or their Medicaid health plan.

Promote Positive Practice and Health System Changes

1. Consider work flow and practice changes that promote integration and co-location of behavioral and physical health. Options include adding a behavioral health counselor on site at primary or family planning clinics and partnering with the local OSAR to have OSAR staff on site certain days of the week. Approaches also include utilizing community health workers as part of pediatric well-child visits to help with maternal depression and referrals to follow-up care and social supports.

2. Champion integrated care by placing mental health peer specialists and recovery coaches in health or other settings (such as community health centers) where mothers already go for their care or their baby's care.

3. Promote implementation of TexasAIM maternal health and safety initiatives in Central Texas hospitals and birthing facilities. In addition to the current maternal safety bundles, health systems could consider implementing the "Reduction of Peripartum Racial/Ethnic Disparities" AIM bundle, which is designed to help health systems understand the impact of implicit bias, take steps to respond to disparities, and monitor process and outcome metrics stratified by race and ethnicity.

4. Promote telehealth visits and initiatives wherever possible, especially for mothers without transportation or child care options. Telehealth initiatives should be coupled with efforts to ensure insurance reimbursement parity between in-person and virtual visits.

Expand and Support Effective Local Programs

1. Support and invest in local substance use providers and community mental health centers that serve Texans regardless of insurance or ability to pay. This can include investing in case managers or other behavioral health specialists who build relationships with women as they move towards recovery and can help ease a mothers' fears and navigate the process in the hospital or birthing center when a mother gives birth.

2. Increase investments in community health workers and *promotoras* at health centers, hospitals, and in the community.

3. Increase support for local Central Texas doula programs — especially local programs designed to serve women of color — to increase access to trained labor and postpartum support for low-income women and women of color.

4. Support partnerships between health systems, local organizations, health plans, and transportation providers to implement creative ways to get Texans to needed health care and postpartum supports.

5. Expand local child car seat donation programs so more families without their own vehicle can get child safety seats.

References

1 American College of Obstetricians and Gynecologists. Screening for Perinatal Depression. Committee Opinion, No. 757. (Oct. 2018). Centers for Disease Control and Prevention. PRAMStat System. Available at: https://www.cdc.gov/prams/prams-data/work-directly-PRAMS-data.html. See Katherine L. Wisner, MD, MS, et al. Onset Timing, Thoughts of Self-harm, and Diagnoses in Postpartum Women with Screen-Positive Depression Findings. JAMA Psychiatry. 70(5):490-498 (2013).

2 American College of Obstetricians and Gynecologists. Screening for Perinatal Depression. Committee Opinion, No. 757. (Oct. 2018).

3 Larsson C, Sydsjo G, Josefsson A. Health, sociodemographic data, and pregnancy outcome in women with antepartum depressive symptoms. Clinical Obstetrics and Gynecology. 104(3):459–66 (2004) (finding that forty-six percent of the women with antepartum depressive symptoms had depressive symptoms at six to eight weeks or six months postpartum or both).

4 T. Veriker, J. Macomber, and O. Golden. Infants of Depressed Mothers Living in Poverty: Opportunities to Identify and Serve. The Urban Institute. (Aug. 2010). See Schmidt RM, et. al. Moderate to severe depressive symptoms among adolescent mothers followed four years postpartum. Journal of Adolescent Health. 38:712-718 (2006) (finding that rates of depressive symptoms among adolescent mothers are higher than rates among adult mothers and nonpregnant/parenting adolescents).

5 Ibid.

6 Holbrook, A., & Kaltenbach, K. Co-Occurring Psychiatric Symptoms in Opioid-Dependent Women: The Prevalence of Antenatal and Postnatal Depression. The American Journal of Drug and Alcohol Abuse. 38(6), 575–579 (2012).

7 Earls, M. Clinical report—Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. Pediatrics. 126(5), 1032-1039 (2010) (citing McLennan JD, Kotelchuck M. Parental prevention practices for young children in the context of maternal depression. Pediatrics. 105(5):1090 –1095 (2000). Kavanaugh M, et. al. Maternal depressive symptoms are adversely associated with prevention practices and parenting behaviors for preschool children. Ambulatory Pediatrics. 6(1):32–37 (2006)).

8 Drewett, R., Blair, P., Emmett, P., & Emond, A. Failure to thrive in term and preterm infants of mothers depressed in the postnatal period: A population-based birth cohort study. Journal of Child Psychology and Psychiatry & Allied Disciplines. 45(2), 359-366 (2004). See Earls, M. Clinical report—Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. Pediatrics. 126(5), 1032-1039 (2010).

9 Goker, A., et. al. Postpartum depression: Is mode of delivery a risk factor? Obstetrics and Gynecology. 616759 (2012). See Martins C, Gaffan E. Effects of early maternal depression on patterns of infant-mother attachment: A meta-analytic investigation. Journal of Child Psychology and Psychiatry. 41(6):737-746 (2000).

10 See Center on the Developing Child at Harvard University. Maternal Depression Can Undermine the Development of Young Children. Working Paper No. 8. (2009). M. England and L. Sim, eds. Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention. National Research Council and Institute of Medicine (NRC/IOM), Washington: National Academies Press. (2009). Available at http://www.ncbi.nlm.nih.gov/books/NBK215117/.

11 Ertel, K. A., Rich-Edwards, J. W., & Koenen, K. C. Maternal depression in the United States: Nationally representative rates and risks. Journal of Women's Health. 20(11), 1609–1617 (2011).

12 Luca, D. L., Garlow, N., Staatz, C., Margiotta, C., & Zivin, K. Societal Costs of Untreated Perinatal Mood and Anxiety Disorders in the United States. Mathematica Policy Research. (Apr. 2019).

13 Substance Abuse and Mental Health Services Administration (SAMHSA). Department of Health and Human Services. "Mental Health and Substance Use Disorders." Retrieved June 12, 2019 from https://www.samhsa.gov/find-help/disorders. Opioid use disorder is a subset of substance use disorder. Opioids are a drug class that includes prescription pain relievers such as oxycodone, hydrocodone, and morphine, and illicit substances such as heroin.

14 Substance Abuse and Mental Health Services Administration. 2015 – 2016 NSDUH State Estimates of Substance Use and Mental Disorders. (Dec. 2017). Available at: https://www.samhsa.gov/data/population-data-nsduh/reports.

15 The National Institute on Drug Abuse. "Substance Use in Women." Retrieved June 12, 2019, from https://www.drugabuse.gov/publications/drugfacts/substance-use-in-women.

16 Heckshser, D., & Hesse, M. Women and Substance Use Disorders. Mens Sana Monographs. 7(1), 50–62 (2009).

17 National Institute on Drug Abuse. "Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)." (Jan. 2018). Available at: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition.

18 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. Table C1 (Sept. 2018). Available at https://www.dshs.texas.gov/mch/MMMTFJointReport2018x.pdf.

19 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. p.10 and Table C1 (Sept. 2018).

20 Centers for Disease Control and Prevention. "Substance Use During Pregnancy." Retrieved June 12, 2019 from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/substance-abuse/substance-abuse-during-pregnancy.htm.

21 Denny CH, Acero CS, Naimi TS, Kim SY. Consumption of Alcohol Beverages and Binge Drinking Among Pregnant Women Aged 18–44 Years — United States, 2015–2017. MMWR Morb. Mortal Wkly. Rep. 68:365–368 (2019).

22 Between 2000 and 2009, opioid use among women who gave birth in the United States increased from 1.19 to 5.63 per 1,000 hospital births per year. Patrick, S. W., Schumacher, R. E., Benneyworth, B. D., Krans, E. E., McAllister, J. M., & Davis, M. M. Neonatal abstinence syndrome and associated health care expenditures: United States, 2000–2009. Journal of the American Medical Association. 307(18), 1934–1940 (2012).

23 Texas Legislative Budget Board. Legislative Budget Board Staff Report: Implement prevention Strategies to Reduce Neonatal Abstinence Syndrome. pp. 237-244 (Jan. 2017). Available at: http://www.lbb.state.tx.us/Documents/Publications/Staff_Report/3729_LBB_Staff_Reports.pdf#abstinence_syndrome.

24 Ibid.

25 Ibid.

26 Texas House of Representatives Select Committee on Opioids and Substance Abuse. Interim Report to the 86th Legislature. p.11 (Nov. 2018). Available at https://house.texas.gov/_media/pdf/committees/reports/85interim/Interim-Report-Select-Committee-on-Opioids-Substance-Abuse-2018.pdf.

27 American Society of Addiction Medicine. "Public Policy Statement: Definition of Addiction." (2011). Available at: https://www.asam.org/resources/definition-of-addiction. Gopman, S. Prenatal and postpartum care of women with substance use disorders. Obstetrics and Gynecology Clinics of North America, 41(2), 213–228 (2014).

28 See American College of Obstetricians and Gynecologists. Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. Obstet Gynecol.130:e81–94 (2017). American Society of Addiction Medicine (ASAM). "Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids." (2017). Available at: https://www.asam.org/resources/publications/magazine/public-policy-statements/2017/01/19/substance-use-misuse-and-use-disorders-during-and-following-pregnancy-with-an-emphasis-on-opioids.

29 Ibid. Gopman S. Prenatal and postpartum care of women with substance use disorders. Obstet Gynecol Clin North Am. 41:213-28 (2014).

30 Substance Abuse and Mental Health Services Administration. Center for Substance Abuse Treatment. Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. 09-4426 (2009). Available at: https://www.ncbi.nlm.nih.gov/books/NBK83252/pdf/Bookshelf_NBK83252.pdf.

31 Ibid. Gopman S. Prenatal and postpartum care of women with substance use disorders. Obstet Gynecol Clin North Am. 41:213-28 (2014).

32 Searing, A., & Ross, D. C. Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies. Center for Children and Families (May 2019). Available at: https://ccf.georgetown.edu/2019/05/09/medicaid-expansion-fills-gaps-in-maternal-health-coverage-leading-to-healthier-mothers-and-babies/.

33 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. Appendix B-4 and B-5 (Sept. 2018).

34 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. p.11 (Sept. 2018).

35 Looking at pregnancy-related deaths in 2012 up to one year postpartum, the mortality rate was 13.9 per 100,000 live births for Non-Hispanic Black women; 6.0 per 100,000 live births for Non-Hispanic White women; 9.3 per 100,000 live births for Hispanic women; and 12.4 per 100,000 live births for women of Other races. Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. p.6 (Sept. 2018).

36 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. p.12 (Sept. 2018).

37 The Task Force's analysis of Medicaid at the time of delivery includes both Medicaid for Pregnant Women coverage and Emergency Medicaid. Medicaid for Pregnant Women is available to women who are income eligible and Texas citizens or meet certain alien status criteria. Emergency Medicaid pays for emergency labor and delivery services to stabilize a patient's medical condition for women who are undocumented or who do not meet the qualifying alien status criteria for Medicaid for Pregnant Women. Emergency Medicaid does not cover prenatal or postpartum care. Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. p.6 (Sept. 2018).

38 Searing, A., & Ross, D. C. Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies. Center for Children and Families (May 2019).

39 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. Table C1 (Sept. 2018) (finding also that drug overdose accounted for 17 percent of all maternal deaths).

40 Ibid. p.10.

41 Ibid. Table D1.

42 Ibid. Table C1.

43 Katherine L. Wisner, MD, MS, et al. Onset Timing, Thoughts of Self-harm, and Diagnoses in Postpartum Women with Screen-Positive Depression Findings. JAMA Psychiatry. 70(5):490-498 (2013).

44 The Centers for Disease Control and Prevention define Severe Maternal Morbidity as unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health. See American College of Obstetricians and Gynecologists and the Society for Maternal–Fetal Medicine, Kilpatrick, S.K., & Ecker, J.L. Severe maternal morbidity: screening and review. Am J Obstet Gynecol. 215(3):B17–B22 (2016).

45 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. p.13 and Appendix E (Sept 2018).

46 See Searing, A., & Ross, D. C. Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies. Center for Children and Families. (May 2019) (citing Eliason, E. "Adoption of Medicaid Expansion under the Affordable Care Act is Associated with Lower Rates of Maternal Mortality." Academy Health 2019 National Health Policy Conference. (Presentation, Washington, Feb. 4, 2019). Available at https://academyhealth.confex.com/academyhealth/2019nhpc/meetingapp.cgi/Paper/29402. Jaime Rosenberg, "Medicaid Expansion Linked to Lower Maternal Mortality Rates," AJMC Managed Markets News. (Feb. 6, 2019). Available at https://www.ajmc.com/conferences/academyhealth-2019/ medicaid-expansion-linked-to-lower-maternal-mortality-rates).

47 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. (Sept 2018).

48 Roundtree, M., Barrett, R., Lluversas, L., Plaza, R. The State of Black Lives in Texas: Health Report. The Institute for Urban Policy Research & Analysis at the University of Texas at Austin. (Mar. 2019). Available at https://liberalarts.utexas.edu/iupra/news/13943.

49 Cohen, S., Janicki-Deverts, D., Doyle, W., Miller, G., Frank, E., Rabin, B.S., & Turner, R. Chronic stress, glucocorticoid receptor resistance, inflammation, and disease risk. PNAS. (Apr. 2012). See Carnegie Mellon University. "How stress influences disease: Study reveals inflammation as the culprit." ScienceDaily. (Apr. 2, 2012). Available at: www.sciencedaily.com/releases/2012/04/120402162546.htm.

50 Shields, G., &. Slavich, G.M. Lifetime Stress Exposure and Health: A Review of Contemporary Assessment Methods and Biological Mechanisms. Soc Personal Psychol Compass. 11(8) (Aug. 2017).

51 Latendresse, G. The Interaction Between Chronic Stress and Pregnancy: Preterm Birth from A Biobehavioral Perspective. Journal of Midwifery & Women's Health. 54(1), 8–17 (2009). Holzman, C. et. al. Maternal weathering and risk of preterm delivery. American Journal of Public Health. 99(10):1864-71 (Oct. 2009). Love, C., David, R. J., Rankin, K. M., & Collins, J. W. Exploring Weathering: Effects of Lifelong Economic Environment and Maternal Age on Low Birth Weight, Small for Gestational Age, and Preterm Birth in African-American and White Women. American Journal of Epidemiology, 172(2), 127–134 (2010).

52 Geronimus, A. T., Hicken, M., Keene, D., & Bound, J. Weathering" and age patterns of allostatic load scores among blacks and whites in the United States. American Journal of Public Health. 96(5), 826-833 (2006). Duru, O. K., Harawa, N. T., Kermah, D., & Norris, K. C. Allostatic Load Burden and Racial Disparities in Mortality. Journal of the National Medical Association. 104(1–2), 89–95 (2012).

53 See Alhusen, J. L., Bower, K., Epstein, E., & Sharps, P. Racial Discrimination and Adverse Birth Outcomes: An Integrative Review. Journal of Midwifery & Women's Health, 61(6), 707–720 (2016). Nuru-Jeter, A., Dominguez, T. P., Hammond, W. P., Leu, J., Skaff, M., Egerter, S., Braveman, P. "It's The Skin You're In": African-American Women Talk About Their Experiences of Racism. An Exploratory Study to Develop Measures of Racism for Birth Outcome Studies. Maternal and Child Health Journal, 13(1), 29–39 (2009). Geronimus, A. T., Hicken, M., Keene, D., & Bound, J. "Weathering" and age patterns of allostatic load scores among blacks and whites in the United States. American Journal of Public Health. 96(5), 826-833 (2006). Derosiers, A. Race and the Inequity in Maternal and Infant Health. Retrieved June 16, 2019, from NICHQ - National Institute for Children's Health Quality website: https://www.nichq.org/insight/race-and-inequity-maternal-and-infant-health.

54 See Lu, M.C., & Halfon, N. Racial and ethnic disparities in birth outcomes: A life-course perspective. Journal of Maternal Child Health. 7(1):13–30 (2003).

55 Centers for Disease Control and Prevention. "Social Determinants of Health: Know What Affects Health." Retrieved June 11, 2019, from https://www.cdc.gov/socialdeterminants/index.htm.

56 Da Costa, P. "Housing discrimination underpins the staggering wealth gap between blacks and whites." Economics Policy Institute. Retrieved June 11, 2019, from https://www.epi.org/blog/housing-discrimination-underpins-the-staggering-wealth-gap-between-blacks-and-whites/.
57 Henry J Kaiser Family Foundation. "Uninsured Rates for the Nonelderly by Race/Ethnicity." Retrieved June 11, 2019 from: https://www.kff.org/uninsured/state-indicator/rate-by-raceethnicity/ (based on the Census Bureau's American Community Survey, 2008-2017).
58 Bhatt, C.B. & Beck-Sagué, C.M. Medicaid Expansion and Infant Mortality in the United States. American Journal of Public Health 108 no. 4:565-567 (Apr. 2018).
59 Bauchner, H. & Maddox, K.J. Medicaid Expansion and Birth Outcomes. Journal of the American Medical Association. 321 no. 16 (Apr. 2019).
60 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. (Sept 2018).
61 Texas has 39 Local Authorities: 37 Local Mental Health Authorities and 2 Local Behavioral Health Authorities.
62 Hogg Foundation for Mental Health. A guide to understanding mental health systems and services in Texas. 4th ed. (Nov. 2018). Available at: http://hogg.utexas.edu/what-we-do/policy-engagement/mental-health-guide.
63 Health Resources and Services Administration. Retrieved June 10, 2019 from: https://data.hrsa.gov/tools/shortage-area/hpsa-find. Note: Hays county is not designated as a mental health professional shortage and instead listed as "Withdrawn", meaning HRSA did not receive required data by the time the publication was released.
64 See Texas Health and Human Services. Uniform Application FY 2018/2019: State Behavioral Health Assessment and Plan Substance Abuse Prevention and Treatment and Community Health Services Block Grant. at p. 36 (Aug. 2017). Available at https://www.dshs.texas.gov/blockgrant/documents/Final-FY2018-2019-Combined.pdf.
65 See Substance Abuse and Mental Health Services Administration. "Substance Abuse Prevention and Treatment Block Grant." Retrieved from: https://www.samhsa.gov/grants/block-grants/sabg.
66 Includes Texas adults with income under 200% of the federal poverty level seeking services at a treatment provider funded through Texas' substance abuse and prevention block grant, which helps fund treatment services for individuals who do not have insurance and have an income less than 200% FPL. Texas Health and Human Services, Behavioral Health Services, Office of Decision Support, Jan. 2018.
67 Texans Care for Children analysis of substance use treatment waitlist data provided by the Texas HHSC via data request. Numbers used refer to the total unduplicated number of people on a waitlist during the course of fiscal year 2017. Note: data includes Substance Abuse Prevention and Treatment block grant-funded providers.
68 Health and Human Services Region 7 is a 30-county area that includes Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coryell, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Lampasas, Lee, Leon, Limestone, Llano, Madison, McLennan, Milam, Mills, Robertson, San Saba, Travis, Washington and Williamson counties.
69 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. Table C2 (Sept. 2018).
70 Texas Department of State Health Services. Regional Analysis of Maternal and Infant Health in Texas, Public Health Region 7. p.52. (Apr 2018). Available at: https://www.dshs.state.tx.us/opds/pdf/07-Regional-Analysis-of-Maternal-and-Infant-Health-in-Texas_PHR-7.pdf (stating that 9.8 percent of births in Central Texas were pre-term in 2015 compared to state's preterm rate of 10.2 percent; and 7.6 percent of newborns in Region 7 had low birth weight, lower than the state's rate of 8.3 percent).
71 Region 7 had the lowest teen birth rate in 2015 compared to all Texas regions. However, Caldwell County had a teen birth rate higher than the state's average. Texas Department of State Health Services. Regional Analysis of Maternal and Infant Health in Texas, Public Health Region 7. p.52(Apr 2018).
72 Texas Department of State Health Services. Regional Analysis of Maternal and Infant Health in Texas, Public Health Region 7. p.60 (Apr 2018).
73 Ibid.
74 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. Table C5 (Sept. 2018). Central Texas had a rate of 2.8 overdose maternal deaths per 100,000 live births, which is lower than five of the seven other Texas Regions: 6.4 overdoses per 100.000 live births in Dallas/Fort Worth, 6.0 overdoses per 100,000 live births in the Panhandle, 5.2 overdoses per 100,000 live births in West Texas, 4.4 overdoses per 100,000 live births in San Antonio, and 3.2 overdose maternal deaths per 100,000 live births in South Texas. Dallas/Fort Worth and Houston regions made up 60 percent of the state's maternal overdose deaths between 2012 and 2015 and Central Texas represented 8 percent of the state's maternal overdoses.
75 Based on pooled 2012 to 2015 Pregnancy Risk Assessment Monitoring System (PRAMS) data. CDC provides the participating PRAMS states an indicator of maternal depression symptoms based on two questions: "Since your new baby was born, how often have you felt down, depressed, or hopeless?" and "Since your new baby was born, how often have you had little interest or little pleasure in doing things?" These two questions asking about maternal depressive symptoms were included on the 2012-2015 Texas PRAMS survey. Texas Department of State Health Services. Regional Analysis of Maternal and Infant Health in Texas, Public Health Region 7. p.62 (Apr 2018).
76 Texas Department of State Health Services. Regional Analysis of Maternal and Infant Health in Texas, Public Health Region 7. p.62 (Apr 2018).
77 Ibid. Across Texas, 19.5 percent of Black mothers, 15 percent of Other, 13.7 of HIspanic, and 12 percent of White mothers reported maternal depression. Based on pooled 2012 to 2015 PRAMS data.
78 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. Table D2 (Sept. 2018).
79 Ibid.
80 Texas Department of State Health Services. Regional Analysis of Maternal and Infant Health in Texas, Public Health Region 7. p.49 (Apr 2018).
81 Ibid. at p.53.
82 In 2015, there were 4.8 deaths per 1,000 live births in Central Texas compared to 5.6 deaths per 1,000 live births statewide. Ibid. at p.49.
83 Based on 2010 to 2014 data, in Central Texas, the Feto-Infant Mortality Rates were double for Black mothers compared to their White and Hispanic counterparts: 12.4 fetal and infant deaths per 1,000 live births and fetal deaths for Black mothers, 6.0 per 1,000 for White mothers, 6.3 per 1,000 for Hispanic mothers, and 7.9 per 1,000 for teen mothers. Ibid. at p.64.
84 Ibid.
85 See Texas Department of Family and Protective Services. FY 2018 Disproportionality Analysis. (Oct. 2018). Available at: http://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/Rider_Reports/documents/2018/2018-09-24_Disproportionality_Analysis.pdf. Texans Care for Children analysis of DFPS Databook for FY 2018.
86 Texas Department of Family and Protective Services. FY 2018 Disproportionality Analysis. (Oct. 2018).
87 Texans Care for Children analysis of DFPS Databook for FY 2018 for "Conservatorship: Child Removals" category; and Texans Care for Children analysis of Texas Demographic Center child population data by race/ethnicity for the 30 counties in Region 7.
88 Texas Department of Family and Protective Services. FY 2018 Disproportionality Analysis. (Oct. 2018).
89 Ibid.
90 Texas House of Representatives Select Committee on Opioids and Substance Abuse. Interim Report to the 86th Legislature. p.11 (Nov. 2018).
91 After a report or allegation of child abuse/neglect is made to DFPS Statewide Intake, staff determine whether to refer the case to Child Protective Investigations (CPI) based on Texas' definition of abuse and neglect. DFPS investigators will assess the report and determine whether the parent is willing and able to make changes necessary to keep the child safe. This process can include interviews with the parent(s) and development of a "Safety Plan of Care", which is an agreed-upon plan between the parent and DFPS to ensure child safety and well-being. Investigators could also use Family Based Safety Services (FBSS), which are extra supports from DFPS to ensure child safety, such as family counseling, substance use treatment, or in-home parent coaching. Under FBSS, children remain in the home with their family and caseworkers regularly assess child safety and help connect a family to services. At the end of the investigation, a child may or may not be removed, depending on the case and issues at hand. For more information, please see Texans Care for Children's report, "Parental Substance Use in Texas CPS Cases and Opportunities to Keep Families Safely Together." (Apr. 2019). Available at: https://txchildren.org/posts/2019/4/18/parental-substance-use-in-texas-cps-cases-and-opportunities-to-keep-families-safely-together.
92 For babies with symptoms of neonatal abstinence syndrome, proven approaches like rooming in, breastfeeding, extended skin-to-skin contact with the mother, and low stimuli environments actually shorten neonatal hospital stays and reduce the need for costly medication to treat NAS. Substance Abuse and Mental Health Services Administration. Center for Substance Abuse Treatment. Substance Abuse Treatment: Addressing the Specific Needs of Women. Treatment Improvement Protocol (TIP) Series 51. HHS Publication No. 09-4426 (2009).
93 Tex. Att'y Gen. Opinion No. GA-0291 (Jan. 5, 2005). Available at https://www2.texasattorneygeneral.gov/opinions/opinions/50abbott/op/2005/pdf/ga0291.pdf.
94 Texas Health and Human Services Commission. Guidance on Reporting to DFPS Relating to Prenatal Substance Exposure. (Received 2018) (on file with author).
95 See DFPS Nov. 2018 resource guide: http://www.dfps.state.tx.us/handbooks/CPS/Resource_Guides/PCSP_Resource_Guide.pdf
96 See Department of State Health Services. "Texas AIM." Retrieved from: https://www.dshs.texas.gov/mch/TexasAIM.aspx.
97 Council on Patient Safety in Women's Health Care. "Reduction of Peripartum Racial/Ethnic Disparities (+AIM)". Retrieved June 2019 from: "https://safehealthcareforeverywoman.org/patient-safety-bundles/reduction-of-peripartum-racialethnic-disparities/.
98 Texas Health and Human Services, Behavioral Health Services, Office of Decision Support, Jan. 2018. Includes Texas adults with income under 200% of the federal poverty level seeking services at a treatment provider funded through Texas' substance abuse and prevention block grant, which helps fund treatment services for individuals who do not have insurance and have an income less than 200% FPL.
99 Texans Care for Children analysis of substance use treatment waitlist data provided by the Texas HHSC via data request. Numbers used refer to the total unduplicated number of people on a waitlist during the course of fiscal year 2017, unless otherwise indicated. Note: data includes Substance Abuse Prevention and Treatment block grant-funded providers.
100 Regional data relating to waitlists disaggregated by type of service and by gender are not available at this time. At the county level, there were 702 Texans on a waitlist in Travis county, 53 in Bastrop, 23 in Caldwell, 47 in Hays, and 134 in Williamson county in 2017.
101 For more information, please see Texans Care for Children's report, "Parental Substance Use in Texas CPS Cases and Opportunities to Keep Families Safely Together" (Apr. 2019).
102 Wallace, R., Hughes-Cromwick, P., Mull, H., & Khasnabis, S. Access to Health Care and Nonemergency Medical Transportation: Two Missing Links. Transportation Research Record, 1924(1), 76–84 (Jan. 2005)(finding also that the population most likely to miss medical appointments due to transportation barriers were older, low income, and female; members of a minority; and those with lower educational level). See Syed, S. T., Gerber, B. S., & Sharp, L. K. Traveling towards disease: transportation barriers to health care access. Journal of community health, 38(5), 976–993 (2013).
103 Gier, J. "Missed appointments cost the U.S. healthcare system $150B each year." (Apr. 2017). Retrieved June 11, 2019, from Healthcare Innovation website: https://www.hcinnovationgroup.com/clinical-it/article/13008175/missed-appointments-cost-the-us-healthcare-system-150b-each-year https://www.scisolutions.com/uploads/news/Missed-Appts-Cost-HMT-Article-042617.pdf.
104 Medicaid MTP funds do cover children in Medicaid who travel with their parents or caregiver to the child's appointment and covers Texans with disabilities enrolled in Medicaid who travel with their personal care attendant.
105 United Way Worldwide. "United Way Partners with Lyft to Provide Free Rides to Those in Need." (Jun. 5, 2018). Available at: https://www.unitedway.org/the-latest/press/united-way-partners-with-lyft-to-provide-free-rides-to-those-in-need.
106 White, K., Burke, K., Hopkins, K., & Potter, J. Texas Women's Access to Reproductive Health Services Since the 2016 Statewide Reorganization of Women's Health Programs. University of Texas at Austin, Texas Policy Evaluation Project. (Jun. 2019). Available at https://liberalarts.utexas.edu/txpep/research-briefs/access-to-reproductive-health-services-brief.php.
107 Ibid.
108 American College of Obstetricians and Gynecologists. Screening for Perinatal Depression. Committee Opinion, No. 757. (Oct. 2018).
109 See Accreditation Council for Graduate Medical Education. Obstetrics and Gynecology Milestones. Sept. 2015). Available at:https://www.acgme.org/Specialties/Milestones/pfcatid/12/Obstetrics%20and%20Gynecology; and Accreditation Council for Graduate Medical Education. Psychiatry Milestone. (Jul. 2015). Available at https://www.acgme.org/Specialties/Milestones/pfcatid/21/Psychiatry.
110 Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration, Center for Integrated Health Solutions. "SBIRT: Screening, Brief Intervention, and Referral to Treatment." Retrieved June 10, 2019 from: https://www.integration.samhsa.gov/clinical-practice/sbirt.
111 Ewing JA. Detecting alcoholism: the CAGE questionnaire. JAMA. 252(14):1905-19076471323 (1984).
112 Ibid. Example CAGE questions include: "Have you felt you ought to cut down on your drinking or drug use?" and "Have you felt bad or guilty about your drinking or drug use?".
113 American College of Obstetricians and Gynecologists. At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications. Committee Opinion, No. 496 (Aug. 2011).
114 American College of Obstetricians and Gynecologists. Opioid Use and Opioid Use Disorder in Pregnancy. Committee Opinion, No. 711 (Aug. 2017).
115 Both quantitative and qualitative research shows that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services and by increasing the use of outpatient services. See Mental Health America. "Evidence for Peer Support." (May 2019). Available at: https://www.mentalhealthamerica.net/sites/default/files/Evidence%20for%20Peer%20Support%20May%202019.docx
116 Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report. p.12 (Sept. 2018).
117 Department of State Health Services. "Community Health Worker or Promotor(a) Training and Certification Program." Retrieved June 12, 2019, from https://www.dshs.texas.gov/mch/chw/Community-Health-Workers_Program.aspx.
118 For instance, a study comparing over 65,000 Medicaid-funded births in the West North Central region (Minnesota, North Dakota, Iowa, Missouri, Nebraska and Kansas) and East North Central region (Wisconsin, Michigan, Illinois, and Indiana) to almost 2,000 Medicaid-funded births supported by a doula program in the upper Midwest region found that women with doula care had 22 percent lower chance of a preterm birth. This translated to an average savings of $986 (ranging from $929 to $1047 across states in the study) per doula supported birth after considering doula reimbursement costs. Kozhimannil, K. B., et. al. Modeling the Cost-Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery. Birth. 43:1(2016). See Gruber, K. J., Cupito, S. H., & Dobson, C. F. Impact of Doulas on Healthy Birth Outcomes. Journal of Perinatal Education, 22(1), 49–58 (2013). Kozhimannil, K. B., Hardeman, R. R., Attanasio, L. B., Blauer-Peterson, C., & O'Brien, M. Doula Care, Birth Outcomes, and Costs Among Medicaid Beneficiaries. American Journal of Public Health, 103(4), e113–e121 (2013).
119 See National Partnership for Women and Families "Overdue: Medicaid and Private Insurance Coverage of Doula Care to Strengthen Maternal and Infant Health". (Jan. 2016). Available at: http://www.nationalpartnership.org/our-work/resources/health-care/maternity/overdue-medicaid-and-private-insurance-coverage-of-doula-care-to-strengthen-maternal-and-infant-health-issue-brief.pdf.

About Texans Care for Children

We drive policy change to improve the lives of Texas children today for a stronger Texas tomorrow.

We envision a Texas in which all children grow up to be healthy, safe, successful, and on a path to fulfill their promise.

We are a statewide, non-profit, non-partisan, multi-issue children's policy organization. We develop policy solutions, produce research, and engage Texas community leaders to educate policymakers, the media, and the public about what works to improve the well-being of Texas children and families.

Funded by a variety of foundations and individual donations, our work covers child protective services, youth justice, mental health, maternal and child health, early childhood, and the ways that each of those policy areas work together to shape children's lives and the future of Texas.

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