Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1074

Brief Description: Concerning overdose and suicide fatality reviews.

Sponsors: Representatives Peterson, Rude, Leavitt, Wylie, Kloba, Ortiz-Self, Callan, Riccelli, Davis and Pollet.

Brief Summary of Bill

- Allows local health departments to establish overdose and suicide fatality review teams to review overdose or suicide deaths and develop strategies to prevent future overdose and suicide deaths.

Hearing Date: 1/14/21

Staff: Sarah Cooper (786-7290) and Kim Weidenaar (786-7120).

Background:

Maternal Mortality Review Panel.
The Maternal Mortality Review Panel conducts comprehensive, multidisciplinary reviews of maternal deaths in Washington, identifies factors associated with these deaths, and make recommendations for system changes to improve health care services for women. Information, documents, proceedings, records, and opinions related to the panel are confidential and exempt from public inspection and copying, discovery, or introduction into evidence in civil or criminal actions.

Child Mortality Reviews.
Local health departments are authorized to conduct child mortality reviews. This process may include a systemic review of medical, clinical, and hospital records; home interviews of parents and caretakers of children who have died; analysis of individual case information; and review by

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a team of professionals in order to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with the death.

Washington State Suicide Prevention Plan.
The Department of Health, with advice from the State Suicide Prevention Plan Steering Committee, oversees a statewide suicide prevention plan for people of all ages. The State Suicide Prevention Plan examines data relating to suicide to recognize patterns and key demographic factors; identifies key risk and protective factors relating to suicide; and identifies goals, action areas, and implementation strategies relating to suicide prevention.

Washington State Opioid Response Plan.
The Washington State Opioid Response Plan was created to prevent opioid misuse and abuse; identify and treat opioid use disorder; reduce morbidity and mortality from opioid use disorder; and use data and information to detect misuse and abuse, monitor morbidity and mortality, and evaluate interventions. The State Opioid Response Plan is implemented by state government agencies, local health departments, professional groups, and community organizations.

Uniform Health Care Information Act.
The state Uniform Health Care Information Act (UHCIA) governs the disclosure of health care information by health care providers and their agents or employees. The UHCIA provides that a health care provider may not disclose health care information about a patient unless there is a statutory exception or written authorization by the patient.

Summary of Bill:

Local health departments may establish overdose and suicide fatality review teams to review overdose or suicide deaths and develop strategies to prevent future overdose and suicide deaths. Local health departments may request medical records, autopsy reports, medical examiner reports, coroner reports, school records, criminal justice records, law enforcement reports, and social services records relating to specific overdose or suicide fatalities to conduct an overdose or suicide fatality review. Upon request, health care providers, health care facilities, clinics, schools, criminal justice, law enforcement, laboratories, medical examiners, coroners, professions and facilities licensed by the Department of Health, local health jurisdictions, the Department of Health, the Department of Social and Health Services, and the Department of Children, Youth, and Families must provide all data requested for specific overdose or suicide fatalities to perform an overdose or suicide fatality review to the local health department.

"Overdose or suicide fatality review" is defined as a process to review minor or adult suicide or overdose deaths. This process may include a systematic review of records, interviews, analysis of individual case information, and review of this information by a team of professionals to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with each death.

The Department of Health will aid and support local health departments by assisting local health

departments in collecting reports of suicide or overdose fatality reviews conducted by local health departments, providing technical assistance to local health departments and suicide and overdose review teams (review teams), and encouraging communication among review teams.

Information, documents, proceedings, records, and opinions related to the review teams are confidential, subject to the restrictions on disclosure provided in the Uniform Health Care Information Act, and exempt from public inspection and copying. Such materials can only be used by the review team for an overdose or suicide fatality review. Local health departments may publish statistical compilations and reports related to overdose or suicide fatality reviews; however, any portions of these compilations and reports that identify individual cases and sources of information must be redacted.

Materials collected by review teams for overdose or suicide fatality reviews are exempt from discovery or introduction into evidence in civil or criminal actions. Individuals who participated in activities relating to the review team are exempt from testifying in a civil or criminal action, except when the individual has personal knowledge independent from the panel or public knowledge.

Appropriation: None.

Fiscal Note: Requested on January 7, 2021.

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