FINAL BILL REPORT
SSB 5425

C 317 L 19
Synopsis as Enacted

Brief Description: Concerning maternal mortality reviews.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Cleveland, Keiser, Becker and Hasegawa; by request of Department of Health).

Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness
House Committee on Appropriations

Background: Maternal Mortality Review Panel. In 2016 the Legislature established the Maternal Mortality Review Panel (Review Panel) to conduct comprehensive, multidisciplinary reviews of maternal deaths occurring in Washington State, to identify factors associated with the death, and to make recommendations for system changes to improve healthcare services for women.

"Maternal mortality" or "maternal death" means a death of a woman while pregnant or within one year of delivering or following the end of pregnancy, whether or not the woman's death is related or aggravated by the pregnancy.

The Review Panel is supported by the Department of Health (DOH), and members of the Review Panel are appointed by the secretary of DOH and may include an obstetrician, a physician specializing in maternal fetal medicine, a neonatologist, a midwife with licensure in Washington, a representative from DOH who works in the field of maternal and child health, a DOH epidemiologist with experience analyzing perinatal data, a pathologist, and a representative of the community mental health centers.

All individually identifiable information must be removed before any case review is conducted by the Review Panel. The Review Panel may retain identifiable information regarding facilities where maternal deaths occur, or from which the patient was transferred, and geographic information on each case solely for the purposes of trending and analysis over time.

DOH has the authority to request and receive data for specific maternal deaths from health care providers, health care facilities, clinics, laboratories, medical examiners, coroners,

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professions and facilities licensed by DOH, local health jurisdictions, the Health Care Authority, and the Department of Social and Health Services.

In July 2017 the Review Panel issued their findings and recommendations to the Legislature. The report indicated the state's maternal mortality rates have remained steady since the 1990s, and identified 69 maternal deaths during 2014-2015. Of those deaths identified, the Review Panel determined 16 were pregnancy-related and 53 were pregnancy-associated—not related—deaths. The Review Panel must submit another report in July 2019 and is set to expire on June 30, 2020.

Confidentiality of Mental Health Service Records. Both state and federal law requires health care providers to keep certain patient health care information confidential. Federal law establishes minimum requirements and states may establish additional requirements. Washington State law requires mental health service providers to keep all patient records confidential unless a specific exception applies. Generally, a specific exception may apply when a patient's mental health information is disclosed for the purposes of care coordination, law enforcement, treatment, or research.

Death Investigations Account. The Death Investigations Account (DIA) is an appropriated account that funds various activities related to investigations of deaths in the state. The DIA is funded by revenues that are received from a fee charged by DOH and local registrars for providing certified copies of a birth, death, fetal death, marriage, divorce, annulment, or legal separation record.

Summary: The Review Panel must have at least one person who is a tribal representative as a member. Other members are selected at the discretion of DOH and may include women's medical, nursing, and service providers; obstetric medical, nursing, and service providers; newborn or pediatric medical, nursing, and service providers; birthing hospital or licensed birth center representatives; coroners, medical examiners, or pathologists; behavioral health and service providers; state agency representatives; individuals or organizations that represent the populations most affected by pregnancy-related deaths or pregnancy-associated deaths and lack of access to maternal health care services; a representative from DOH who works in the field of maternal and child health; and a DOH epidemiologist with experience analyzing perinatal data.

The Review Panel's June 30, 2020, expiration date is eliminated. The Review Panel must submit a report to the Senate and House health care committees by October 1, 2019, and every three years thereafter.

DOH has the authority to request and receive data for specific maternal deaths from Department of Children, Youth, and Families, and a patient's mental health service records may be released to the Secretary of Health for the purposes of the Review Panel. DOH may enter into signed written data-sharing agreements that permit DOH to release either data or findings with indirect identifiers, or both, to the Centers for Disease Control and Prevention, regional maternal mortality review efforts, local health jurisdictions of Washington State, or tribes, at DOH's discretion. A written-data sharing agreement must:

- include a description of the proposed purpose of the request, the scientific justification for the proposal, the type of data needed, and the purpose for which the data will be used;
- include the methods to be used to protect the confidentiality and security of the data;
- prohibit redisclosure of any identifiers without express written permission from DOH;
- prohibit the recipient of the data from attempting to determine the identity of persons or parties whose information is included in the data or use the data in any manner that identifies individuals or their family members, or health care providers and facilities;
- state that ownership of the data remains with DOH, and ownership is not transferred to those authorized to receive and use the data under the agreement; and
- require the recipient of the data to include appropriate citations when the data is used in research reports or publications or research findings.

Hospitals and licensed birth centers must make a reasonable and good faith effort to report all deaths that occur during pregnancy or within 42 days of the end of pregnancy to the local coroner or medical examiner. These deaths must be reported within 36 hours after death. Local coroners or medical examiners that receive the death report must conduct a death investigation, with autopsy strongly recommended. Autopsies must follow DOH guidelines, and will be reimbursed to counties at 100 percent of cost by the state's DIA.

Technical and clarifying changes are made including:

- maternal mortality is changed to mean a death of woman while pregnant or within one year of the end of a pregnancy from any cause;
- the Review Panel may retain identifiable information regarding where maternal deaths occur, or facilities from which a patient whose record is or will be examined by the Review Panel was transferred, and geographic information on each case for the purposes of determining trends, performing analysis over time, and for quality improvement efforts; and
- DOH may request specific maternal death data to coordinate quality improvement efforts.

Votes on Final Passage:

Senate	46	0	
House	98	0	(House amended)
Senate	47	0	(Senate concurred)

Effective: July 28, 2019