SENATE BILL REPORT
SB 6534

As Reported by Senate Committee On:
Human Services, Mental Health & Housing, 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, 2/04/16 [DPS-WM].

SENATE COMMITTEE ON HUMAN SERVICES, MENTAL HEALTH & HOUSING

Majority Report: That Substitute Senate Bill No. 6534 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.
Signed by Senators O'Ban, Chair; Miloscia, Vice Chair; Darneille, Ranking Minority Member; Hargrove and Padden.

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

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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 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 (Recommended Substitute): 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 of delivering or following the end of pregnancy, whether or not the woman's death is related or aggravated by 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 with licensure in Washington;
- a representative from DOH who works in the field of maternal and child health;
- a DOH epidemiologist with experience analyzing perinatal data;
- a pathologist;
- 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 within 90 days of the death 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 biennially 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 24 months, including statistics and causes; evidence-based system changes, and possible legislation to improve maternal outcomes and reduce preventable maternal deaths in Washington.

EFFECT OF CHANGES MADE BY HUMAN SERVICES, MENTAL HEALTH & HOUSING COMMITTEE (Recommended Substitute): The definition of "maternal death" is clarified. The review panel will not include an adverse registered nurse practitioner or a medical examiner but will include a pathologist. The midwife that serves on the panel must be licensed in WA. It is clarified where the review panel will get its information and what information will be used in its review. Deaths reported to the panel must be done within 90 days of the death. The report required is to be submitted biennially - as opposed to annually. The panel is to report on evidence-based system changes and possible legislation to improve maternal outcomes and reduce preventable maternal deaths in Washington.

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 on Original Bill: 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 on Original Bill: 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 on Original Bill: No one.