HOUSE BILL REPORT
HB 1074

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to overdose and suicide fatality reviews.

Brief Description: Concerning overdose and suicide fatality reviews.

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

Brief History:
Committee Activity:
Health Care & Wellness: 1/14/21, 1/20/21 [DPS].

Brief Summary of Substitute 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.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 15 members: Representatives Cody, Chair; Bateman, Vice Chair; Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Bronoske, Davis, Harris, Macri, Maycumber, Riccelli, Rude, Simmons, Stonier, Tharinger and Ybarra.

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

Background:

Maternal Mortality Review Panel.
The Maternal Mortality Review Panel conducts comprehensive, multidisciplinary reviews

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of maternal deaths in Washington, identifies factors associated with these deaths, and makes 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 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 (DOH), 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.

Prescription Monitoring Program.
The DOH maintains a prescription monitoring program (PMP) to monitor the prescribing and dispensing of all Schedule II, III, IV, and V controlled substances. Generally, prescription information submitted to the DOH is confidential; however, data in the PMP may be accessed by authorized individuals and entities.

Summary of Substitute Bill:

Local health departments may establish overdose and suicide fatality review teams (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 relating to an overdose or suicide, 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 (DOH), local health jurisdictions, the DOH, 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. However, the DOH may only provide information and records consistent with the Uniform Health Care Information Act and the prescription monitoring program statutes.

"Overdose or suicide fatality review" is defined as a confidential process to review minor or adult suicide or overdose deaths. This process may include a systematic review of records, confidential 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 DOH will aid and support local health departments by assisting local health departments in collecting reports of overdose or suicide fatality reviews conducted by local health departments, providing technical assistance to local health departments and 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. Further, all information, documents, proceedings, records, and opinions collected by the review teams are 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 review; 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 review 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.

Substitute Bill Compared to Original Bill:

The substitute bill: (1) allows the Department of Health to respond to requests for data to the extent permitted by the prescription monitoring program; (2) changes any reference to "panel" to "overdose and suicide fatality review team"; (3) limits medical records to medical records related to overdose or suicide; (4) clarifies that review teams may only request records relating to an overdose or suicide; (5) requires all meetings, proceedings and deliberations of the overdose and suicide fatality review team to be confidential; and (6) reaffirms the confidentiality of the overdose and suicide fatality review team's process and interviews.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) The crisis of suicide and opioid overdose is not new and has been exacerbated by the pandemic. This bill would give county health departments the ability to gather information to find trends and solutions with the goal of preventing deaths. Similar review teams have already been effective at addressing child and maternal mortality. This is a voluntary bill that would not provide real budget constraints.

(Opposed) None.

(Other) Although the overdose and suicide review teams are intended to operate a confidential and protected process, the language requires perfecting to preserve confidentiality. For example, the bill includes discretionary language when it should provide clear and mandatory protection of records. Furthermore, the term "medical records" should be narrowed to refer only to medical records related to overdose and suicide. Overall, this bill needs to be tightened up to make sure the review process is truly confidential and protected.

Persons Testifying:

(In support) Representative Peterson, prime sponsor.

(Other) Lisa Thatcher, Washington State Hospital Association.

Persons Signed In To Testify But Not Testifying: None.