

FINAL BILL REPORT

E2SSB 6534

C 238 L 16
Synopsis as Enacted

Brief Description: Establishing a maternal mortality review panel.

Sponsors: Senate Committee on Ways & Means (originally sponsored by Senators O'Ban and Becker).

Senate Committee on Health Care
Senate Committee on Human Services, Mental Health & Housing
Senate Committee on Ways & Means
House Committee on Health Care & Wellness
House Committee on Appropriations

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 (Department) 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

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most people refer to as maternal death. Due to limited resources, there is limited staffing for this subcommittee.

Summary: A maternal mortality review panel (panel) is 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 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 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 bill is null and void if it is not funded in the budget. The act expires June 30, 2020.

Votes on Final Passage:

Senate	49	0	
House	95	0	(House amended)
Senate	47	0	(Senate concurred)

Effective: June 9, 2016