Health and Human Services

Maternal Mortality and Morbidity Review Committee

March 27, 2026

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.

Maternal Mortality and Morbidity Review Committee studies maternal mortality and morbidity by studying and reviewing cases of pregnancy-related deaths and trends in severe maternal morbidity, determining the feasibility of the task force studying cases of severe maternal morbidity, and recommending ways to help reduce the incidence of pregnancy-related deaths and severe maternal morbidity in Texas.

The Texas Maternal Mortality and Morbidity Review Committee (MMMRC) is a 23-member multidisciplinary committee. Chapter 34, Texas Health and Safety Code, Section 34.002, directs the MMMRC to study and review:

- Cases of pregnancy-related deaths;
- Trends, rates, or disparities in pregnancy-related deaths and severe maternal morbidity;
- Health conditions and factors that disproportionately affect the most at-risk populations; and
- Best practices and programs operating in other states that have reduced rates of deaths related to pregnancy.

The MMMRC uses standard methods to review identified pregnancy-associated death cases to determine cause of death and pregnancy-relatedness. For deaths determined to be pregnancy-related, the MMMRC builds consensus to determine potential preventability, contributing factors, and actionable recommendations. The MMMRC also studies state trends in maternal morbidity and mortality rates and disparities to aid recommendation development.
Through this process, the MMMRC develops recommendations to help reduce the incidence of preventable pregnancy-related deaths and severe maternal morbidity in the state.

A committee member must regularly participate in case review calls and committee meetings. Committee meetings are held in Austin or virtually at least quarterly or at the call of the DSHS Commissioner. In-person meeting participation is strongly encouraged. The MMMRC may also ask members to participate in subcommittee meetings, projects, and presentations. Committee members do not receive reimbursement for travel expenses to participate on the committee. If a member misses three consecutive meetings within a one-year period, with or without notice, the member may be removed from the committee.

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Name	City	Membership Category
Amy Raines-Milenkov, DrPH	Fort Worth	Researcher- Pregnancy-related Deaths
Angeline D. Opina Gonzalez, MD	Houston	Physician - Cardiology
Avi Ruderman, MD	Dallas	Physician - Emergency Care
Barbara Orlando, MD, Ph.D.	Houston	Physician - Anesthesiology
Carey Eppes, MD, MPH	Houston	Physician - Maternal Fetal Medicine
Presiding Officer Carla Ortique, MD	Houston	Physician - Obstetrics
Christina Murphey, Ph.D., RNC-OB	Corpus Christi	Nurse - Labor and Delivery
Vacant		Physician - Oncology
Ingrid Skop, MD	San Antonio	Community Member - Rural
James Hill, MD, COL (ret)	San Antonio	Physician - Maternal Fetal Medicine
Kelly Fegan-Bohm, MD, MPH, MA	Austin	DSHS Representative - State Epidemiologist
Lindsey Vasquez, MD, CPE, FACOG	Richmond	Managed Care Organization Representative
Manda Hall, MD	Austin	DSHS Representative - Associate Commissioner Community Health Improvement Division
Meenakshi Awasthi, MD, MPP, MS	Houston	Community member - Urban
Meitra Doty, MD	Dallas	Physician - Psychiatry
Morna Gonsoulin, MD	Rosenberg	Physician - Medical Examiner
Vacant		Registered Nurse
Assistant Presiding Officer Patrick Ramsey, MD, MSPH, FACOG	San Antonio	Physician - Maternal Fetal Medicine
Robin Page, Ph.D., APRN, CNM, FACMN	College Station	Certified Nurse - Midwife
Sarah Hartman, MD	Houston	Physician - Pathologist
Sherri Onyiego, MD, Ph.D., FAAFP	Houston	Physician - Family Practice

Name	City	Membership Category
Vacant		Social Worker/Social Service Provider

1. Call to order, welcome, and roll call. The meeting was convened by Carla Ortique, MD, presiding officer.

2. Consideration of December 5, 2025, draft meeting minutes. The minutes were approved as drafted.

3. Texas Maternal Mortality and Morbidity Review Committee chair and subcommittees updates.

Dr. Ortique reflected on the committee's core case-review questions: whether deaths are pregnancy-related, causes/contributors, preventability, and recommendations to prevent future deaths. Highlights shared by the Chair included:

- Ongoing focus on increasing access to comprehensive care across the lifespan.
- Extension of access to care to 12 months postpartum cited as a major success.
- Mental health identified as a leading cause area, contributing to development of PeriPAN (statewide network enabling real-time psychiatric consultation for clinicians).
- Legislative allocation of $6M supported a new data system enabling earlier/quicker access to maternal health data and committee findings.
- Pilot programs supported for violence prevention and substance use disorder.

The committee will be completing the biennial report in 2026, and members were asked to consider and share best practices from other states/jurisdictions for inclusion.

The Perinatal Psychiatry Access Network, PeriPAN, can enhance your capacity to provide the perinatal mental health standard of care your patients need. There is no cost to you or your patients for this evidence-based, clinician-to-clinician program. Texas PeriPAN offers real-time access to a multidisciplinary network of mental health experts—including reproductive psychiatrists—for peer-to-peer consults by phone, vetted and personalized referrals and resources, and behavioral health CMEs. Looking for help with a child or adolescent patient? Call CPAN.

PeriPAN is for clinicians serving pregnant and postpartum women, including:

- OB/GYNs
- Pediatricians
- Family Practice Clinicians

- Psychiatrists
- Psychologists
- Midwives
- Other Primary Care Physicians
- Nurses and Other Clinicians

Perinatal Psychiatry Access Network (PeriPAN) – TCMHCC

Dr. Ortique mentioned the Sunset process and encouraged public participation via sunset.texas.gov.

"Relief from redaction" has reduced a major bottleneck, helping the committee become more contemporary in reviews; the committee is on track to complete the 2024 cohort review.

Dr. Ramsey (Co-chair) provided a rural health update from participation in the Rural Texas Maternal Health Assembly and the Rural Texas Maternal Health Rescue Plan effort. There are documented rural vs urban disparities (national): 37 maternal deaths per 100,000 live births in rural communities vs 20 per 100,000 in urban areas. The Texas access gaps: 49% of Texas counties have no obstetric services; patients may drive 30 minutes to several hours for labor and delivery. Regarding hospital capacity and financial risk: 58% of hospitals do not have L&D; among those that do, 49% are high risk/losing money and 12% are at risk for closure.

2025 legislative success was noted: HB 18 (Rural Health Stabilization and Innovation Act) passed May 25, establishing the Rural Texas Strong program with grant opportunities. The grant focus areas are: access/coverage, chronic disease, workforce strategies, equipment/infrastructure, outdated technology/cybersecurity, and rural facility financial health. The Rural Texas Maternal Health Assembly is continuing to meet; an updated rescue plan is expected by summer, and could be presented to MMRC at a June or September meeting.

Improving Healthcare Access for Mothers in Rural Texas

Overview The Rural Texas Maternal Health Assembly includes diverse stakeholders, rural healthcare providers and administrators, senior officials from key state entities, and representatives from advisory committees. Selected members of the Assembly serve as a Working Group to delve deeper into the key issues identified through a survey of all Assembly members. To date, 38 Assembly members have responded to

this survey to identify key issues and potential solutions for Texas mothers. Potential solutions and policy recommendations will be discussed during an in-person Assembly meeting in Austin, TX on September 6, 2024. The Rural Texas Maternal Health Assembly work group will finalize a Position Paper with comprehensive solutions and recommendations after this in-person meeting in Austin, TX. The final Position Paper with actionable policy recommendations for Texas will be published in mid-October.

On March 1, 2024, Texas implemented House Bill 12, extending Medicaid postpartum coverage to 12 months. Despite this progress, rural Texas mothers still face significant healthcare barriers.

On July 25, 2024, the Rural Texas Maternal Health Assembly was convened to address healthcare access obstacles and key issues faced by Texas mothers and rural providers in Texas.

A comprehensive Position Paper, developed by this diverse Assembly of healthcare experts, aims to address these challenges and propose actionable solutions for Texas.

rural-texas-maternal-health-plan-2025.pdf

Dr. Ortique noted Commissioner Dr. Jennifer Shuford's directive to expand analysis of rural vs urban outcomes, including whether drivers/leading causes differ, acknowledging access as a key factor. The chair also raised the idea (in the context of violence as a leading cause) of potentially adding representation from first responders/law enforcement to broaden perspective and consider their role as "extenders of health," particularly in rural areas.

Dr. Sherry Onyego (Maternal Health Disparities Subcommittee) shared:

- Collaboration with the Scientific Publication/Research efforts and joint logistics planning, including IRB processes/protocols, to support deeper-dive analyses (including rural/urban trends and other charged factors).
- Continued work on best practices and tools used during case review, including development of a homicide review tool/framework.

Dr. Kelly Faganbaum provided an update on the homicide tool work commenting that they have met with multiple case-review small groups (with program staff) to review the tool and collect feedback; updates ongoing based on committee input.

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Dr. Robyn Page (Research and Publication Subcommittee) reported that the subcommittee met Feb 12, 2026 with DSHS Maternal Health Division and members from research/publications and disparities focusing on rural vs urban outcomes. DSHS epidemiology team is developing a research plan including county-level analyses, non-medical drivers of health, and identification of "maternity care deserts." Dr. Ortique noted other states are adopting tools developed by this committee (e.g., non-medical drivers of health tool, cancer tool, COVID timeline).

4. Texas Maternal Mortality and Morbidity Review Committee Operational and Maternal Health and Safety Initiatives updates

DSHS Maternal and Child Health Unit Director provided operational updates. The next joint biennial report is due September 1, 2026.

As of the day prior to this meeting, MMRC completed case review of the 2021 cohort. 2024 cohort re-review is expected to be completed in April 2026. Findings and recommendations from both 2021 and 2024 cohorts will be included in the report. MMRC will meet June 4–5 for recommendations development.

Case cohort identification update (as of March 3): 277 cases identified for 2021, and 194 cases identified for 2024. There was the benefit of more contemporary review: for the 2024 cohort, DSHS identified incorrect pregnancy status information on 41 death certificates; The process involves Vital Statistics notifying certifiers so pregnancy status can be corrected, improving state/national statistics.

Data modernization updates: Texas Health Data updated with severe maternal morbidity through 2023 and pregnancy-associated deaths through 2023; additional maternal mortality updates planned in the coming year. Texas Health Data includes an MMRC-specific dashboard showing case review progress after each quarterly meeting.

Membership/appointments update: Eight committee positions are either vacant or expired. Applications are under review for eight roles: critical care physician, social worker/social service provider, labor & delivery nurse (RN), family practice physician, obstetrics physician, oncology physician, and an epidemiologist/biostatistician/researcher focused on pregnancy-related deaths. The selection panel will meet in spring 2026 and commissioner appointments are expected to be announced in summer 2026.

Maternal health and safety initiatives updates: Texas AIM: launched a new data reporting guide (January 2026) with updated measures/resources for sepsis and updated reporting forms for severe hypertension in pregnancy and obstetric hemorrhage sustainability.

Texas AIM: launched Simulation Champions Call series (February 2026) led by Dr. Shad Dearing and implementation mentors; 12 calls are scheduled over five months. As of March 19, Texas AIM completed four of five planned "Action Period 2" calls, reaching 455 cumulative improvement team members.

Learning Session 3 is planned for late April/May 2026 in Houston, Grapevine, and Austin; focus on sustainability/holding gains, with hospital team data sharing and interactive breakouts (including sepsis debriefing practice, identification systems review, and patient/family experience exploration).

Hear Her Texas: continued English/Spanish awareness campaign on urgent maternal warning signs using ongoing digital media; planning next phase. The Hear Her Texas microsite in final preparation with hoped-for full launch in early April. Hear Her Texas | Texas DSHS

Dr. Manda Hall (Deputy Commissioner, Community Health Improvement Division) added the contemporary review enabled the long-standing goal of correcting death certificate data in time before data file closure and national submission. The team has already begun processes to identify the 2025 case cohort. She encouraged committee/public to use Texas Health Data noting that the data has been updated through 2023 and MMRC dashboard updates are in progress to improve timely public access (case identification, review status, and pregnancy-related determinations).

Discussion

Dr. Patrick Ramsey asked whether the 41 corrected death certificates had common themes that could inform future modifications; Dr. Ernst-Mendez indicated the epidemiology team would need to answer and she would follow up.

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5. Society for Maternal Fetal Medicine Position Paper Presentation

Summary Dr. Catherine (Carrie) Epps (Baylor College of Medicine; SMFM Board; presenting for SMFM Health Policy & Advocacy Committee) shared SMFM recommendations for state Maternal Mortality and Morbidity Review Committees (MMRCs) and progress on implementation. The SMFM's stated aim is to strengthen MMRC authority, completeness, timeliness, equity-focused reporting, and translation of findings into action.

SMFM's key recommendations for MMRCs (1–11)

- Maintain an active MMRC in every state with authority to obtain complete records.
- Ensure "complete records" include prenatal/hospital/ED records, vital records (birth/death certificates), informant interviews, and relevant social service records to capture non-medical drivers of health.
- Review all deaths during pregnancy and through 1 year postpartum, regardless of pregnancy intention or how the pregnancy ended.
- Avoid excluding deaths that may appear "incidental"; specifically ensure overdose, mental illness, suicide, and intimate partner violence deaths are reviewed to assess pregnancy-relatedness.
- Set timeliness goals aligned with CDC standards: identify cases within 1 year of death, review within 2 years, and publish a public report within 3 years.
- Report leading causes of death stratified by race/ethnicity and other social factors (e.g., insurance type, geographic location such as urban/rural) to identify drivers of inequities.
- Submit findings in standardized form to CDC's MMRIa to support national aggregation and to ensure large-state data meaningfully informs U.S. estimates.
- Thoroughly complete MMRIa decision forms for each case, including: pregnancy-relatedness, cause of death, preventability, contributing factors, recommended actions, and anticipated impact.
- Keep MMRCs nonpartisan to protect credibility, objectivity, autonomy, and the non-punitive nature of reviews (including protection from legal use).
- Ensure diverse membership across clinical disciplines and non-clinical/community perspectives, including people with lived experience, to reduce blind spots and improve equity.
- Conduct informant interviews with families/close contacts whenever possible to add context (stressors, access barriers, patient experience), improve patient/family-level recommendations, and honor the deceased.

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- Provide stable, consistent funding sufficient to support timely reviews, regular reports, and informant interviews.
- Establish mechanisms to act on MMRC recommendations (e.g., perinatal quality collaboratives, legislative proposals), emphasizing that "a report on a shelf doesn't mean much."

Dr. Epps cited multi-state committee findings (2020 report across 38 states; 525 pregnancy-related deaths): leading causes included mental health, cardiovascular, infection, hemorrhage, embolism, and hypertensive disorders; causes varied by race/ethnicity; >80% of deaths were deemed preventable. The importance of patient/family-related contribution was noted as common (cited as 33%), but patient/family-level recommendations were rare (cited as 3.6%).

The Chair commented that what gets labeled "patient/family contributors" often reflects structural/community drivers (social determinants/non-medical drivers of health) rather than individual "fault," reinforcing the need for better context and more aligned recommendations.

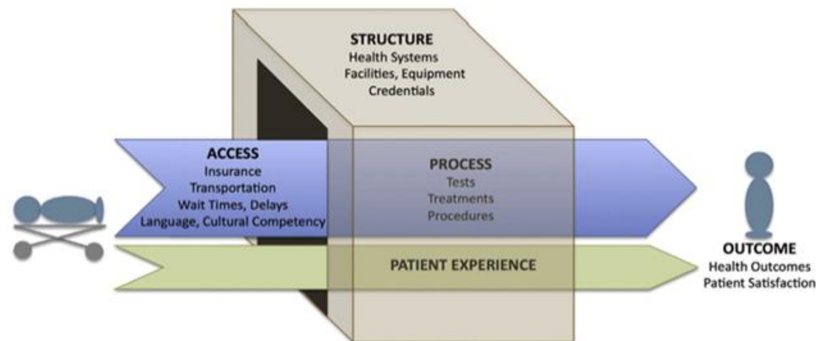
Presentation

Objective: Introduce SMFM recommendations for MMRCs and highlight current state progress toward implementing those recommendations.

RECOMMENDATION 1 Every state should maintain an active MMRC that has the authority to obtain complete records.

MMRCs review deaths and information about each case.

FIGURE
Five components of health care quality



Agency for Healthcare Research and Quality 5 domains of quality.
SMFM. Measuring quality of care in obstetrics. Am J Obstet Gynecol 2016.

RECOMMENDATION 2 MMRCs should review all deaths occurring during pregnancy and within one year after the end of pregnancy. [...] Certain types of death during pregnancy or the postpartum period may be incidental to pregnancy (e.g., motor vehicle accidents). These deaths are classified as pregnancy-associated rather than pregnancy-related and may be excluded from the scope of MMRC review. However, deaths attributed to drug overdose, mental illness, suicide, and intimate partner violence (IPV) should not be considered incidental and should be thoroughly reviewed to assess pregnancy-relatedness.

RECOMMENDATION 3 MMRCs should set a goal of identifying cases within one year of death, reviewing those cases within two years of death, and disseminating a public report within three years of death.

RECOMMENDATION 4 Data should be reported for leading causes of death by race and ethnicity and other social factors, such as insurance type and geographic location.

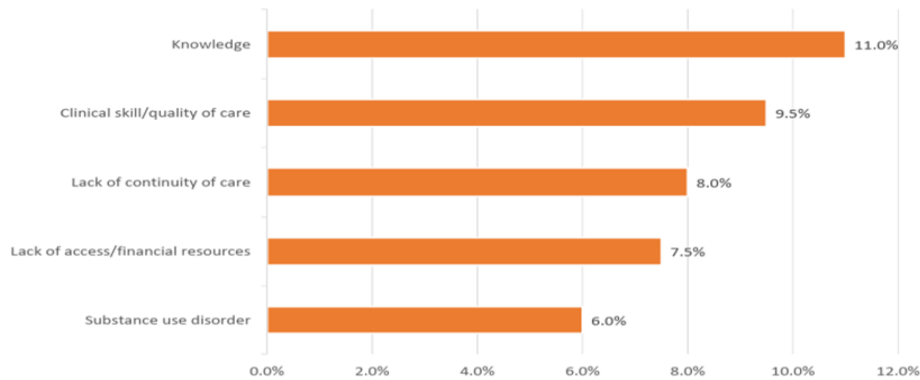
RECOMMENDATION 5 MMRCs should report their data and findings in a standardized format using CDC's Maternal Mortality Review Information Application (MMRIA).

Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 38 U.S. States, 2020 Key points

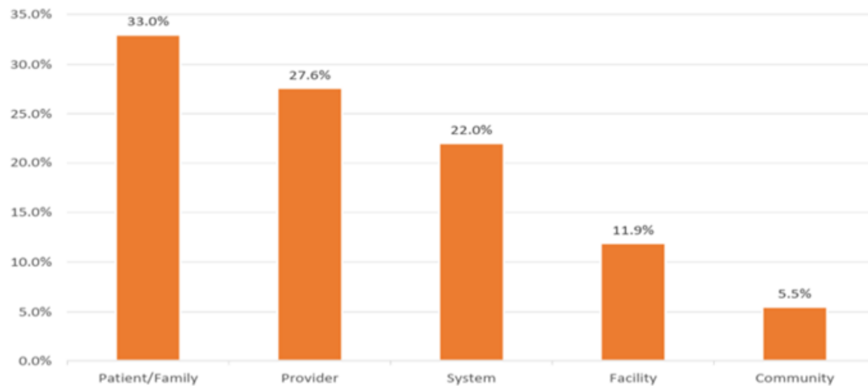
- Data on 525 pregnancy-related deaths during pregnancy, delivery, and up to 1 year postpartum among residents of 38 states during 2020
- Among the 525 pregnancy-related deaths, an underlying cause of death was identified for 511
- 6 most frequent underlying causes: mental health conditions, cardiovascular conditions, infection, hemorrhage, embolism, and hypertensive disorders of pregnancy
- The leading cause of pregnancy-related death varied by race and ethnicity
- Over 80% of pregnancy-related deaths were determined to be preventable

RECOMMENDATION 6 The CDC MMRIA committee decisions form “Contributing Factors and Recommendations for Action” section should be thoroughly considered and completed for every pregnancy-related case.

Top Five Contributing Factor Classes in 2021



Contributing Factor Levels in 2021



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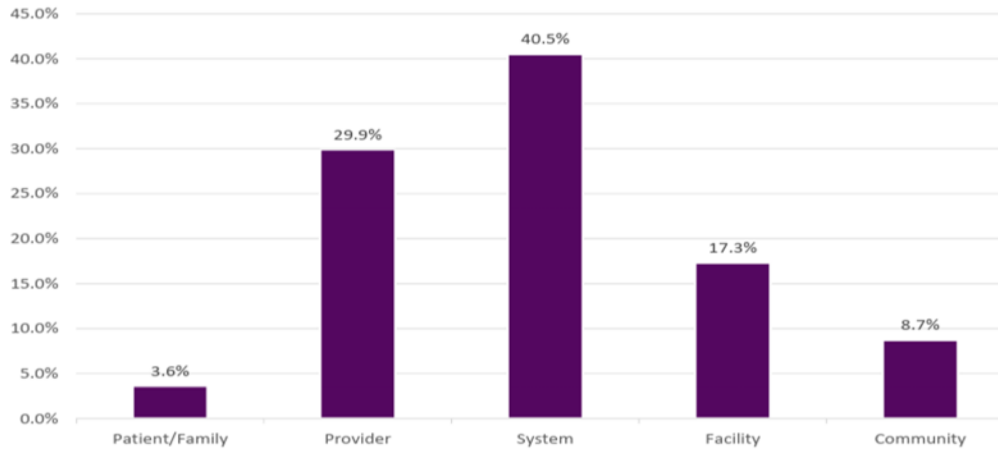
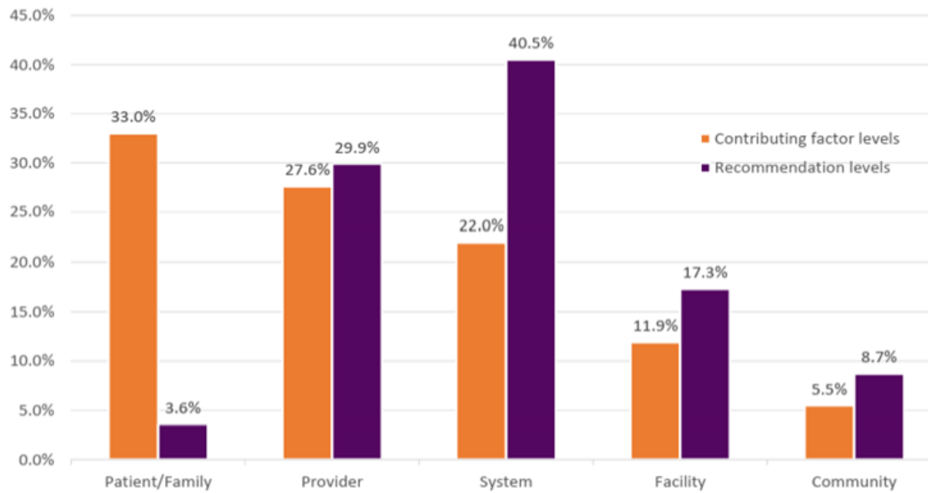
Recommendation Levels in 2021



Contributing Factor and Recommendation Levels in 2021



RECOMMENDATION 7 MMRCs should be non-partisan bodies.

Why should MMRCs remain non-partisan

Credibility **Objectivity** **Autonomy** **Protection**

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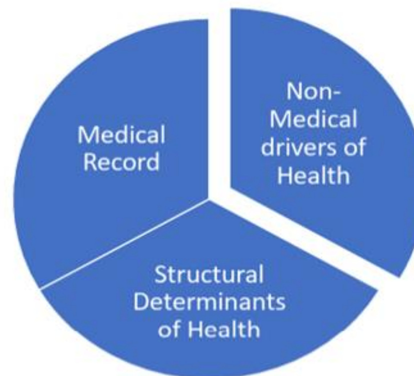
RECOMMENDATION 8 MMRC members should include representatives from various clinical and nonclinical disciplines, local organizations, and community members.

Clinical Experts: Doctors, Nurses, Midwives

Nonclinical professionals: social work, public health, law enforcement, behavioral health

Community members: advocates, those with lived-experience

RECOMMENDATION 9 MMRCs should conduct interviews of deceased individuals' families and close contacts whenever possible.



RECOMMENDATION 10 MMRCs should have stable and consistent funding.

RECOMMENDATION 11 Mechanisms should be established to act based on findings and recommendations from MMRCs (e.g. perinatal quality care collaborative, legislative proposals, etc.).

Discussion. Committee discussion emphasized MMRC's role is to provide a deep review and evidence-based recommendations; implementation though is carried forward by partners.

Dr. Ramsey highlighted Recommendation #11 and Texas implementation pathways, including the Perinatal Advisory Council (PAC), Texas AIM, and the Texas Collaborative for Healthy Mothers and Babies. He provided the California example where a deep dive on cardiac deaths led to an AIM bundle, and this is planned for Texas in the future.

- Dr. Epps noted Texas's required levels-of-care structure and existing hospital-level case reviews, enabling the MMRC to focus more on broader policy and community/patient-family domains while informing facility QI and collaboratives.

We need partners and collaboratives to make a difference from the analysis and recommendations. AIM bundles have been created from the efforts of MMMRCs.

6. Perinatal Advisory Committee Presentation(PAC) David B. Nelson, MD

Summary. The PAC shared updates since the prior MMRC update (December) and noted election of new officers: Dr. David Nelson as chair and Dr. David Lam as co-chair. Ongoing PAC work includes monitoring regionalization/designation status for maternal and neonatal levels of care (Levels 1–4), including tracking speed/process of surveys and geographic distribution.

- Current facility counts: 215 maternal designated facilities and 224 neonatal designated facilities.
- Tracking unintended consequences of regionalization, including discontinued services/level closures, and mapping access (e.g., active facilities within a 60-mile radius) with rural access in mind.
- Neonatal back transfers: in December 2025, the executive commissioner authorized HHSC Medicaid & Dental Benefits Policy to proceed with development to make neonatal back transfers a paid Medicaid benefit; policy language development and approval expected to take ~18 months.
- Maternal designation surveying bodies changed from ACOG to the Joint Commission; current maternal survey capability includes Texas EMS Trauma and Acute Care Foundation Services and the Joint Commission.
- Supporting state guidance/legislation-- pre-hospital whole blood transfusion pilot program; PAC formed a subcommittee and approved maternal-care

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guideline, noting Rh exposure/alloimmunization risks and implications for future pregnancies; PAC is also developing recommendations for pre-hospital whole blood for neonates <28 days.

- Centers for Excellence in Fetal Diagnosis and Therapy (HB 2131): PAC revived stalled work post-COVID delays; subcommittees defined what qualifies as a center, focusing threshold on fetoscopy and open fetal surgery (not routine diagnostics/needle-based procedures).
- Placenta accreta spectrum (HB 1164): PAC incorporated MMRC-informed screening/diagnosis/coordinated treatment into the existing designation process (rather than creating a separate designation track); rule change recommendations submitted Oct 2021 and adopted; designation surveys now include these elements; resources available via the cited website.
- PAC data: prior analyses showed reductions in severe maternal morbidity over time (transfusion, hysterectomy, ICU admission), with notable reductions at Level 1–2 facilities consistent with appropriate transfer/regionalization into Level 3–4 centers; findings were shared at an SMFM annual meeting.
- Neonatal outcomes analysis is ongoing and more complex (no single codified composite like SMM); PAC reviewed late-onset sepsis noting a steady decline 2016–2022 and is examining BPD, ROP, and other measures, accounting for confounders like gestational age and evolving viability.
- The PAC 2026 meeting dates are: June 16, 2026; September 3, 2026; December 3, 2026 (and are all hybrid meetings).

Presentation

Maternal and Neonatal Levels of Care Hospital Designation

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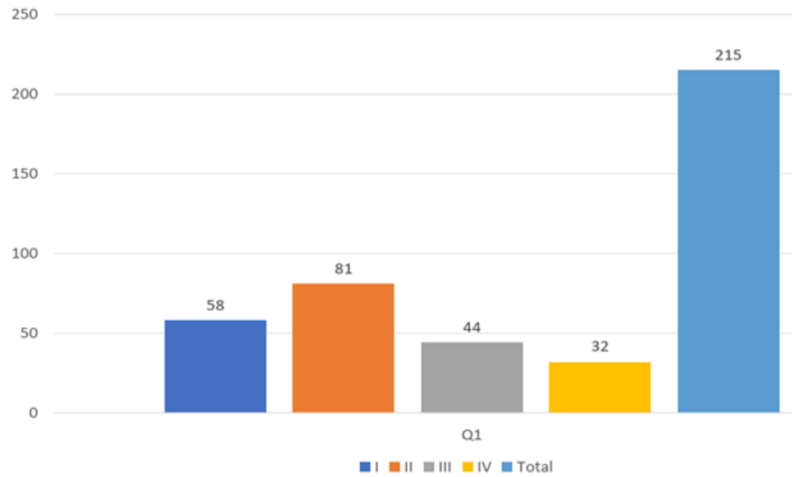
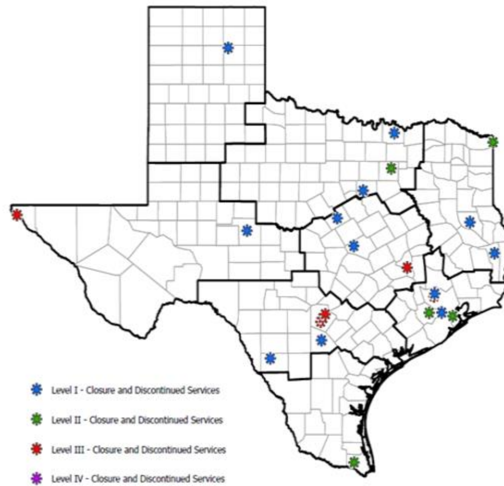
Maternal Designated Facilities



Maternal Facilities – Closure and Discontinued Services



Maternal - Current/Closure/ Discontinued Services (60-mile R)

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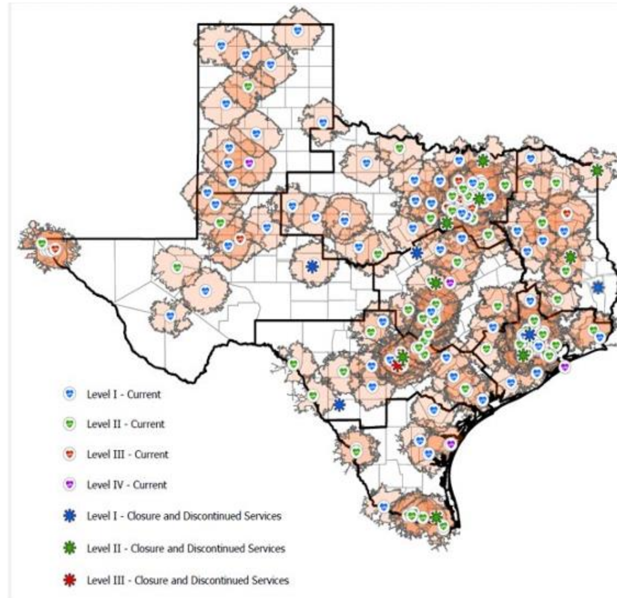
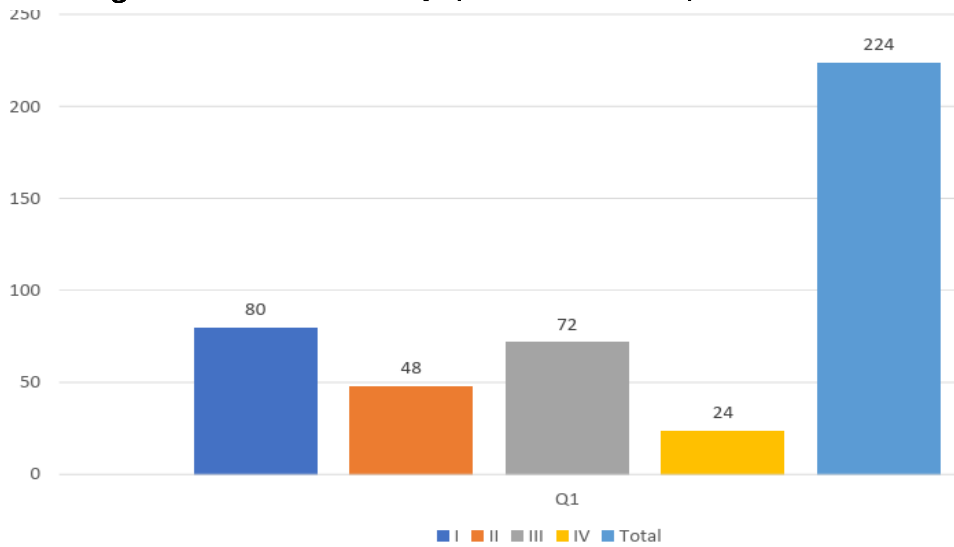
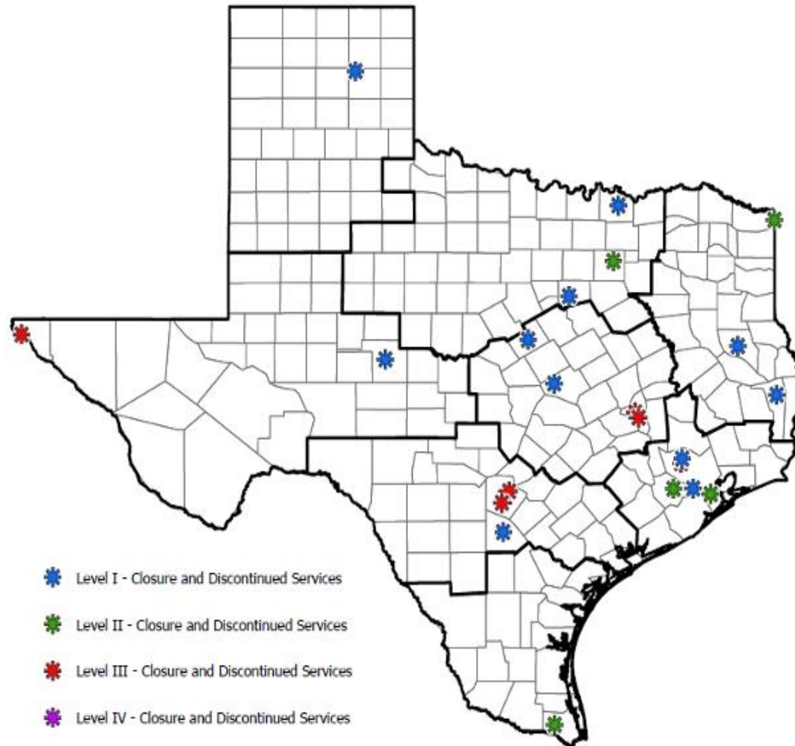


Neonatal Designated Facilities

Neonatal Designated Facilities FY'26 Q1 (9/1/25 – 11/30/25)



Neonatal Facilities – Closure and Discontinued Services



PAC & Neonatal Back Transfers from HB 15 that established the PAC

Neonatal Back Transfers The12/17/2025 update at PAC meeting informed us the Executive Commissioner authorized HHSC Medicaid & Dental Benefits Policy (MDBP) to proceed with policy development to make Neonatal Back Transfers (NBX) a paid Medicaid Benefit! Since approval from the Executive Commissioner, MDBP has been actively meeting both internally and with our contractor regarding NBX. Policy language development underway; review and approval can take up to 18 months.

Back (retro) Transfers

Up to 20% of newborn infants retro-transferred to a lower level of care require readmission to a higher-level facility. In this study, we developed and validated a prediction rule (The Rule for Elective Transfer between Units for Recovering Neonates) to identify clinical characteristics of infants at risk for failing retro-transfer. In the 1970s, regionalization of neonatal care was proposed in the United States as a strategy to improve neonatal outcomes. Regionalization emphasizes the importance

of matching patients with health care facilities that are able to provide an appropriate level of care. The American Academy of Pediatrics (AAP) has defined levels of care for neonatal intensive care units (NICUs), ranging from Level I units (well newborn nurseries) to Level IV units (regional NICUs with pediatric surgical subspecialists). Recent changes in the landscape of health care in the United States, such as the establishment of Accountable Care Organizations, have brought the importance of responsibility for care within regional networks to the forefront. However, there has been a trend toward expansion of community hospital services to include care for sicker infants, effectively deregionalizing systems of neonatal care. This shift further emphasizes the need for neonatal transfers to be both appropriate and well-planned.

Within perinatal care networks, 2 types of acute inter-hospital transport pertain to the ill neonate: maternal transfer prior to delivery or infant transport to a higher level NICU after delivery. Although a highly regionalized system favors the former, either situation results in admission to a NICU that may be distant from the intended birth hospital and family's home. Acute neonatal transport has been investigated widely, particularly with respect to extremely preterm and very low birth weight infants. On the other hand, retro-transfer of infants to a lower level of care for convalescence following a period of intensive care is less well studied. Transferring infants who no longer require intensive care to community hospitals closer to home has many potential advantages, including decreased family stress, earlier involvement of primary providers, and more efficient use of resources within a care network. Prior studies suggest that transfer of stable, recovering infants to lower level special care nurseries is safe and cost effective, particularly when they will spend >1 week in the community hospital. Although some cost savings may be offset by a trend toward longer length of stay in the community hospital, others have shown that overall length of stay is similar to that of the referring NICU for low birth weight infants

Times of high patient volume or acuity may create the need to identify which infants have least need for high-level ICU services and would be the best candidates for retro-transfer. These stressors not only affect decisions surrounding retro transfer, but also discharge; indeed, discharge of moderately preterm infants is closely correlated with unit census. There is also wide variation in the discharge timing for moderately preterm infants across regions of the United States and internationally, which highlights an opportunity for improvement in practice that could be extended to decisions about retro-transfer timing.

Although retro-transfer of convalescing infants is an essential component of regionalized perinatal care systems, fostering the goal of matching patient need with hospital capability, up to 20% of infants transferred to a lower level of care require subsequent readmission to a higher level of care.[31] There are no established

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standards to guide clinicians in determining when an infant in the NICU is appropriate for transfer back to a community hospital. This study aims to develop and validate a prediction rule to assist clinicians in determining an infant's readiness for transfer to a lower level of neonatal care that minimizes the risk for transfer back to a Level III or IV NICU.

Predicting Successful Neonatal Retrotransfer to a Lower Level of Care - PMC

Mothers' Perceptions of the Quality of Their Infants' Back Transfer - ScienceDirect

Predicting Successful Neonatal Retro-Transfer to a Lower Level of Care - The Journal of Pediatrics

Maternal Level of Care survey process organizations

- The Joint Commission replaces ACOG
- Texas EMS Trama & Acute Care Foundation (TETAF)
- Both organizations presented at 9/4/2025 PAC meeting

Pre-Hospital Whole Blood Pilot Program

Pre-Hospital Whole Blood Pilot Program : Prehospital Whole Blood Transfusion: Maternal Guidelines

Purpose : To provide guidance on the use of Low Titer Group O Whole Blood in the resuscitation of reproductive-aged females from trauma or medical causes, including pregnant patients, prior to admission to a treating facility.

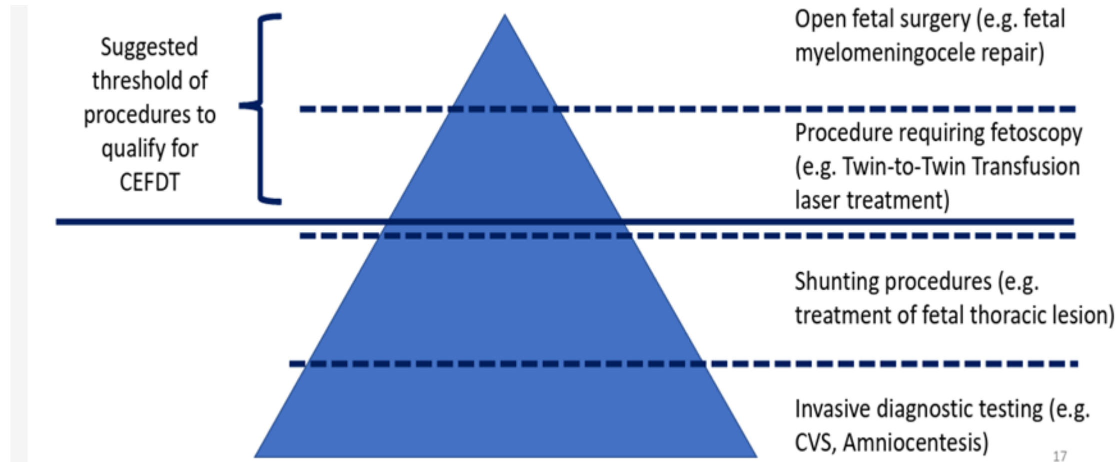
Definitions and Abbreviations:

- Reproductive age female: 12-55 years
- Low Titer O Whole Blood: LTOWB
- Rhesus Factor: Rh
- Rh immunoglobulin: RhIG

Practice Guideline: For reproductive-aged females with clinical parameters indicative of hemorrhage shock from trauma or medical causes (e.g., ruptured ectopic pregnancy, pregnancy-related hemorrhage) who are unresponsive to initial resuscitative measures, administration of LTOWB prior to hospital arrival is recommended.

PAC SUBCOMMITTEE: Centers of Excellence for Fetal Diagnosis and Therapy.

The Subcommittee agreed to provide threshold of procedure types for qualified centers:



Placenta Accreta Spectrum Disorder: Texas HB 1164 enacted by the Texas 87th Regular Legislative session empowers PAC, with input from subject matter experts, stakeholders, researchers, patient advocates, DSHS and other interested individuals, to develop considerations for patient safety practices and recommendations for maternal rules related to the diagnosis, referral, transport, and management of women with Placenta Accreta Spectrum Disorders. To prepare initial considerations, a PAC PASD Subcommittee has been established with intent to develop impactful and reasonable recommendations based on input from any diverse individuals with interest, lived experience, or expertise with this condition.

The subcommittee met several times with stakeholders and experts then presented maternal rule language revisions in two PAC meetings which resulted in these two documents being submitted to Commissioner John Hellerstedt, MD on Oct. 20, 2021.

Resource: Perinatal Advisory Council | Texas Health and Human Services

PAC subcommittee on Perinatal data

Data on Levels of Care (PAC data subcommittee using Medicaid Data)

Neonatal Morbidity Trends

- Late onset sepsis saw a steady decline from 2016 to 2022

- Higher diagnosis in advanced NICU than lower level nurseries
- Bronchopulmonary dysplasia: higher numbers in level 2, 3, NICU and SCN in 2018 and 2022 than 2016
- Retinopathy of prematurity: greater numbers in 2018 and 2022 than 2016 in level 2 and 3. Level 4 showed opposite trend

2026 PAC Meeting Dates Hybrid Meetings are scheduled for the following dates at HHSC offices in Austin: June 16, 2026, 9 am; Sept 03, 2026, 9 am; December 03, 2026, 9 am. Perinatal Advisory Council | Texas Health and Human Services

Discussion. No discussion

7. MMMRC Bylaws Discussion

Members had received the draft bylaws amendments about two weeks prior and again during the past week. The bylaws were approved without discussion.

8. Future agenda items

Updated Maternal Health Rescue Plan when it is finalized.

9. Public comment

Tiffany Inglis (Chief Medical Officer, Sara/Cera Prognostics; OB-GYN background and payer experience) presented on preterm birth prevention. She cited Texas preterm birth rate (~11.1%) and March of Dimes grade "D," and noted limitations of current risk tools that had been missing 60%+ of subsequent preterm births. She described the PreTRM proteomic test via finger-stick blood draw at 18–20 weeks, claiming it identifies more women at risk than short cervix screening or history alone. She referenced the PRIME randomized controlled trial (5,000+ women, 19 sites; published January in the Society for Maternal-Fetal Medicine journal) reporting reductions in early preterm birth, neonatal morbidity/mortality, and NICU admissions.

Nakeenia Wilson (Maternal Health Equity Collaborative (Maternal Health Equity Collaborative) ; community advocate; former MMRC member) emphasized recommendations related to obtaining complete records and incorporating family/close

contact and informant interviews. Ms. Wilson stated that when such interviews were included, case reviews and recommendations were more comprehensive. She also emphasized the importance of committee diversity and specifically advocated for stronger community member representation to balance clinician-focused recommendations.

Morgan Miles (doula and social worker) requested clearer data differentiation for social determinants and disparities specifically data on urban vs rural; race/ethnicity differences; access to doulas/midwives; and food assistance. Ms. Miles highlighted transportation, food access, and housing as contributors to stress/anxiety and related maternal morbidity and appreciated the Texas Health Data website for supporting social-service work and funding efforts.

Dinah Warren (certified nurse-midwife) stated she and others plan to testify to the Sunset Commission, emphasizing the committee's importance and concerns about communication restrictions between members. She commented on Texas' MMRC size/composition comparing it to Arizona and Colorado, arguing Texas could consider increasing membership and diversity. She shared an example from Colorado's report methodology that assessed whether cesarean section contributed to death and argued Texans deserve similarly specific insights.

10. Executive session: to review cases under Texas Health and Safety Code, Chapter 34. Texas Maternal Mortality and Morbidity Review Committee, Section 34.007. Selection and Review of Cases as authorized by Section 34.004.

11. Adjourn. Following the Executive Session, the meeting was adjourned.

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