

Tarrant County Maternal & Infant Health Coalition

2024 Year in Review



Executive Summary

2024 marked the second full year of partnership for the Tarrant County Maternal and Infant Health Coalition, comprised of the leadership of all local major health systems, as well as on-the-ground maternal and infant health care partners. During this time, the strategy and goals of the Coalition transitioned from landscape analysis and an in-depth understanding of maternal health in Tarrant County, to strategy design and implementation of an on-the-ground pilot to better connect mothers with the resources they need through a comprehensive system of care and closed-loop referral process.

Core to this pilot is the integration of a high-tech and high-touch approach. A universal access point via the Parent Pass™ app is free and accessible to all families, while a high-touch service model via Help Me Grow child specialist navigators enables high-need families to walk through each step of connecting with a resource over the phone. Through multiple universal and targeted strategies aimed to connect with mothers and increase overall county-wide resource navigation, the work underway through the pilot is extending the region's collective capacity to refer mothers to 600+ diverse resources in the community ensuring all mothers and babies – and especially those most at risk – are connecting to the resources they need to thrive.

The early, community-focused and collaborative efforts of the Coalition also provided a critical foundation for Dallas and Tarrant Counties to come together to apply for a \$45 Million ARPA-H Federal grant to reduce maternal mortality by 20% over three years.

As the Coalition continues our work forward, we remain committed to a data-driven approach that seeks to align all activities and efforts to address maternal health through a cohesive and coordinated approach that is easy to navigate for mothers and providers, ultimately creating a relationship-centered system of care that addresses the whole health of every mother and baby in our community.



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Addressing a Critical Issue in Tarrant County

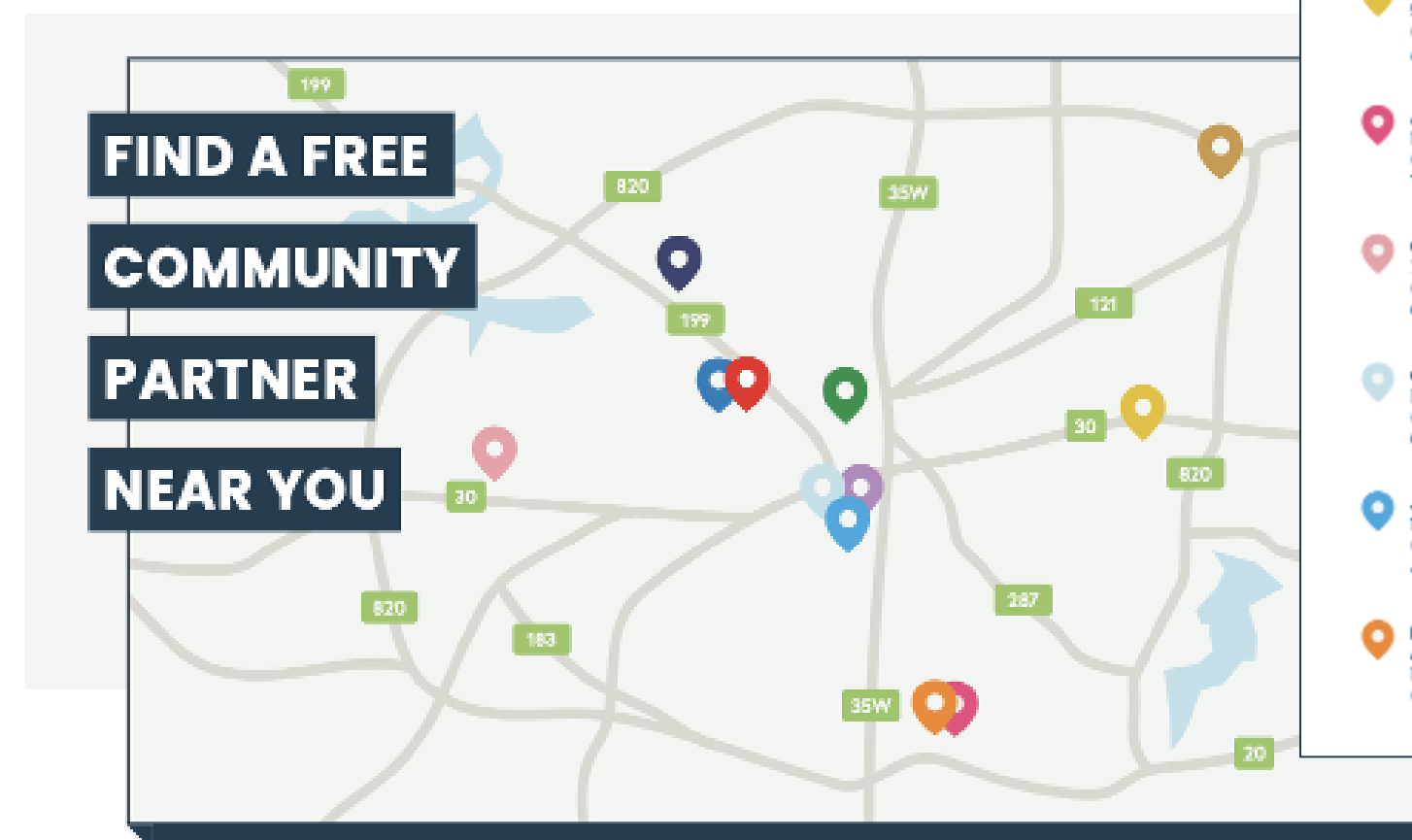
- **Texas accounts for 10% of all births in the U.S.**
- **Tarrant County's Public Health Region has 2nd highest maternal mortality rate among Black women in Texas.**
- **Mental health conditions are a leading cause of pregnancy-related deaths.**
- **1 in 7 Texas women experience depression within 6 months after pregnancy.**

Coalition Progress to Date

The Tarrant County Maternal & Infant Health Coalition, comprised of the local major hospital systems and nonprofit maternal healthcare partners, has been working together for the last 2 years to collectively define key issues to tackle as a coalition, shared goals, and associated success metrics. The Coalition's progress to date has included:

- 1) Executing a **joint Medicaid renewal communication campaign** to inform the unprecedented number of mothers who were at risk of losing their Medicaid coverage,
- 2) Building a **comprehensive resource map of maternal and infant health services** available to Tarrant County mothers from prenatal to one year postnatal through a detailed mapping exercise across all of the Coalition partners, and
- 3) Interviewing **79 local mothers to augment the resource map** based on mothers' lived experience with maternal and infant health resources, in a partnership with the University of Michigan Zero to Thrive Collaborative.
- 4) Launching **local pilot to scale Help Me Grow, close referral loops, and increase overall awareness of and access to services.**

To view the Coalition's 2023 Year in Review summary, [click here](#) or use this QR code.



<p>Ab Christian Learning Center Appointment Only 5005 Brentwood Stair Rd, Suite 200, Fort Worth, TX 76112 (817) 457-3911 ABCChrist.org</p>	<p>Muslim Tues 7600 (882)</p>
<p>Aging and Disability Resource Center Appointment Only 1300 Circle Dr, Suite 104, Fort Worth, TX 76119 (855) YES-ADRC (855) 937-2372 TarrantCountyADRC.org</p>	<p>North 2332 (817) NTAC</p>
<p>Cook Children's Health Plan Appointment Only 7000 Calmont Ave, Fort Worth, TX 76118 (882) 303-8225 CommunityMarketing@cookchildrens.org CookCHP.org</p>	<p>Tarrant 300 (817) TCCD</p>
<p>Guardianship Services Inc. 1125 College Ave, Fort Worth, TX 76104 (773) 241-2565 GuardianshipServices.org</p>	<p>Tarrant 1101 S (817) TarrantCountyTX.gov</p>
<p>JPS Eligibility and Enrollment Center 1325 S. Main St, Fort Worth, TX 76104 (817) 702-1001 JPSHealthNet.org</p>	<p>Tarrant Area Food Bank 2600 Cullen Street, Fort Worth, TX 76107 1-866-430-8143 TABF.org/snap</p>
<p>My Health My Resources of Tarrant County (MHMR) Appointment Only 1300 Circle Dr, Fort Worth, TX 76119 (817) 569-4141</p>	<p>United Way Tarrant County / Area Agency on Aging Benefits Counselors 201 N. Rupert St, Suite 107, Fort Worth, TX 76107 Call Diana at (817) 258-8036 or (817) 258-8000, ext 1 UnitedWayTarrant.org/aaac</p>

The COVID-19 Continuous Coverage for Medicaid has ended. The state is checking renewals and eligibility.

KEEP YOUR FAMILY'S MEDICAID COVERAGE!

TARRANT COUNTY PARENTS CAN **TAKE 3**

You can take 3 important steps today to make sure you keep your Medicaid coverage.

- 1 **Update your family's Medicaid information.** A Texas benefits account can help you apply for or use your benefits.
YOURTEXASBENEFITS.COM
- 2 **If you get a yellow envelope, follow the directions.** You will need to send the documents requested.
- 3 **A free community partner program (CPP) can help you.** Contact a CPP today to ask questions or get help to apply.

Map with partner information on back.

A message from your local Tarrant County healthcare providers.

A pregnant woman in a blue, vertically-ribbed dress is shown from the waist up, holding her belly with both hands. The background is a soft-focus bokeh of green and yellow light, suggesting an outdoor setting with trees. The text is overlaid on the left side of the image.

Tarrant County Maternal and Infant Health

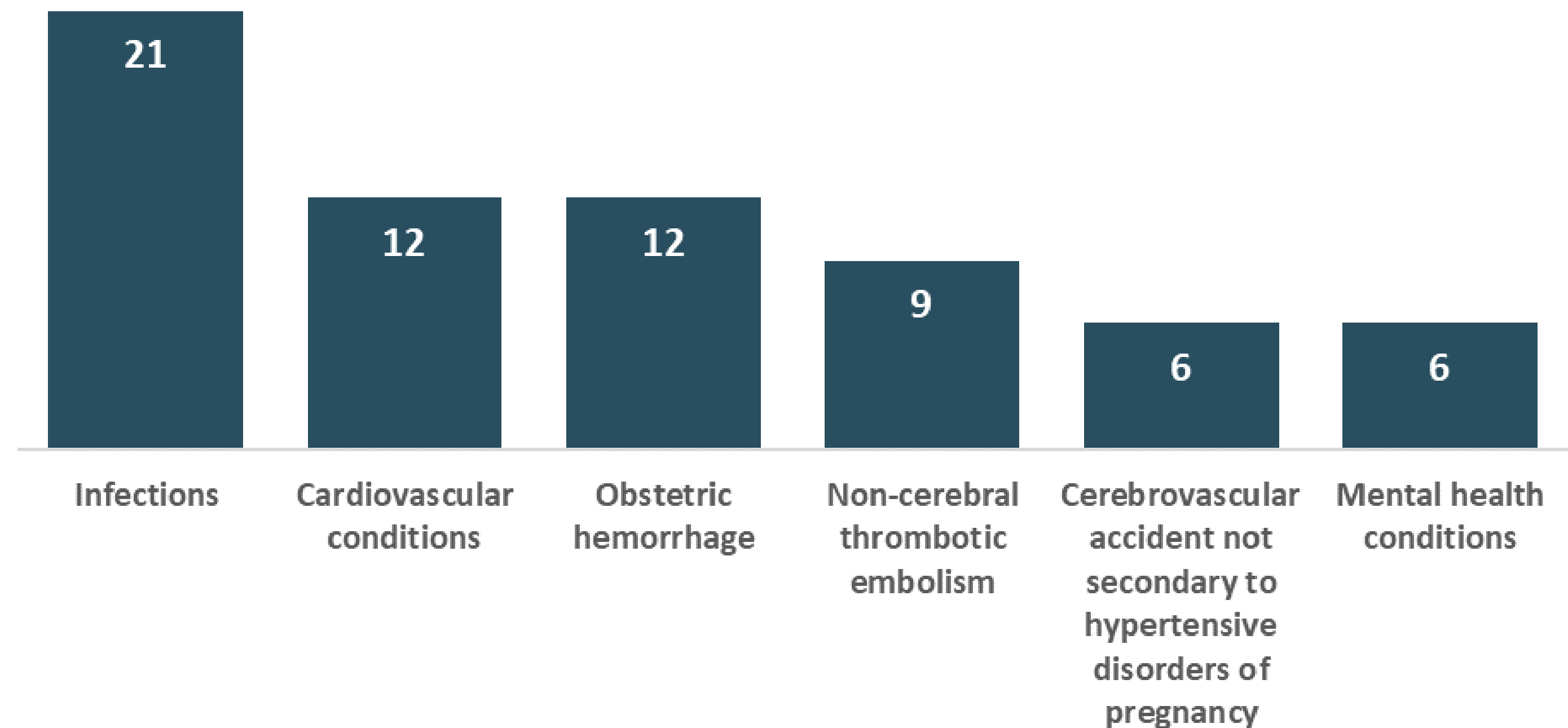
Data Update

Leading causes of death among pregnancy-related deaths

Reviewed by Texas Maternal Mortality and Morbidity Review Committee (MMMRC), Texas, 2020

Finding #3

Six underlying causes of death accounted for 78 percent of all 2020 pregnancy-related deaths. (n=85)



Leading causes of death by race/ethnicity among pregnancy-related deaths

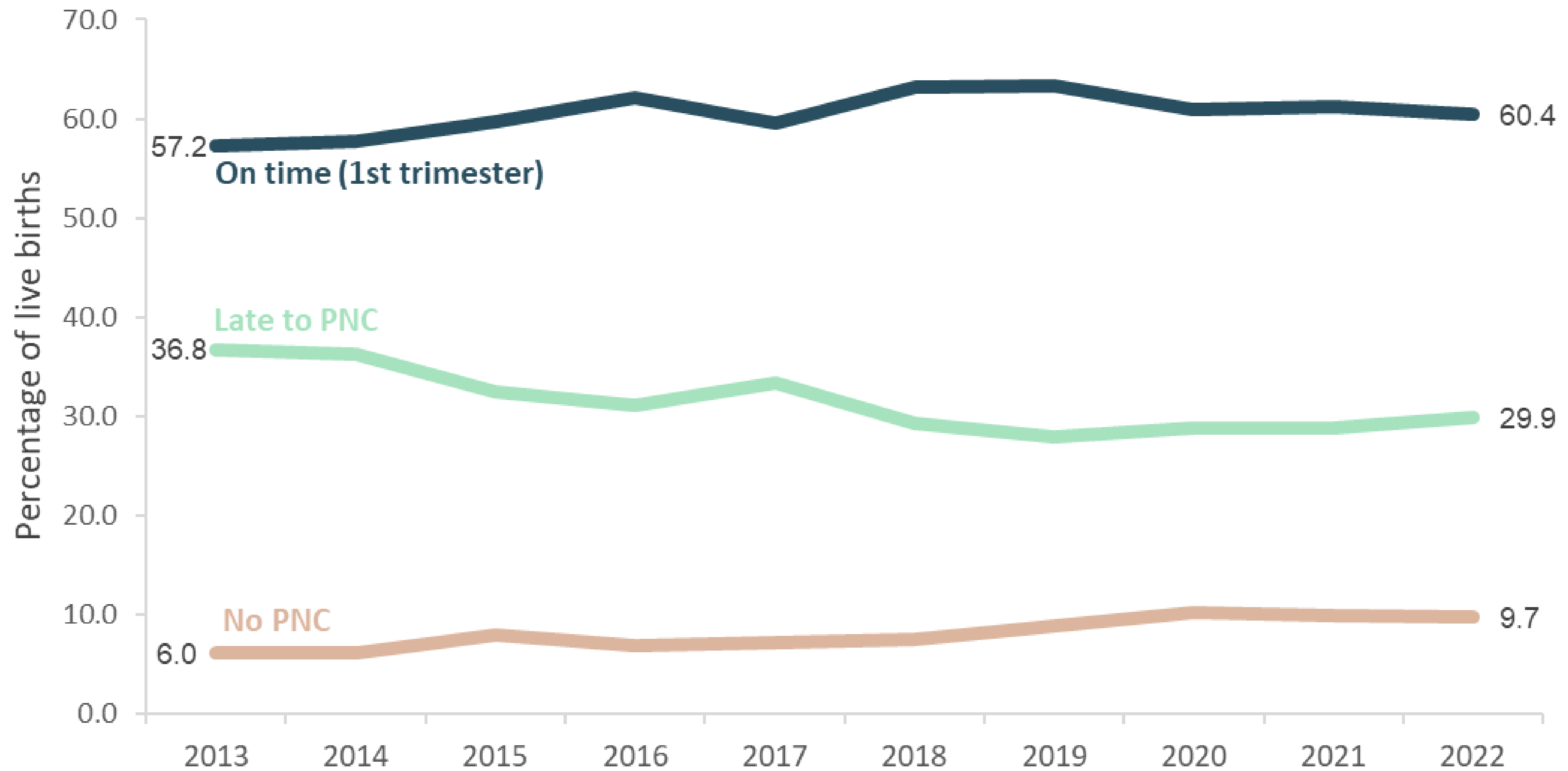
Reviewed by Texas Maternal Mortality and Morbidity Review Committee (MMMRC), Texas, 2019–2020

Finding #10

The leading causes of pregnancy-related death varied by race and ethnicity. (n=148)

- Hispanic – Infections **(22)**
- Non-Hispanic Black – Non-cerebral thrombotic embolism **(7)**
- Non-Hispanic White – Mental health conditions **(13)**
- Non-Hispanic Other – Cardiovascular conditions **(3)**

Prenatal care initiation amount Tarrant County, births, 2013-2022*



*2022 data are provisional and subject to change
Data source: Texas Department of State Health Services

Perinatal Periods of Risk: Phase 1

- Potentially 26% of fetal–infant deaths in Tarrant County were preventable, with the largest proportion of preventable deaths occurring among non–Hispanic Blacks (49%).
- Overall, 45% of excess deaths in Tarrant County occurred in the Maternal Health/Prematurity risk period.
- Non–Hispanic Blacks had the highest excess fetal–infant mortality rate (5.01).
- Non–Hispanic Blacks had high excess rates in the Maternal Health/Prematurity (2.33), Maternal Care (1.25), and Infant Health risk periods (1.30).

**Intervention Area with Greatest Potential Impact Overall
in Tarrant County:**

Non-Hispanic Black Maternal Health/Prematurity

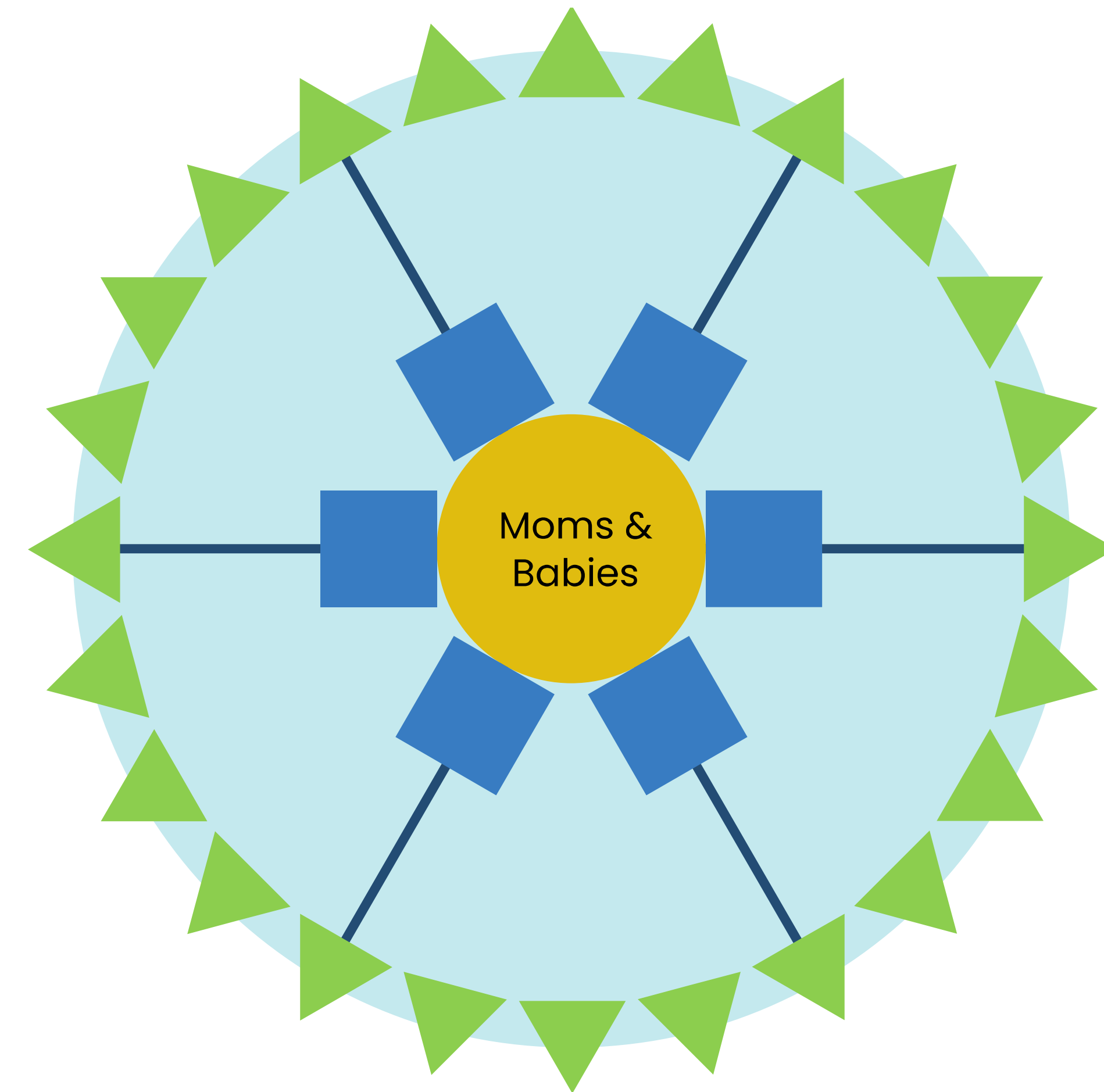


Maternal Health Pilot

Progress to Date

Overview of Pilot Project

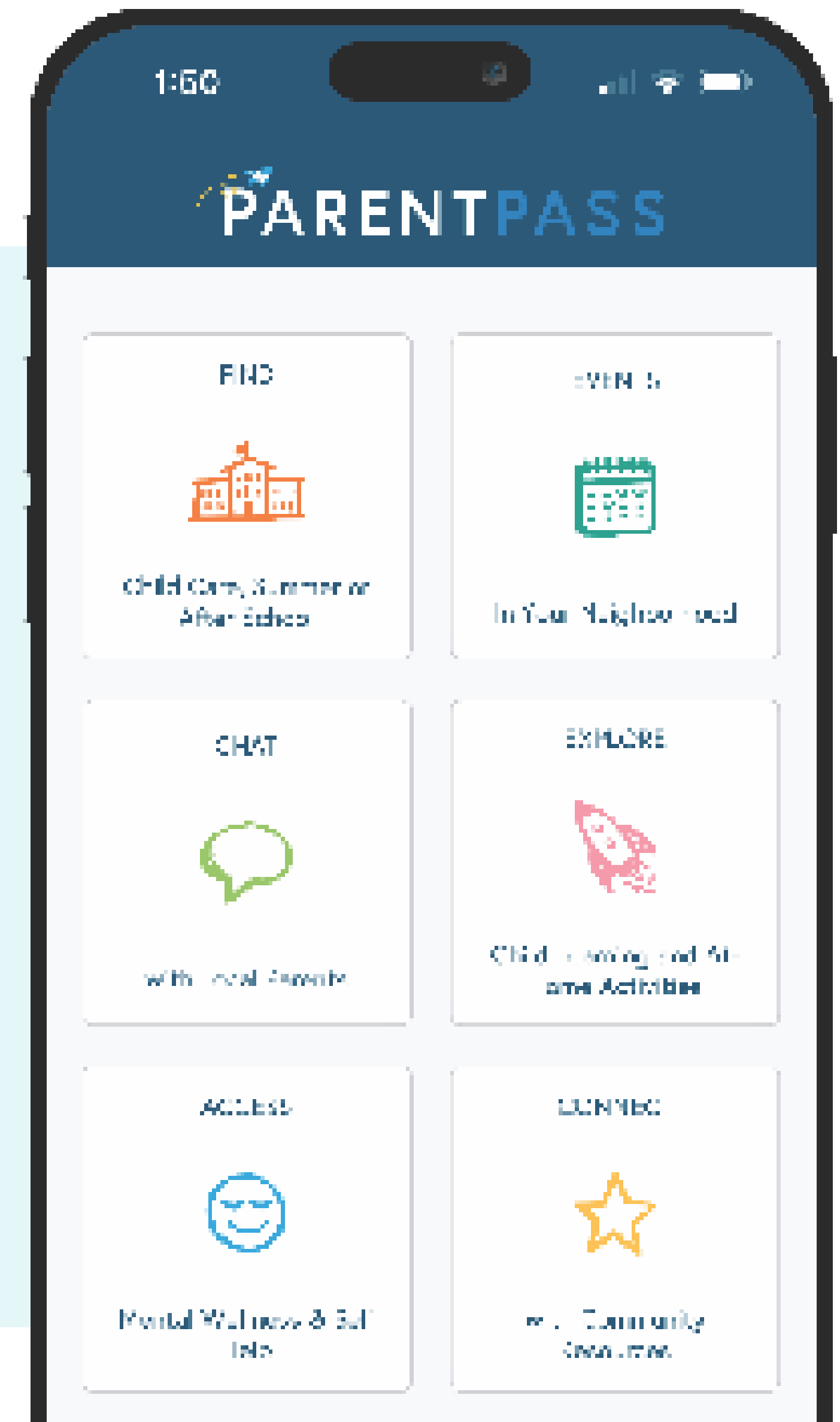
- ✓ **6 Health Systems** – THR, Baylor, JPS, Cook Children’s, MHMR & NTACHC
- ✓ **Parent Pass™ + trained child specialists – “navigators”** refer mothers to 600+ community resources
- ✓ **Help Me Grow Navigators** follow up to ensure **successful referral**
- ✓ **TCU School of Medicine** students embed into each hospital to provide additional interventions and supports identified by the coalition over four (4) years as part of their overall research and education.



Overview of Pilot Project

The Maternal & Infant Health Coalition pilot will incorporate **the use of technology (via the Parent Pass™ app)** as a central access point for mothers, and utilize **trained child specialists – “navigators” (via the Help Me Grow phone line embedded in the app)** to act as an extension of hospital partners’ nursing teams, extending their capacity by enabling them to refer mothers to 600+ diverse resources in the community via navigators who will follow up to ensure a warm handoff referral is completed, and each mother received the services she needed.

In addition, a research partnership **with TCU School of Medicine** will allow medical students to embed into each of the hospital locations provide additional interventions and supports identified by the coalition. TCU Medical Students will be paired with TCU Faculty to deliver the additional interventions and supports, with a commitment of providing this service over four (4) years as part of their overall research and education.



Maternal & Infant Health Coalition Pilot

Background and key strategies for Tarrant County Pilot

A

Parent Pass as Entry to Help Me Grow

Train frontline hospital and health care staff at key entities to engage parents:

- Ensure warm hand-offs
- Find child-care availability
- Access discharge paperwork

LEVEL 1

B

Help Me Grow Navigator Learning Cohort

Hospital and health care team members to be trained as HMG Navigators to provide HMG Navigator services internally to their clients and expand overall HMG Navigation across the county

LEVEL 2

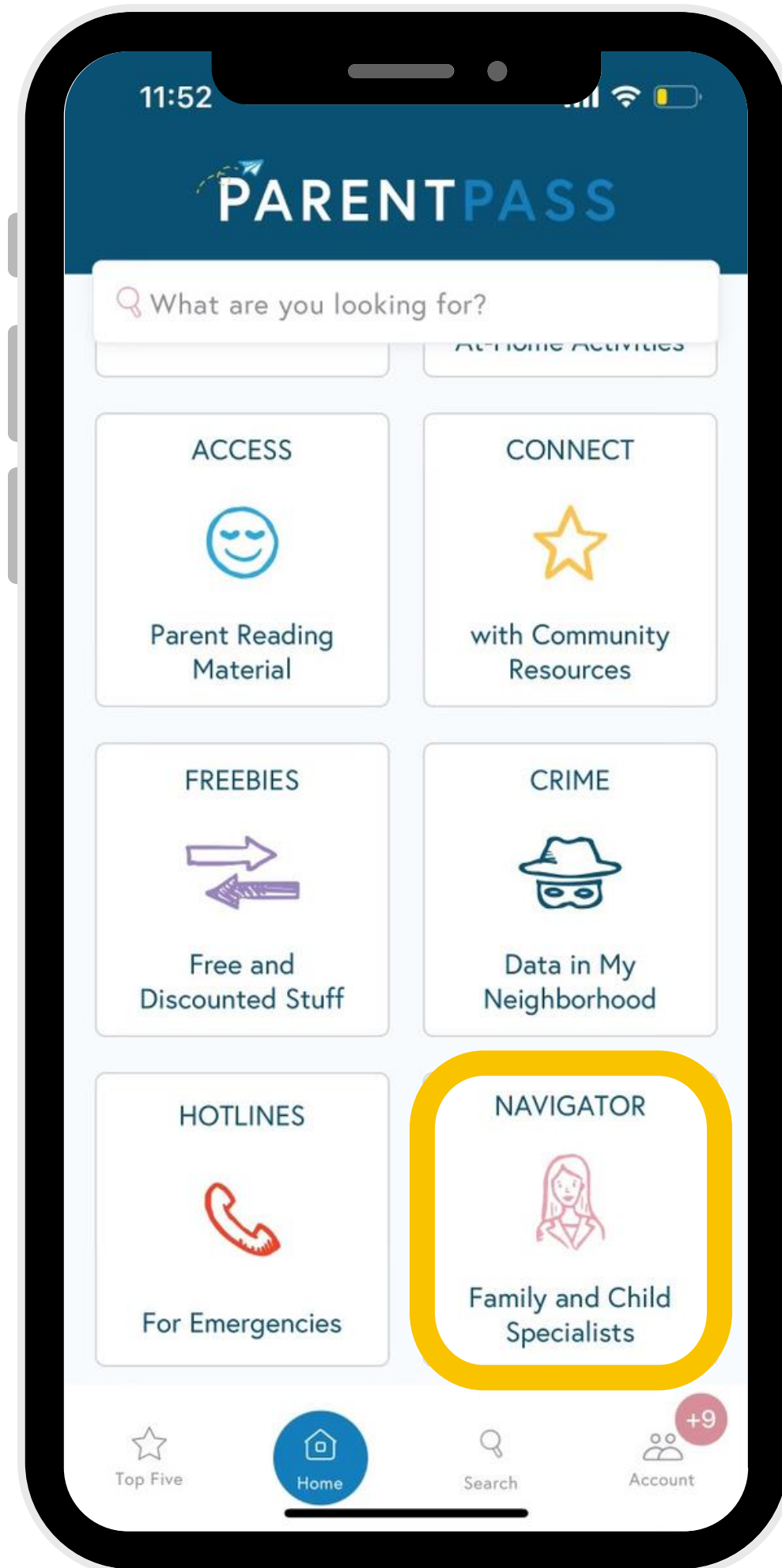
C

HMG Navigation at JPS

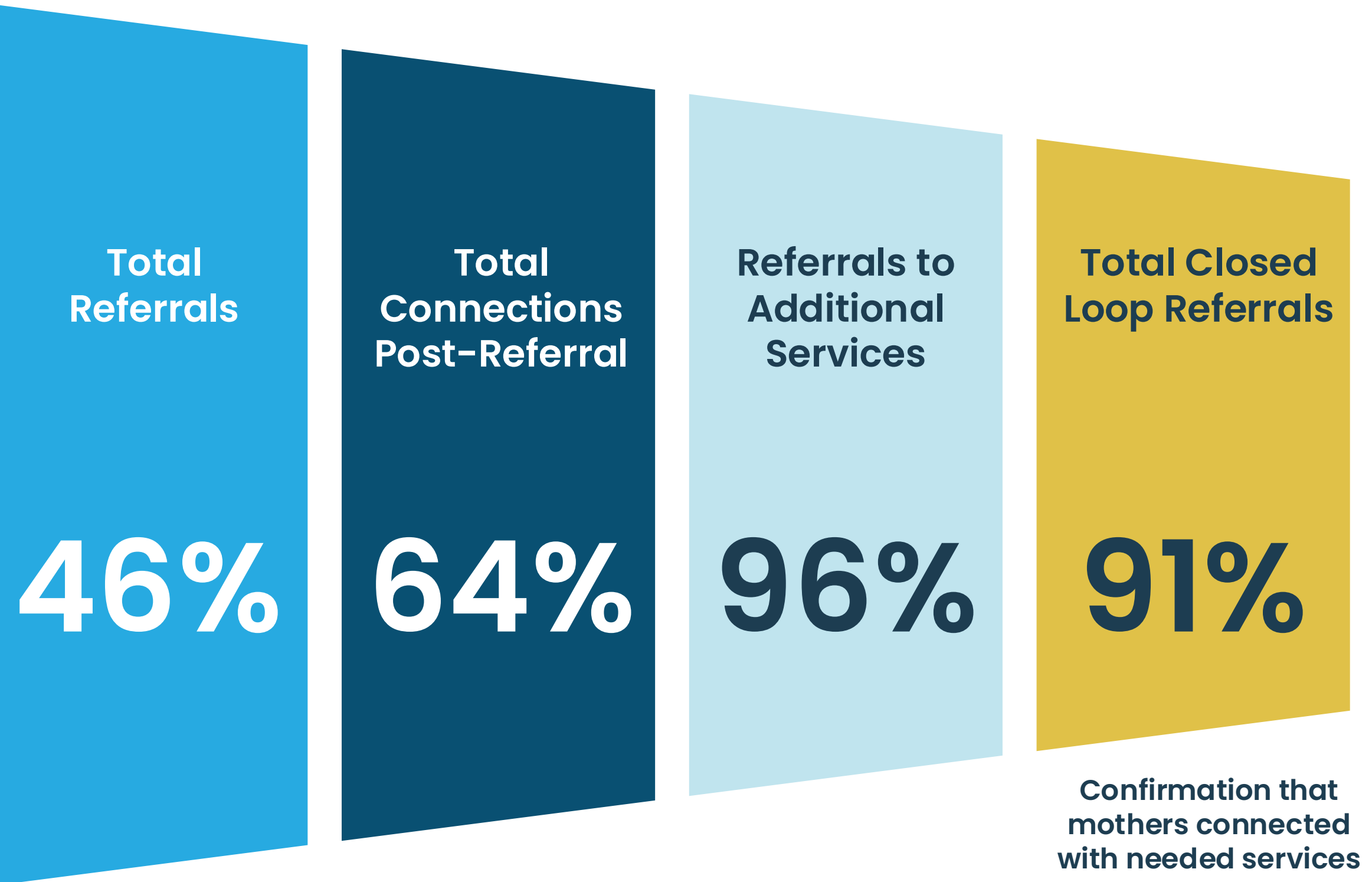
HMG Navigation at JPS: Place (and fund) a Perinatal (HMG) RN Navigator at JPS full time

LEVEL 3

Creating a Cohesive, Closed-Loop System of Care



Single
Connection Point
for Mothers



Key Goals & How We Will Measure Success

GOALS

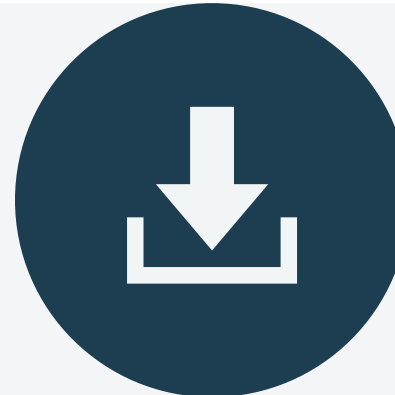
SUCCESS METRICS

Goal #1: Increase the number of closed-loop referrals to needed services for mothers participating in the pilot.



Success Metric #1: Number of closed loop referrals for mothers originated through pilot partners/locations.

Goal #2: Increase the number of Parent Pass™ downloads with new mothers in the hospital setting as a connecting and centralized resource for families.



Success Metric #2: Number of Parent Pass™ downloads per participating hospital location.

Goal #3: Improve maternal health outcomes for those mothers participating in the pilot.



Success Metric #3: % of hypertension patients treated prenatally, % of first trimester prenatal care, % of traumatic births, % of surveyed mothers reporting healthy post-partum and baby.

Goal #4: Capture and communicate meaningful, actionable data insights related to the closed-loop continuum of care for hospital partners and community stakeholders.



Success Metric #4: # of maternal health referral trends identified through the data, % of satisfied mothers participating in pilot, # of hospitals that agree to sustain investment of the pilot.

Maternal & Infant Health Coalition Pilot: Key Stats

2X Doubled the region's capacity of Help Me Grow navigators

100+ Hours of training across hospitals in last 90 days

91% On track to meet closed-loop referral success rate with mothers served

6 Major health systems engaged (and CC)

MIHC Pilot: Experience of Mothers

Priority Areas Identified

85%	Child Development
10%	Activities
8%	Food
5%	Utilities
2%	Legal
1%	Housing

Experience of Mothers

100%	of parents felt satisfied and listened to
100%	of parents felt the family navigator provided information and resources to address their concerns
100%	of parents felt better prepared to help their child and family

“The whole process felt so personalized and that my navigator truly cared about me and my family.”

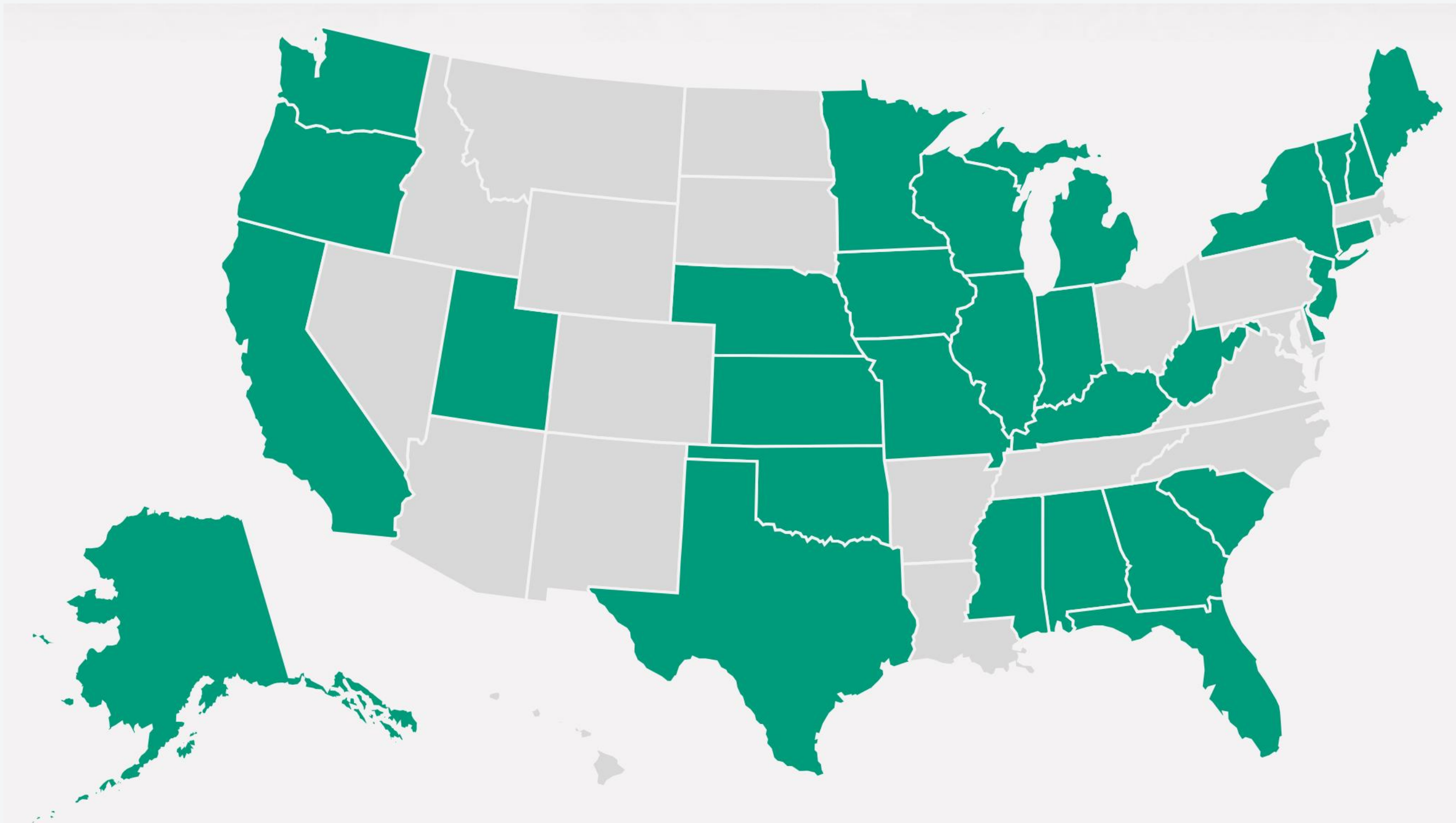
“The help and service I received was so good. The resources I have learned about were just what I needed as a new mom. Katherine was amazing.”

A woman with dark, curly hair is sitting and holding a baby. She is wearing an orange shirt. The baby is wearing a pink and white striped shirt. The background shows a wooden chair and a green plant. The text "Community Partner Highlights" is overlaid in white, bold font, with a white horizontal line underneath it.

Community Partner Highlights

Help Me Grow

Evidence-Based, National Model

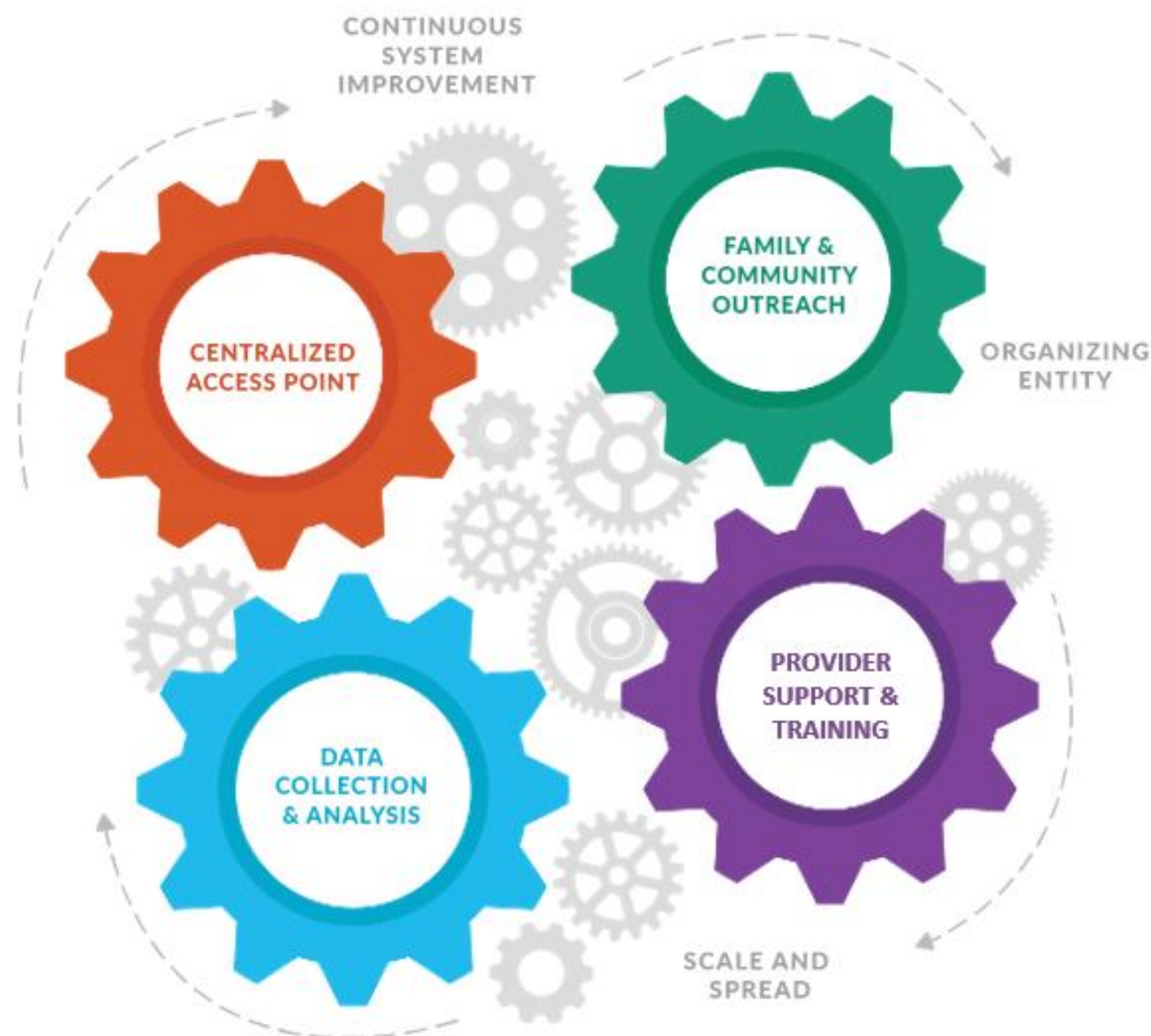


- **30 States**
- **Centralized Access Point**
- **Data Collection & Analysis**
- **Family & Community Outreach**
- **Child Health & Provide Outreach**

National Center Fidelity Assessment

HMG North Texas has met full implementation and fidelity of the National's Model Core Components

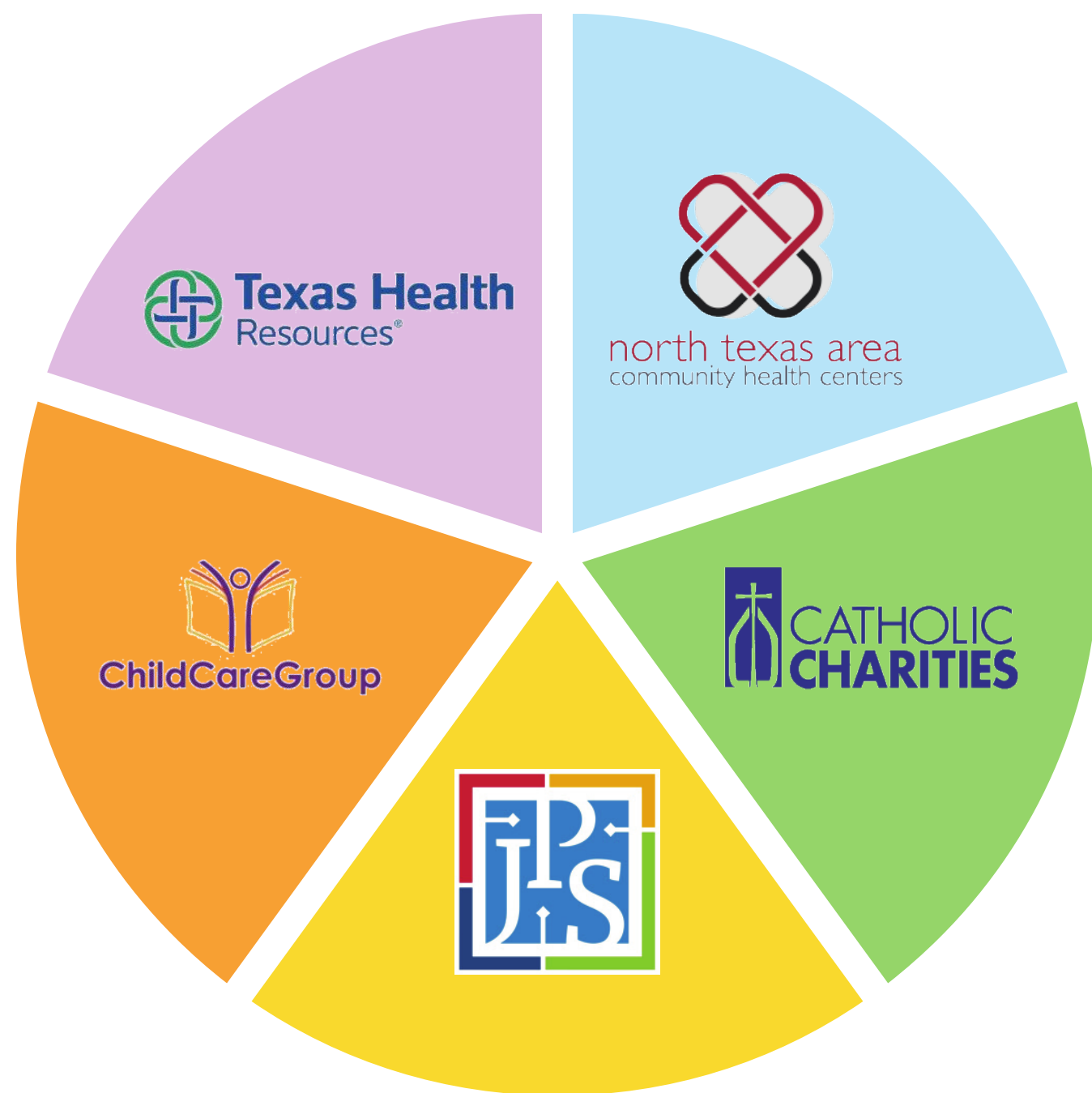
Model Core Components



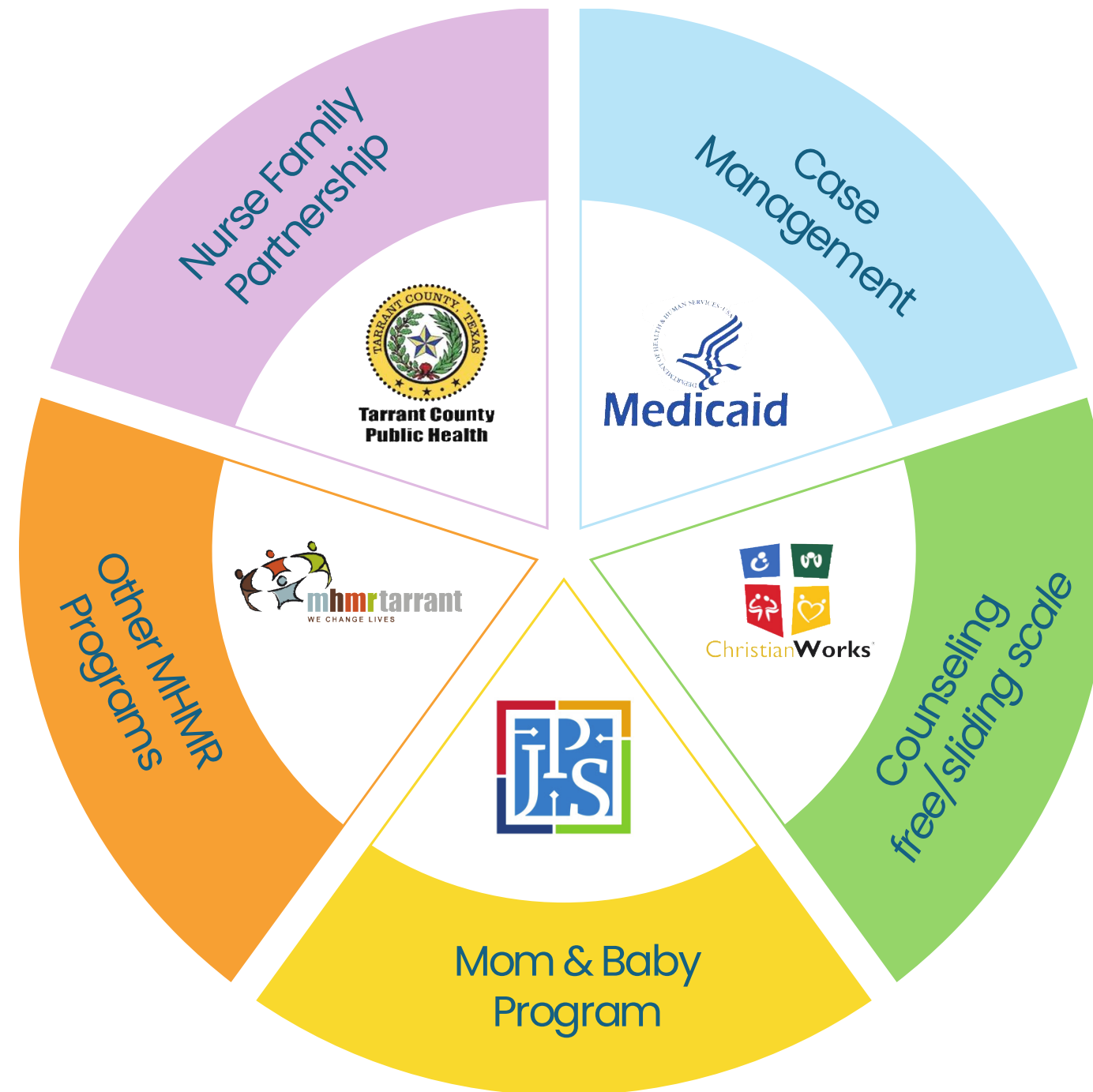
- Specialized child development phone line
- Linkage to service and follow-up
- Researching resources for families
- Real time directory maintenance

Navigation

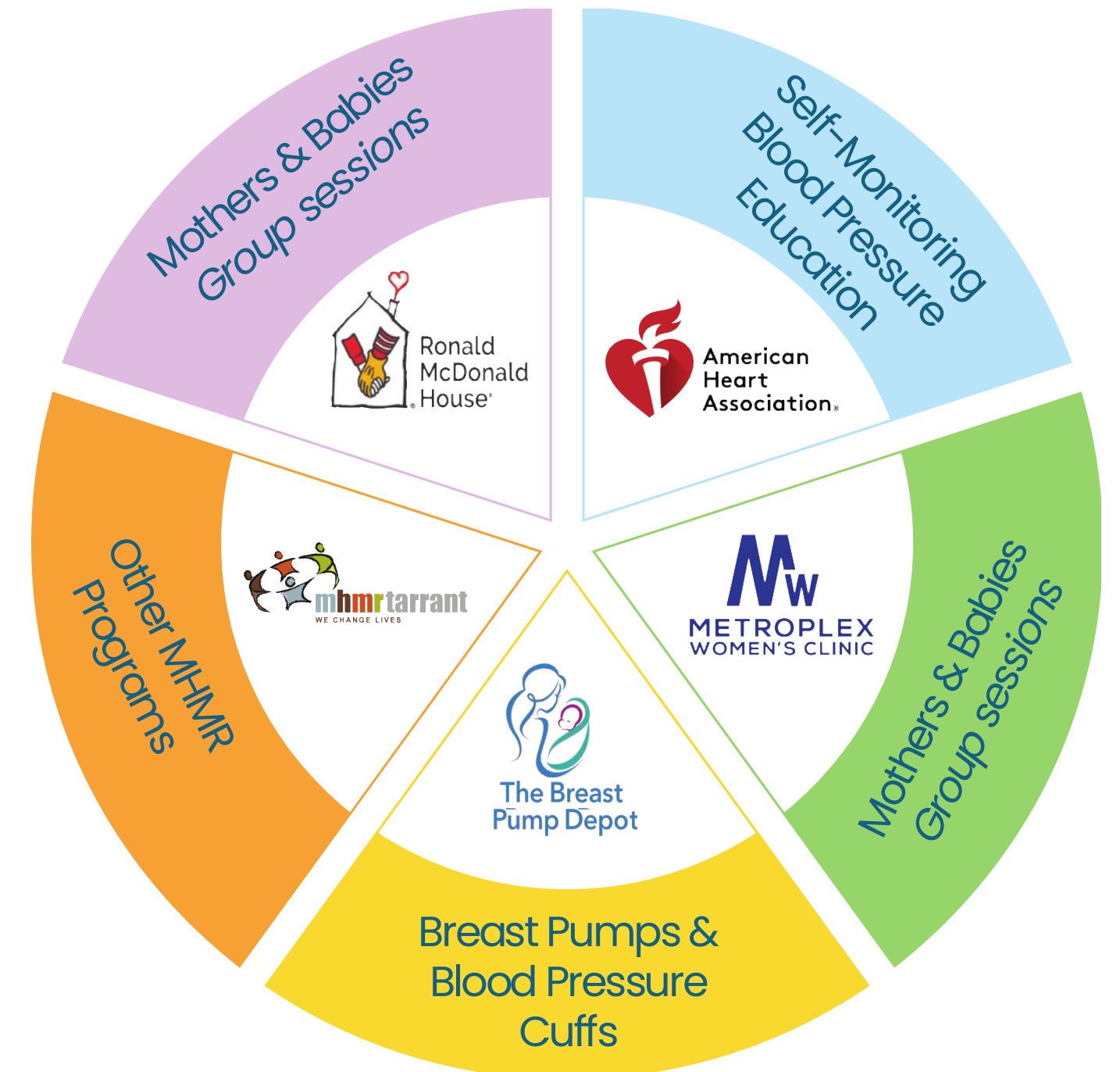
Navigation Partnerships



Community Referrals



Programming



Help Me Grow Data Snapshot – 2024 Year to Date

Community Referrals Received:
2,083

Referrals Provided by Perinatal Connections:
1,229

1,937

Clients received Perinatal Nurse Navigation



598

Prenatal Nurse Visits Completed



1,549

Comprehensive Postpartum Nurse Home Visits Completed



474

Mothers & Babies Sessions Delivered by Family Support Coaches



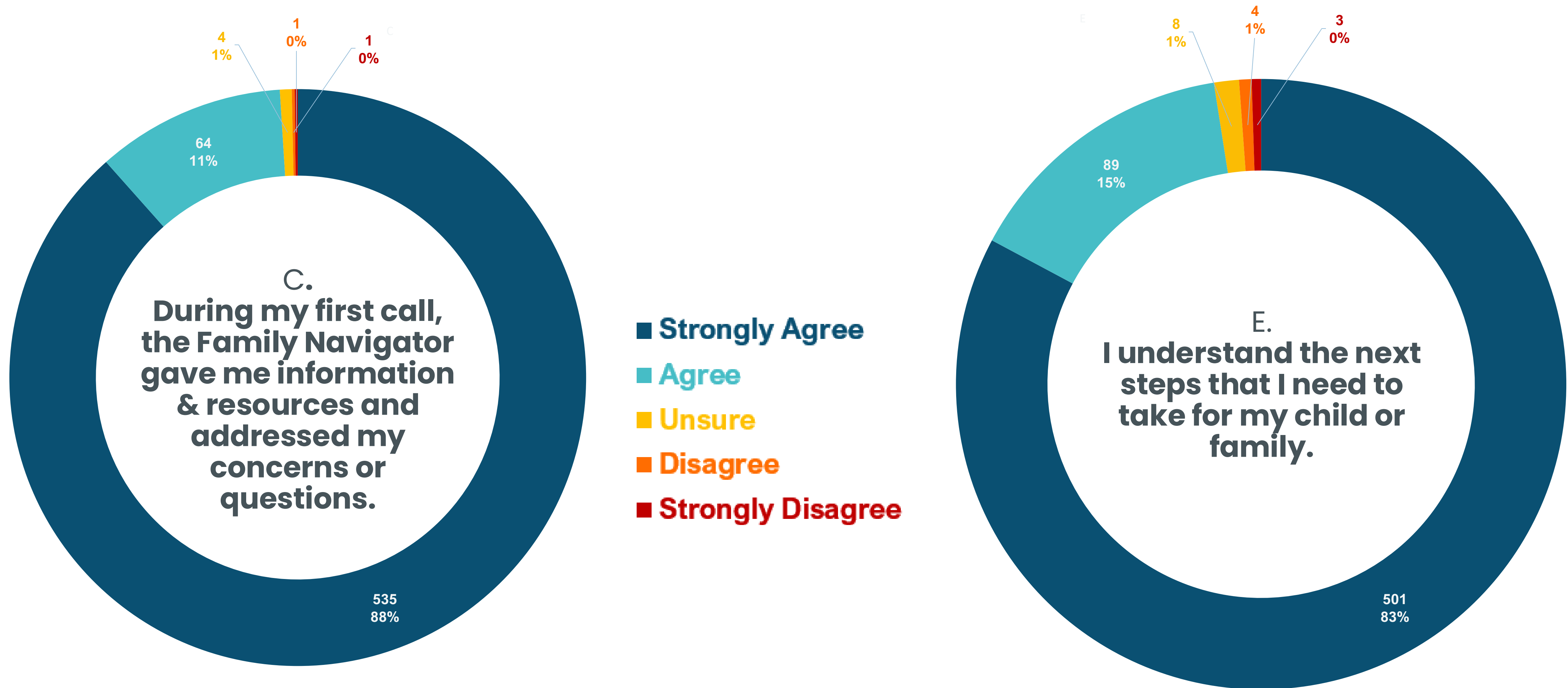
97%

of clients with a positive depression screening who were connected to follow up resources

99%

of clients that received a postpartum nurse home visit that received a depression screening

Help Me Grow North Texas Family Impact Survey





Douglas + Team Birth Initiatives



GET UNITED

OUR PROGRESS



MARCH 2023

Began outreach into the 76104 ZIP code area and surrounding community.



FALL 2023

Launched first doula training cohort in October.

Identified TeamBirth to support maternal health outcomes. Three-year collaboration created.



MARCH 2024

Started second 40-member doula cohort training.



JULY 2024

Launched first TeamBirth cohort of hospital systems.

Began third 40-member doula cohort training.



ONGOING

Track impact data and continue outreach to expand programs across Texas.

SEPT 2022



SUMMER 2023

Hosted focus groups and design sessions.
Opened applications for first 40-member doula training cohort.



JANUARY 2024

Introduced TeamBirth model integration to Tarrant County hospital system leaders.



MAY 2024

Announced first TeamBirth hospital system cohort.



AUGUST 2024

Met with TCU medical/nursing schools to discuss program integration.
Signed contract with OB COAP.

DOULA PROGRAM HIGHLIGHTS

120

Doulas graduated from training program

89

People registered for first 40-person cohort within 48 hours

5

Doulas hired onto the project and providing full spectrum/postpartum doula support to local women

21

Scholarships allocated to trained doulas to provide free care to their clients

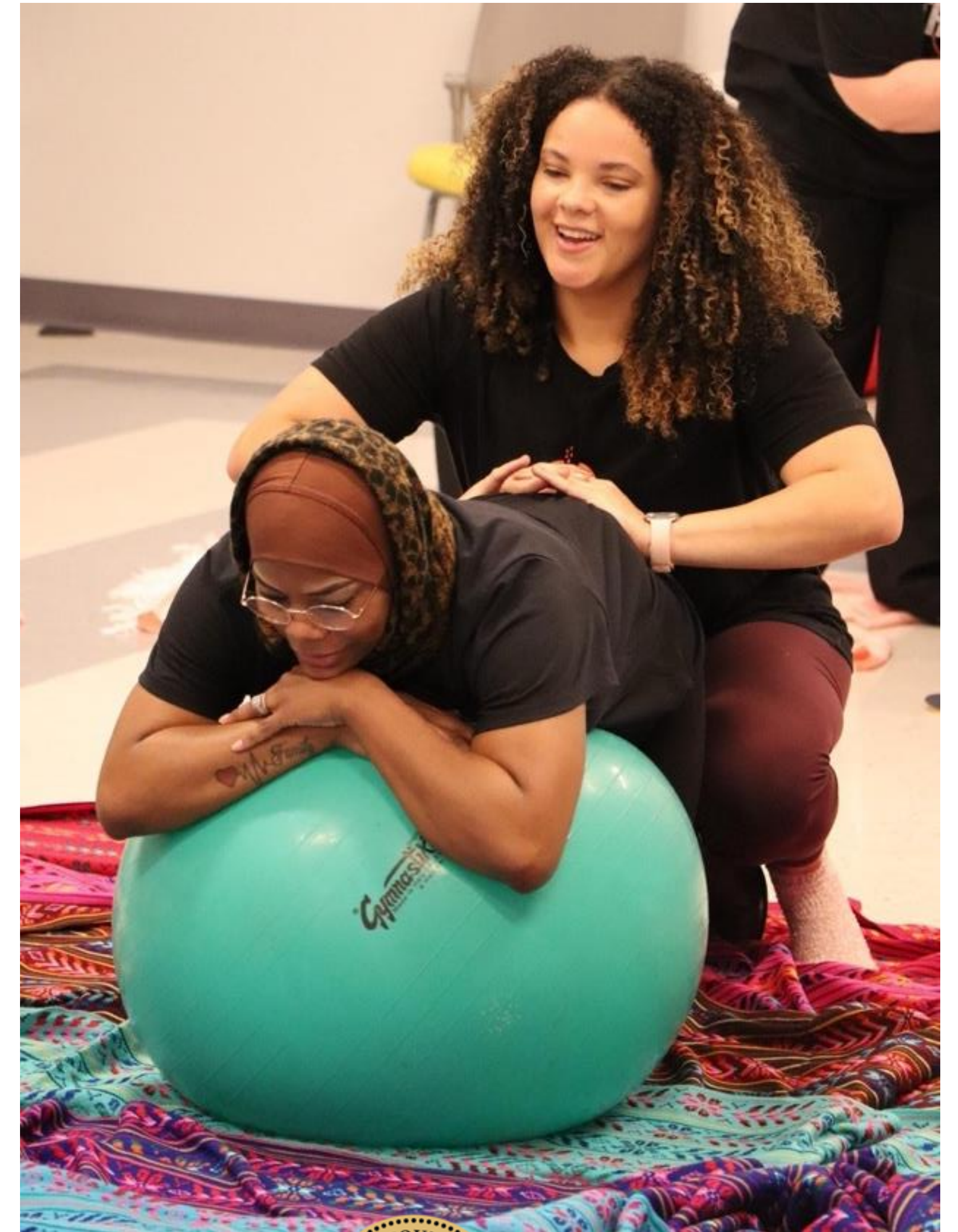
101

Moms currently receiving doula support*

42

Clients have successfully given birth with doula support*

*As of Nov. 20, 2024



ABOUT TEAMBIRTH

TeamBirth is a care process innovation involving a series of team huddles between the patient and their care team, **designed to empower each team member to contribute information, reliably structure communication and help the team arrive at shared plans together.**

WHO

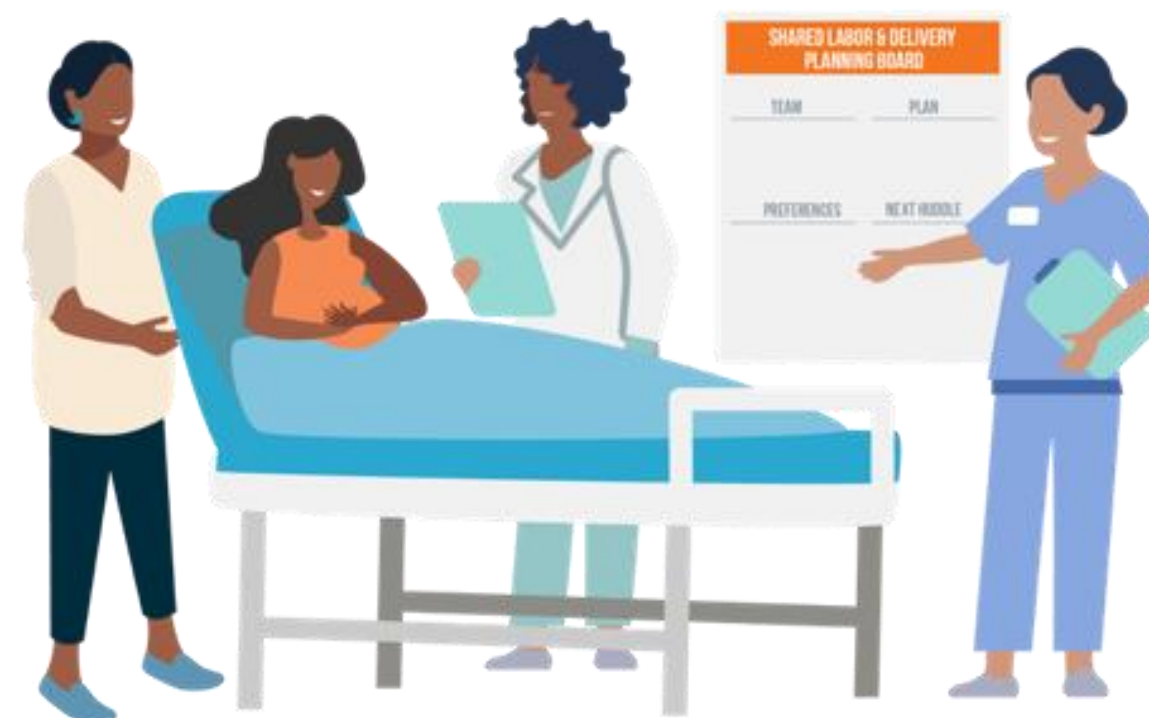
The **entire direct care team**, including the person in labor and their support

WHEN

At **admission** and at **major decision** points or **changes** in care plans throughout labor and postpartum

WHAT

Discuss preferences; care plans for mom and baby, labor progress* and expectations for the next huddle



WHY

Give all team members the **opportunity to participate** in shared decision-making

TEAMBIRTH SHOWS REDUCTIONS IN C-SECTIONS

Case Study: Oklahoma Hospital

An Oklahoma hospital reported improved clinical and staff retention outcomes after implementing TeamBirth.

↑ Nurse Retention

↑ Birth Volume

↓ NTSV Cesarean Birth Rate *

Significant and sustained decrease.

Hospital's NTSV Cesarean births

33%

Pre-launch

24%

Post-launch

* NTSV = Proportion of live babies born at or beyond 37 weeks to women in their first pregnancy, no twins or beyond and non-breech births

TCU Applied Research Overview

A 4-year research project for students at the Burnett School of Medicine:

1. Rediscover curiosity and questioning
2. Develop and refine skills for information discovery and critical appraisal
3. Human Subjects Training
4. Identify research Mentor/Team and construct project plan (2028 and beyond)
5. Complete research project of multiple types (data)
6. Write thesis and present poster



BURNETT
SCHOOL *of* MEDICINE

Current Student Projects on Maternal Health

Student	Mentor	
2025		
Troia, Thomas	Jay Herd (BAS)	RCT of a novel Bluetooth-enabled at home blood pressure monitoring of all postpartum patients, to decrease readmissions, morbidity, and mortality due to severe postpartum hypertensive crisis, versus standard postpartum follow up as recommended by ACOG
2026		
Duyile, Ope	Shanna Combs (Cook)	How Does Delivery of Postpartum Depression Preventative Strategies through a Perinatal Continuum of Services Impact Maternal Health? An Observational Study
Eletel, Lucy	David Riley (Cook)	Out of Hospital Birth Neonatal Outcomes
Jamali, Taylor	Andy Vu (JPS)	The success of vaginal delivery of at-term patients with BMI \geq 40 kg/m ² at John Peter Smith Hospital from 2017-2022
Maknojia, Joohi	Amy Raines (UNTHSC)	Postpartum Doula Support for Black Mothers
Noyes, Claire	Ariane Secrest (MHB)	The Experiences of Women Receiving Maternity Care at Birthing Centers
2027		
Conley, Mary	Ariane Secrest (MHB) and Dawn Elliot (TCU)	Maternal Mistreatment in Tarrant County
Johnson, Paige	Jacqueline Garda (BAS)	The Impact of Screening, Brief Intervention, and Refer to Treatment (SBIRT) Method on Maternal Substance Use



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ARPA-H

Final Application

Today's Opportunity: The ARPA-H Grant A Potential to Unlock \$45M for Maternal Health in North Texas

The Dallas-Fort Worth region has significantly higher rates of maternal mortality than the national average, impacting Black and Latina mothers disproportionately. To help advance proven clinical and innovative community-based solutions, key institutions and leaders across Dallas and Tarrant Counties partnered together to apply for an Advanced Research Project Agency for Health (ARPA-H) Federal Grant Opportunity to reduce obstetric complications by 20% over three years.

This would bring an unprecedented level of regional support to moms and babies, and reduce the number of local women dying from pregnancy-related complications by 600 annually. Beyond the promise of improving maternal health outcomes, these interventions would save \$60 million in health care costs for our region.



This opportunity builds upon the early success of the Tarrant County Maternal and Infant Health Coalition's work, combining the Coalition's pilot approach and partnership with proven clinical interventions underway at UT Southwestern. Core to the proposal are four intervention strategies that address maternal mortality at the individual, clinical, and community levels of care.

Today's Opportunity: The ARPA-H Grant A Potential to Unlock \$45M for Maternal Health in North Texas

Two co-
primes



Health Systems



Capabilities and Delivery Partners



Texas' second-largest community center



National leader in health analytics and advanced data science



Coalition manager and federal funding coordinator (CPAL)



Tarrant County Maternal and Infant Health Coalition

Operational partners



Scalable Interventions | Four Innovations Spanning the Care Continuum

The North Texas ARPA-H proposal includes four interventions that have shown evidence-based outcome improvements in the DFW patient population—but have not been scaled due to access barriers and inadequate preventive care incentives. Should North Texas be awarded this grant, these interventions will begin to be deployed at scale in Q1 2025.

Prepartum

1. Universally **provide iron supplementation** (on-site, no charge) to reduce intrapartum transfusions due to anemia

Intrapartum

2. Standardize **hospitals' simulation exercises** for hemorrhage events, “rehearsals” that increase speed of life-saving treatments

Postpartum

3. Discharge **hypertensive patients with blood pressure cuffs** coupled with virtual nurse visits to ensure at-home readings are taking place

4. Deploy cutting-edge population- and patient-level analytics to focus these interventions and existing community supports on most underserved communities and highest-risk patients

Thank you
to our partners
for making this
work possible.



United Way
of Tarrant County