

SENATE BILL REPORT

E2SSB 6534

As Amended by House, March 3, 2016

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: Human Services, Mental Health & Housing: 2/01/16, 2/04/16 [DPS-WM].

Ways & Means: 2/08/16, 2/09/16 [DP2S].

Passed Senate: 2/16/16, 49-0.

Passed House: 3/03/16, 95-0.

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)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 6534 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Hill, Chair; Braun, Vice Chair; Dammeier, Vice Chair; Honeyford, Vice Chair, Capital Budget Chair; Hargrove, Ranking Member; Keiser, Assistant Ranking Member on the Capital Budget; Ranker, Ranking Minority Member, Operating; Bailey, Becker, Billig, Brown, Conway, Darneille, Hasegawa, Hewitt, Nelson, O'Ban, Padden, Parlette, Pedersen, Rolfes, Schoesler and Warnick.

Staff: Mark Eliason (786-7454)

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.

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 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 Engrossed Second Substitute 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 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 may 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; and
- a representative of the community mental health centers;

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.

DOH shall identify maternal deaths. DOH has the authority to request and receive data for specific maternal deaths from health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, professions and facilities licensed by DOH, local health jurisdictions, the Health Care Authority, and the Department of Social and Health Services.

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 maternal deaths 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.

The Act expires on June 30, 2020.

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 (Human Services, Mental Health & Housing): 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 (Human Services, Mental Health & Housing): 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.

Staff Summary of Public Testimony on First Substitute (Ways & Means): PRO: This bill is a priority of the Medical Association, as it is a very important issue. The bill is still a work in progress, the proponents are working with the Department of Health to get the estimated costs down.

Persons Testifying on First Substitute (Ways & Means): PRO: Sean Graham, Washington State Medical Association.

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

House Amendment(s):

- 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.
- Eliminates the Department of Health's 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.