

SENATE BILL REPORT

SHB 1074

As of February 15, 2022

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

Brief Description: Concerning overdose and suicide fatality reviews.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Peterson, Rude, Leavitt, Wylie, Kloba, Ortiz-Self, Callan, Riccelli, Davis and Pollet).

Brief History: Passed House: 1/21/22, 97-0.

Committee Activity: Behavioral Health Subcommittee to Health & Long Term Care: 3/12/21, 3/19/21 [DP]; 2/15/22.

Brief Summary of Bill

- Allows local health departments to establish multidisciplinary overdose and suicide fatality review teams to review overdose or suicide deaths and to develop strategies for the prevention of overdose and suicide deaths.
- Provides for confidentiality and technical assistance by the state Department of Health.

SENATE COMMITTEE ON BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE

Staff: Kevin Black (786-7747)

Background: A local health department is a county or district which provides public health services in a given area. Local health boards have the power to supervise the maintenance of health and sanitary measures for the protection of public health within their jurisdiction, and may enact local rules and regulations and provide for the control of dangerous,

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contagious, or infectious disease.

Health Review Panels. Several health review panel provisions exist in state law.

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 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 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.

Summary of Bill: A local health department may establish multidisciplinary overdose and suicide fatality review teams to review overdose or suicide deaths and to develop strategies for the prevention of overdose and suicide fatalities. The Department of Health must assist by responding to requests for data, providing technical assistance to review teams, encouraging communication among review teams, and entering the reports into a database.

Health care information, documents, proceedings, records, and opinions collected as part of an overdose or suicide fatality review are confidential and may be used solely by local health departments for the review. These documents are not subject to public inspection and may not be subject to discovery or introduction into evidence in any civil or criminal action, nor may a participant be required to testify regarding the review proceedings. Review team members may not be subject to civil action based on their participation in the

review team. Meetings and deliberations of the review team are confidential and must be conducted in executive session. Local health departments may publish statistical compilations and reports related to overdose and suicide fatalities with personally identifying information redacted.

An overdose and suicide fatality review team may request and receive data from health care providers, health care facilities, clinics, schools, criminal justice, law enforcement, laboratories, medical examiners, coroners, professional and facilities licensed by the Department of Health, local health jurisdictions, the Health Care Authority, Department of Health, Department of Social and Health Services, Department of Children, Youth, and Families, and their licensees and providers. Examinations may proceed through a medical examiner, coroner, or other process identified by the local department of health.

Appropriation: None.

Fiscal Note: Available.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony (Regular Session 2022): PRO: The need for community-based strategies to address overdose and suicide deaths has only been exacerbated by the pandemic. This is the next critical area of work for our health system. Information helps develop and implement community-based strategies to address the causes of these deaths. As opioids became an undeniable health crisis, community efforts to gather information have been frustrated by data-gathering barriers. I cannot overstate the value of investigation and data in protecting communities. This bill creates a valuable tool for public health to fulfill its mission to prevent injury or death, mirroring the child death review process. Please amend the bill to include withdrawal deaths. Please require DOH to examine this data on an aggregate level to identify patterns revealed on a statewide level to look for solutions.

Persons Testifying: PRO: Marc Stern; Jaime Boddin, WSALPHO; Jefferson Ketchel, WSPHA.

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