SENATE BILL REPORT
SB 6534

As of February 4, 2016

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

Brief Description: Establishing a maternal mortality review panel.

Sponsors: Senators O'Ban and Becker.

Brief History:
Committee Activity: Human Services, Mental Health & Housing: 2/01/16.

SENATE COMMITTEE ON HUMAN SERVICES, MENTAL HEALTH & HOUSING

Staff: Alison Mendiola (786-7444)

Background: Maternal Mortality Subcommittee. In late 2000, in response to two maternal deaths that were initially thought to have similar causes, the State of Washington Perinatal Advisory Committee formed the Maternal Mortality Subcommittee.

Committee goals include: analyzing patterns by disease, hospital, provider types; attempting to identify preventable deaths and potential interventions; attempting to define an acceptable/ irreducible minimum incidence of maternal mortality; proposing enhancements to the system or make recommendations for a new system; and communicating information and trends to provider groups.

The maternal mortality surveillance subcommittee members include: perinatologists, obstetricians, nurses, midwives, epidemiologists, and Department of Health (DOH) staff. Reviews are conducted every two to three years. All deaths that occur within a year of pregnancy are reviewed. The review panel looks at all the data available concerning these deaths and their circumstances, and may include a death certificate; a birth/fetal death certificate for deaths that linked to a live birth or fetal death within a year before death; and any hospitalization data on deaths that occurred within a year of a hospitalization for pregnancy or delivery.

The subcommittee then makes an assessment based on timing of the death relative to the pregnancy, taking into account any risk factors, diagnoses or procedures to identify cause of death. The subcommittee identifies two groups of deaths: pregnancy-associated deaths (deaths within one year of delivery due to any cause) and pregnancy-related deaths (subset of

---

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

pregnancy-associated deaths that only includes women whose death was caused by the pregnancy or a condition that was exacerbated by pregnancy). This second group is what most people refer to as maternal death. Due to limited resources, there is limited staffing for this subcommittee.

Summary of Bill: Maternal Mortality Review Panel. A maternal mortality review panel (Review Panel) is established to conduct comprehensive, multidisciplinary reviews of maternal deaths to identify factors associated with the death and make recommendations for system changes to improve healthcare services for women.

"Maternal mortality" or "maternal death" means a death of a woman while pregnant or within one year following the end of pregnancy, whether or not the woman's death is a result of the pregnancy.

The members of the Review Panel are appointed by the Secretary of the DOH, serve without compensation, and include:

- an obstetrician;
- a physician specializing in maternal fetal medicine;
- a neonatologist;
- a midwife;
- an advanced registered nurse practitioner who practices in obstetrics;
- a representative from DOH who works in the field of maternal and child health;
- a DOH epidemiologist with experience analyzing perinatal data;
- a medical examiner;
- a representative of the community mental health centers; and
- a member of the public.

The Review Panel's proceedings, records, and opinions are confidential and not subject to public disclosure. Panel members may not be questioned in any civil or criminal proceeding regarding the information presented in, or opinions formed as a result of, a meeting of the panel.

All individually identifiable information must be removed before any case review by the panel.

Health care providers, health care facilities, clinics, laboratories, and medical examiners are to report maternal deaths to the review panel and to the Secretary of the DOH. If a root cause analysis of a maternal death has been completed, the findings of the analysis must be provided to the review panel.

Reporting requirements. By July 1, 2017, and annually thereafter, the review panel must submit a report to the Secretary of DOH and to the Legislature. The report must protect the confidentiality of all decedents and other participants involved.

The report must include: a description of the adverse events reviewed by the panel during the preceding twelve months, including statistics and causes; correction action plans to address adverse events; and recommendations for system changes and legislation relating to the delivery of health care.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: This bill is a work in progress. The State previously had this type of review panel but its budget was cut during the recession. Other states have similar panels - having the panels helps reduce maternal death. In California preventable maternal deaths went down two thirds and, based on findings in Colorado, they are now looking at depression. In Washington, over 85,000 women give birth each year. The last time this panel met was in 2012, but the last time data was discussed was 2009. We are long over due for a look at what is going on in Washington. Maternal deaths have doubled in the United States over the last 30 years. This is not a women's issue but a human issue.

Persons Testifying: PRO: Sean Graham, Washington State Medical Association; and Dr. Jane Dimer, American Congress of Obstetricians and Gynecologists (ACOG).

Persons Signed In To Testify But Not Testifying: No one.