S-4630.1

SECOND SUBSTITUTE SENATE BILL 6534

State of Washington 64th Legislature 2016 Regular Session

By Senate Ways & Means (originally sponsored by Senators O'Ban and Becker)

READ FIRST TIME 02/09/16.

AN ACT Relating to establishing a maternal mortality review panel; adding a new section to chapter 70.54 RCW; and providing an expiration date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 70.54 RCW to read as follows:

(1) For the purposes of this section, "maternal mortality" or "maternal death" means a death of a woman while pregnant or within one year of delivering or following the end of a pregnancy, whether or not the woman's death is related to or aggravated by the pregnancy.

(2) A maternal mortality review panel is established to conduct comprehensive, multidisciplinary reviews of maternal deaths in Washington to identify factors associated with the deaths and make recommendations for system changes to improve health care services for women in this state. The members of the panel must be appointed by the secretary of the department of health, must serve without compensation, and must include:

(a) An obstetrician;

(b) A physician specializing in maternal fetal medicine;

(c) A neonatologist;

(d) A midwife with licensure in the state of Washington;

(e) A representative from the department of health who works in the field of maternal and child health;

(f) A department of health epidemiologist with experience analyzing perinatal data;

(g) A pathologist;

(h) A representative of the community mental health centers; and

(i) A member of the public.

(3) The maternal mortality review panel must conduct comprehensive, multidisciplinary reviews of maternal mortality in Washington from reported deaths and from deaths identified by linkage of state vital records and administrative data. The panel must use the patient's inpatient medical records, outpatient medical records, root cause analyses, autopsy reports, and other available relevant information in its review. The panel may not call witnesses or take testimony from any individual involved in the investigation of a maternal death or enforce any public health standard or criminal law or otherwise participate in any legal proceeding relating to a maternal death.

(4)(a) The maternal mortality review panel's proceedings, records, and opinions are confidential and are not subject to disclosure under chapter 42.56 RCW. Panel members may not be questioned in any civil or criminal proceeding regarding the information presented in or opinions formed as a result of a meeting of the panel. This subsection does not prevent a member of the panel from testifying to information obtained independently of the panel or which is public information.

(b) The maternal mortality review panel and the secretary of the department of health may retain identifiable information regarding facilities where maternal deaths, or from which the patient was transferred, occur and geographic information on each case solely for the purposes of trending and analysis over time. All individually identifiable information must be removed before any case review by the panel.

(5) Health care providers, health care facilities, clinics, laboratories, and medical examiners must report maternal deaths to the maternal mortality review panel and to the secretary of the department of health within ninety days of the death. If a root cause analysis of a maternal death has been completed, the findings of the analysis must be included in the records supplied to the panel.

(6) By July 1, 2017, and biennially thereafter, the maternal mortality review panel must submit a report to the secretary of the department of health and the health care committees of the senate and house of representatives. The report must protect the confidentiality of all decedents and other participants involved in any incident. The report must be distributed to relevant stakeholder groups for performance improvement. Interim results may be shared at the Washington state hospital association safe tables for performance improvement. The report must include the following:

(a) A description of the adverse events reviewed by the panel during the preceding twenty-four months, including statistics and causes blinded by patient, provider, and organization; and

(b) Evidence-based system changes and possible legislation to improve maternal outcomes and reduce preventable maternal deaths in Washington.

(7) This section expires June 30, 2020.

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