HOUSE BILL REPORT
SSB 5425

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to maternal mortality reviews.

Brief Description: Concerning maternal mortality reviews.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Cleveland, Keiser, Becker and Hasegawa; by request of Department of Health).

Brief History:
Committee Activity:
Health Care & Wellness: 3/15/19, 3/20/19 [DP].

Brief Summary of Substitute Bill

- Modifies the definition of "maternal death" for purposes of the Maternal Mortality Review Panel (Panel) and the composition of the Panel.
- Allows the Panel to retain and obtain identifiable data for purposes of quality improvement.
- Allows the Panel to share data or findings with other public health agencies and tribes pursuant to a data sharing agreement.
- Repeals the provision that would have expired the Panel on June 30, 2020.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 15 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Chambers, Davis, DeBolt, Harris, Jinkins, Maycumber, Riccelli, Robinson, Stonier, Thai and Tharinger.

Staff: Kim Weidenaar (786-7120).

Background:

Maternal Mortality Review Panel.

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.

In 2016 the Maternal Mortality Review Panel (Panel) was 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 Panel and Secretary may retain identifiable data regarding facilities where maternal deaths occur or from where the patient was transferred and geographic data on each case for the sole purposes of trending and analysis over time. 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 panel expires June 30, 2020.

Autopsy Reimbursement.
Generally the cost of an autopsy is borne by the county in which the autopsy is performed. However, there are instances in which some costs may be reimbursed by the death investigations account or by the Department of Labor and Industries when an autopsy was requested by the Department of Labor and Industries.

Summary of Bill:

The Maternal Mortality Review Panel (Panel) must include at least one tribal representative, and may include at the discretion of the Department of Health (Department): women's medical, nursing, and service providers' perinatal medical, nursing, and service providers; obstetric medical, nursing, and service providers; newborn or pediatric medical, nursing, and service providers; birthing hospital or licensed birth center representative; coroners, medical examiners, or pathologists; behavioral health or service providers; state agency representatives; individuals or organizations that represent the populations most affected by pregnancy related deaths or pregnancy associated deaths and lack access to maternal health services; in addition to the representative from the Department who works in maternal and child health and a Department epidemiologist with experience analyzing perinatal data.

"Maternal mortality" or "maternal death" is defined as a death of a woman while pregnant or within one year of the end of a pregnancy from any cause.

The Panel and the Department may retain identifiable information regarding facilities where maternal deaths occur, or facilities from which the patient was transferred, and geographic information on each case for the purposes of quality improvement efforts, in addition to determining trends and performing analysis over time.

The Department may access additional data related to maternal deaths for the purposes of coordinating quality improvement efforts in addition to determining whether a maternal death was related to or aggravated by a pregnancy or if it was preventable. The Department is also authorized to access data related to specific maternal deaths from the Department of Children, Youth, and Families and its licensees and providers.

The Panel must submit a report by October 1, 2019, and then every three years.

The Department may release data or findings with indirect identifiers to the centers for disease control and prevention, regional maternal mortality review efforts, local health jurisdictions of Washington, or tribes at the Department's discretion if provided through a signed written data-sharing agreement. The agreement must:

- include a description of the proposed purpose of the request, the scientific justification, the type of data needed, and the purpose for which the data will be used;
- include the methods to be used to protect the confidentiality and security of the data;
- prohibit redisclosure of any identifiers unless there is express permission from the Department;
- prohibit the recipient of the data from attempting to identify persons whose information is included in the data set;
- state that ownership of data provided remains with the Department; and
- require the recipient of the data to include appropriate citations when the data is used in research reports, publications, or findings.

The Department may deny a request for data or findings that does not meet these requirements.

Hospitals and licensed birth centers must make a reasonable and good faith effort to report within 36 hours of death all deaths that occur during pregnancy or within 42 days of the end of pregnancy to the local coroner or medical examiner. Coroners or medical examiners notified of a maternal death must conduct a death investigation and an autopsy is strongly recommended. Autopsies performed must follow the Department's guidelines for performance of an autopsy and must be reimbursed at 100 percent to the counties for autopsy services.

The authority to disclose mental health information and records without an authorization is amended to include the Secretary of Health for purposes of the panel.

The provision expiring the panel on June 30, 2020, is repealed.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) This bill makes the mortality review panel permanent and aligns with Centers for Disease Control and Prevention recommendations. There is a lot of support for the bill and the changes that were made. This bill will improve birth outcomes and women's health in Washington.

The panel was created in a bill passed in 2016. A lot of work has been done by the panel to look for trends and possible ways to prevent deaths, but there is still much work to be done. Without this bill the panel will sunset and the panel has just begun to scratch the surface to make an impact on maternal deaths. There are known pregnancy related deaths that happen after 42 days and so extending the definition is needed. There are also significant racial and ethnic disparities. There is a four times greater death rate for African Americans and eight times greater rate for Native Americans.

There are many things that still need to examined and analyzed. The panel is only just beginning to be able to look into why these death occur. There are still many questions such as why some woman die from hemorrhage and others do not. Trends continue to change and there is still a lot to learn. Each mother who dies leaves behind a devastated family and at least one motherless child. There needs to be an ability to do something with this information so that these deaths do not continue.

(Opposed) None.

Persons Testifying: Lacy Fehrenbach, Department of Health; and Dale Reisner, American College of Obstetricians and Gynecologists.

Persons Signed In To Testify But Not Testifying: None.