HOUSE BILL REPORT
E2SSB 6534

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to establishing a maternal mortality review panel.

Brief Description: Establishing a maternal mortality review panel.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators O'Ban and Becker).

Brief History:
Committee Activity:
Health Care & Wellness: 2/24/16, 2/26/16 [DPA].

Brief Summary of Engrossed Second Substitute Bill
(As Amended by Committee)

- Establishes a maternal mortality review panel to conduct reviews of maternal deaths in Washington and make recommendations for evidence-based system changes and possible legislation to improve maternal outcomes and reduce preventable maternal deaths.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass as amended. Signed by 14 members: Representatives Cody, Chair; Riccelli, Vice Chair; Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Jinkins, Johnson, Moeller, Robinson, Short, Tharinger and Van De Wege.

Staff: Chris Blake (786-7392).

Background:

The federal Centers for Disease Control and Prevention (CDC) collects data related to pregnancy-related deaths. The data is collected by the CDC through the submission by each state of death certificates for all women who die during pregnancy or within one year of

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pregnancy. In addition, states submit corresponding birth certificates or fetal death certificates when making such a match is possible.

About 600 women in the United States die each year due to pregnancy or delivery-related complications. Since the CDC began collecting data in 1986, the trend in pregnancy-related mortality has increased from 7.2 pregnancy-related deaths per 100,000 live births in 1987 to 15.9 in 2012.

Summary of Amended Bill:

A maternal mortality review panel (panel) is established to conduct comprehensive, multidisciplinary reviews of maternal deaths in Washington, identify factors associated with these deaths, and make recommendations for system changes to improve health care services for women. The terms "maternal mortality" and "maternal death" mean the death of a woman while pregnant or within one year following delivery or the end of a pregnancy, whether or not the death is related to or aggravated by the pregnancy.

The panel is appointed by the Secretary of Health (Secretary) and may include an obstetrician, a physician specializing in maternal fetal medicine, a neonatologist, a licensed midwife, a Department of Health (Department) representative who works in the field of maternal and child health, a Department epidemiologist with experience analyzing prenatal data, a pathologist, and a representative of community mental health centers.

The Department must review available data to identify maternal deaths. The Department may access additional data to assist it in determining whether a maternal death was related to or aggravated by the pregnancy and whether the maternal death was preventable. The additional data include information related to specific maternal deaths such as medical records, autopsy reports, medical examiner reports, coroner reports, and social services records and information from health care providers, health care facilities, clinics, laboratories, and medical examiners, coroners, health professions and facilities, local health jurisdictions, the Health Care Authority and its licensees and providers, and the Department of Social and Health Services and its licensees and providers.

The panel must submit biennial reports to the Secretary and legislative health care committees beginning July 1, 2017. The report must include a description of the maternal deaths reviewed by the panel in the prior two years, including aggregated statistics and causes, and evidence-based system changes and possible legislation to improve maternal outcomes and reduce preventable deaths in Washington. The report must be distributed to relevant stakeholder groups for performance improvement.

Persons who attend panel meetings or prepare materials for the panel may not testify in civil or criminal actions about the panel's proceedings or information, documents, records, or opinions, unless the testimony relates to their personal knowledge acquired independently of the panel. Panel members and persons providing information to the panel are immune from civil damages.

Information, documents, proceedings, records, and opinions related to the panel are confidential and exempt from public inspection and copying. Such materials are also exempt from discovery or introduction into evidence in civil or criminal actions. The panel and the Secretary may only retain information identifying facilities related to occurrences of maternal deaths for the purpose of analysis over time.

The act expires June 30, 2020.

Amended Bill Compared to Engrossed Second Substitute Bill:

The amended bill adds specificity to legal protections for maternal mortality review panel (panel) members and materials by: (1) exempting panel information, proceedings, records, and opinions from discovery or as evidence in any criminal or civil action; (2) prohibiting persons attending review panel meetings or preparing materials for the review panel from testifying in any civil or criminal action as to the contents of the meeting or materials, unless the person has personal knowledge of the matter that is independent of the panel; and (3) providing immunity from civil damages to panel members. Information and documents related to maternal mortality reviews are confidential and exempt from public inspection and copying.

The amended bill eliminates the Department of Health's (Department) authority to obtain adverse event records related to maternal deaths. Upon request of the Department, identified health care providers, health care facilities, and government agencies and contractors must submit medical records, autopsy reports, medical examiner reports, coroner reports, social services records, information and records related to sexually transmitted diseases, and other requested data related to specific maternal deaths.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Amended Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) Washington used to have a maternal mortality review program, but it was eliminated during the recession. This was a real benefit when Washington had it. The ability for Washington to look at its data stopped in 2008 just as the rest of the country was reporting increasing rates of maternal mortality. The prior panel never had the ability to look at chart notes or autopsy reports, so the previous review panel was never able to get a handle on what was causing maternal mortality in Washington to allow for educational programs and improved access to care.

National maternal mortality rates have doubled over the last 30 years, but the rate in Washington is not known. It is important to analyze incidents of maternal deaths and do

everything possible to promote patient safety. California has a committee similar to the one in this bill and it allowed them to find the cause of much of the increase in maternal mortality and California's maternal mortality rates dropped by two-thirds in the last year. Without a program in statute, there is reluctance to move forward with this work. This bill has been included in the Senate budget.

(Opposed) None.

Persons Testifying: Senator O'Ban, prime sponsor; Sean Graham, Washington State Medical Association; and Dale Reisner, American College of Obstetrics.

Persons Signed In To Testify But Not Testifying: None.