NEIL ABERCROMBIE
GOVERNOR OF HAWAII

LORETTA J. FUDDY, A.C.S.W., M.P.H.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

House Committee on Health

S.B. 1238, SD. 2, Relating to Health

Testimony of Loretta J. Fuddy, A.C.S.W., M.P.H.
Director of Health

March 13, 2013

Department's Position: The Department of Health (DOH) appreciates the intent of this measure which establishes the maternal mortality review panel to conduct comprehensive reviews of maternal deaths in Hawaii. This would include the collection, analysis, and dissemination of maternal mortality information and preparation of an annual report.

Fiscal Implications: Funding is necessary to conduct the comprehensive reviews, collect and analyze this data, produce and distribute related reports, and provide reimbursement for committee expenses such as travel.

Purpose and Justification: The bill amends Hawaii Revised Statute, Chapter 324 to establish a Maternal Mortality Review Panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in Hawaii to identify factors associated with the deaths and make recommendations for system changes to improve health care and maternal mortality for women in Hawaii. This panel would be responsible for submission of an annual report to the legislature on their activities, incidents of maternal deaths in the State, and recommendations to reduce the number of preventable maternal deaths.

We are concerned that existing Hawaii Revised Statute, Chapter 324, Part I "Maternal and Perinatal Studies" may not provide sufficient authority to establish a maternal mortality review panel in

Hawaii. While the DOH is authorized to conduct maternal mortality reviews based on Part 1 of chapter 324, it may be difficult to collect the necessary documentation based solely on the provisions of chapter 324. The Maternal and Perinatal Studies provisions are not as comprehensive as other mortality review programs administered by the Department. Despite their more comprehensive statutory authority, other mortality review committees, such as those for infant death and domestic violence encounter data collection problems when the data sought falls under federal confidentiality laws and regulations (examples include education records and substance abuse records).

We are also concerned that existing Sections 324-1 and 324-2 in Part I of Chapter 324, Hawaii Revised Statutes are significantly different from many of the provisions of the new material that has been proposed to be added to Part 1, and the difference will create ambiguities, conflicts and confusion. We are recommending that reference to the DOH in these two sections be deleted so that the maternal and perinatal study committee of the Hawaii Medical Association or any in-hospital staff committee can continue to operate under Part 1.

Accordingly, we are offering a proposed H.D.1 to address the concerns highlighted above. The proposed language is modeled after existing statute on other mortality reviews (Child Death Review and Domestic Violence Fatality Review), removes conflicting language on the type of information to be made available to the panel, and leaves untouched the current statute on Maternal and Perinatal Studies.

Thank you for the opportunity to testify.

THE SENATE
TWENTY-SEVENTH LEGISLATURE, 2013

STATE OF HAWAII

S.B. NO. 1238 Proposed HD1

A BILL FOR AN ACT

RELATING TO HEALTH.

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

SECTION 1. Chapter 324, Hawaii Revised Statutes, is amended by adding a new part to be appropriately designated and to read as follows:

"**§324-A Definitions.** As used in this part, unless the context requires otherwise:

"Department" means the department of health.

"Director" means the director of health or the director's designated representative.

"Family" means:

(1) Each legal parent;

(2) The natural mother;

(3) The natural father;

(4) The adjudicated, presumed, or concerned natural father as defined under section 578-2;

(5) Each parent's spouse or former spouses;

(6) Each sibling or person related by consanguinity or marriage;

(7) Each person residing in the same dwelling unit; and

(8) Any other person who, or legal entity that, is a child's legal or physical custodian or guardian, or who is otherwise responsible for the child's care, other than an authorized agency that assumes such a legal status or relationship with the child under chapter 587A.

"Maternal mortality", “maternal death” or “maternal mortality event” means the following:

(1) "Pregnancy-related death" means the death of a woman while pregnant or within one year of the end of the pregnancy, regardless of whether the pregnancy is normal or ectopic, from any cause related to or aggravated by her pregnancy or its management, but not from accidental or incidental causes;

(2) "Pregnancy-associated death" means the death of a woman while pregnant or within one year of the end of pregnancy, irrespective of cause; and

(3) "Pregnancy-associated, but not pregnancy-related death" means the death of a woman while pregnant or within one year of the end of pregnancy due to a cause unrelated to pregnancy.

“Maternal mortality review information” means information regarding the mother and mother’s family, including but not limited to:

(1) Social, medical, and legal histories;

(2) Death and birth certificates;

(3) Law enforcement investigative data;

(4) Medical examiner or coroner investigative data;

(5) Parole and probation information and records;

(6) Information and records of social service agencies;

(7) Educational records; and

(8) Health care institution information.

"Panel" means the maternal mortality panel.

§324-B Maternal mortality review panel; established. (a) There is established a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in Hawaii for the purposes of identifying factors associated with the deaths and making recommendations for system changes to improve health care services for women in this State. The members of the panel shall be appointed by the director, in collaboration with the organizations listed below, and shall consist of:

(1) Two members from the Hawaii Section of the American Congress of Obstetricians and Gynecologists, one of

whom shall be a generalist and one of whom shall be a maternal fetal medicine specialist;

(2) One member from the Hawaii Chapter of the American Academy of Pediatrics, specializing in neonatology;

(3) One member from the Hawaii Medical Association;

(4) One member from the Hawaii Chapter of the American College of Nurse Midwives;

(5) One member from the Hawaii Section of the Association of Women's Health, Obstetric and Neonatal Nurses;

(6) The head of the department’s maternal and child health branch, or a designee;

(7) An epidemiologist from the department with experience analyzing perinatal data, or a designee;

(8) The chief medical examiner, pathologist, or designee;

(9) A representative of community mental health centers; and

(10) A member of the public.

(b) The term of each member shall be three years; provided that the initial members' terms shall be staggered in a manner to be determined by the director. The director shall appoint the initial chair of the panel, who shall call the first meeting of the panel and serve as chair for six months, after which time the panel shall elect its chair. Members of the maternal mortality review panel shall serve without compensation

but shall be reimbursed for actual expenses necessary for the performance of their duties.

(c) The director may delegate to the panel the functions of collecting, analyzing, and disseminating maternal mortality review information organizing and convening meetings of the panel; and other substantive and administrative tasks as may be incident to these activities. The activities of the panel and its employees or agents shall be subject to the same confidentiality provisions as apply to members of the panel.

§324-C Duties of the maternal mortality review panel .

(a) The panel, in collaboration with the director or the director's designee, shall conduct comprehensive, multidisciplinary reviews of maternal mortality in Hawaii. The panel shall not be subject to part I, chapter 92.

(b) Each member of the panel shall be responsible for disseminating the panel's recommendations to the member's institution or professional organization, as applicable. The panel’s recommendations shall not contain any information that would permit identification of a person and shall be disseminated through the institution's or organization's quality assurance program to protect the confidentiality of all persons involved in any maternal mortality event.

(c) The director, in collaboration with the panel, shall submit an annual report no later than twenty days prior to the

convening of each regular session to the legislature on the panel's activities and the incidents of maternal deaths in the State. The report shall include statistics setting forth the number of maternal deaths in the State, identifiable trends in maternal deaths, including possible causes, and recommendations for system changes and proposed legislation relating to the delivery of health care in the State.

(d) The panel shall not have the power to:

(1) Call witnesses or take testimony from any individual involved in the investigation of a maternal death; or

(2) Enforce any public health standard or criminal law, or otherwise participate in any legal proceeding, except to the extent that a member of the panel is involved in the investigation of a maternal death or resulting prosecution and participates in the legal proceeding in the course of performing the member's duties outside of the panel.

§324-D Access to information. (a) All providers of medical care and state and county agencies shall report all maternal mortality events to the director.

(b) Upon written request of the director, all providers of medical care and state and county agencies shall disclose to the department, and those individuals appointed by the director to

the panel, maternal mortality review information regarding the circumstances of a maternal death so that the department may conduct a multidisciplinary review of maternal mortality pursuant to section 321-31 and this part.

(c) To the extent that this section conflicts with other state confidentiality laws, this section shall prevail.

§324-E Exception. Information regarding an ongoing civil or criminal investigation shall be disclosed at the discretion of the applicable state, county, or federal law enforcement agency.

§324-F Use of maternal mortality review information and records. (a) Except as otherwise provided in this part, all maternal mortality review information acquired by the department during its review of maternal deaths pursuant to this part, is confidential and may only be disclosed as necessary to carry out the purposes of this part.

(b) Maternal mortality review information and statistical compilations of data that do not contain any information that would permit the identification of any person shall be public records.

(c) No individual participating in the panel's review of a maternal death may be questioned in any civil or criminal proceeding regarding information presented in or opinions formed

as a result of a panel meeting. Nothing is this subsection shall be construed to prevent a person from testifying to information obtained independently of the department's request for maternal mortality review information or the panel's review of the maternal death, or which is public information, or where disclosure is required by a court of law.

(d) Maternal mortality review information held by the department as a result of maternal mortality reviews conducted under this part are not subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding, except that maternal mortality review information otherwise available from other sources is not immune from subpoena, discovery, or introduction into evidence through those sources solely because they were provided as required by this part.

(e) The director shall have access to individually identifiable information relating to each maternal mortality event on a case-by-case basis where public health is at risk.

(f) The director may retain identifiable information regarding facilities where a maternal mortality event occurred and geographic information on each maternal mortality event solely for the purposes of trending and analysis of maternal mortality events over time.

(g) When any providers of medical care or state or county agencies required to provide information in response to the director's request pursuant to section 324-D completes a root cause analysis of a maternal mortality event, the findings of the root cause analysis shall be included in the maternal mortality review information provided to the department and panel members.

§324- G__ Immunity from liability. The panel, its members and any medical provider, state or county agency, or individual participating in, or cooperating in, the review of a maternal death pursuant to this part shall not be held civilly or criminally liable for providing the information required under this part.

§324-H Rules. The director, with the advice and recommendation of a majority of the members of the panel, shall adopt rules pursuant to chapter 91 related to the following:

(1) The system for identifying and reporting maternal mortality events to the director;

(2) The form and manner through which the director and the members of the panel may acquire information pursuant to this part;

(3) The protocol to be used in contacting a family member of the deceased woman for a discussion of the maternal

mortality event, including allowing family members to delay or refuse such a discussion; and

(4) The confidentiality provisions of this part.

SECTION 2. Section 324-1, Hawaii Revised Statutes, is amended to read as follows:

"§324-1 Sources of information protected. Any person, hospital, sanitorium, nursing or rest home, or other similar medical facility may provide information, interviews, reports, statements, memoranda, or other data or material relating to the condition and treatment of any person to the maternal and perinatal mortality study committee of the Hawaii Medical Association, or any in-hospital staff committee, to be used in the course of any study for the purpose of reducing morbidity or mortality.

No liability of any kind or character for damages or other relief shall arise or be enforced against any person or organization by reason of having provided the information or material, or by reason of having released or published the findings, conclusions, and summaries of the research or study committees to advance medical research and medical education."

SECTION 3. Section 324-2, Hawaii Revised Statutes, is amended to read as follows:

"§324-2 Identification of persons studied; restriction. The maternal and perinatal mortality study committee of the

Hawaii Medical Association, or any in-hospital staff committee shall use or publish this material only for the purpose of advancing medical research, medical education, or education of the public in the interest of reducing morbidity or mortality. In all events, the identity, or any group of facts which tends to lead to the identity, of any person whose condition or treatment has been studied shall be confidential and shall not be revealed under any circumstances."

SECTION 2. There is appropriated out of the general revenues of the State of Hawaii the sum of $ or so much thereof as may be necessary for fiscal year 2013-2014 and the same sum or so much thereof as may be necessary for fiscal year 2014-2015 for the implementation and operation of the maternal mortality review panel.

The sums appropriated shall be expended by the department of health for the purposes of this Act.

SECTION 3. In codifying the new sections added by section 1 of this Act, the revisor of statutes shall substitute appropriate section numbers for the letters used in designating the new sections in this Act.

SECTION 4. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 5. This Act shall take effect upon on July 1, 2050.

Planned Parenthood®

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March 13, 2013

Testimony in Support: SB 1238 SD2

To: Chair Della Au Belatti, Vice Chair Dee Morikawa, and Members of the House Committee on Health
From: Katie Reardon Polidoro, Director of Public Affairs & Government Relations, Planned Parenthood of Hawaii
Re: Testimony in Support of SB 1238 SD2 Relating to Maternal Mortality Review

Planned Parenthood of Hawaii supports SB 1238 SD2, which establishes a Maternal Mortality Review Panel. We are very concerned about the increase in maternal deaths in the United States. According to the Centers For Disease Control, that rate has doubled over the last 25 years, to 12.1 in 2010. Hawaii's maternal death rate is 13.7 deaths per 100,000 live births, ranking us 37th in the country when it comes to maternal mortality, according to the National Women's Law Center.

Despite our relatively high rate of pregnancy related deaths, Hawaii does not currently have a maternal mortality review panel. We believe that a multidisciplinary review panel will help identify problems, decrease maternal mortality, and improve women's health in general in our state. Therefore, we support SB 1238 SD2 and ask this Committee to pass it. Mahalo.

March 13, 2013 - Wednesday
8:30 AM
Conference Room 329
State Capitol

To: Representative Della Au Belatti, Chair
Representative Dee Morikawa, Vice Chair
House Committee on Health

From: Ghislaine Chock, APRN-RX
Nurse Practitioner
Waianae Coast Comprehensive Health Center

Re: SB 1238 SD2 Relating to Health (Maternal Mortality Review Panel)

Position: Strongly Support

Dear Chair Belatti, Vice Chair Morikawa and Health Committee Members:

I agree with the American Congress of Obstetricians and Gynecologists (ACOG), Hawaii Section and strongly supports SB1238 SD2, which establishes a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in Hawaii for the purpose of identifying factors associated with those deaths towards improving services for all women in our state. We urge you to support Women's Health and amend the effective date from July 1, 2050 that effectively defeats this bill, to **January 1, 2014**.

morikawa2 - Shaun

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 12, 2013 11:49 AM
To: HLTtestimony
Cc: joyamarshall2003@yahoo.com
Subject: *Submitted testimony for SB1238 on Mar 13, 2013 08:30AM*

SB1238
Submitted on: 3/12/2013
Testimony for HLT on Mar 13, 2013 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Joy Marshall	Individual	Support	Yes

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing , improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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morikawa2 - Shaun

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 12, 2013 2:55 PM
To: HLTtestimony
Cc: kterada@wcchc.com
Subject: Submitted testimony for SB1238 on Mar 13, 2013 08:30AM

SB1238
Submitted on: 3/12/2013
Testimony for HLT on Mar 13, 2013 08:30AM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Kathy Terada FNP	Individual	Comments Only	No

Comments: I urge you to support the establishment of the Hawaii Maternal Mortality Review Panel and to amend the effective date to January 1, 2014. Reviewing maternal mortality can guide us towards system changes unique to Hawaii's population, which lead to decreased maternal mortality as well as improvement of services to all of Hawaii's women. Thank you for the opportunity to present this testimony.

Please note that testimony submitted less than 24 hours prior to the hearing , improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Raydeen Busse, MD, FACOG
1401 S. Beretania St, Suite 310
Honolulu, HI 96814

March 13, 2013 - Wednesday
8:30 AM
Conference Room 329
State Capitol

To: Representative Della Au Belatti, Chair
Representative Dee Morikawa, Vice Chair
House Committee on Health

From: Raydeen M Busse, MD, FACOG

Re: SB 1238 SD2 Relating to Health (Maternal Mortality Review Panel)

Position: Strongly Support

Dear Chair Belatti, Vice Chair Morikawa and Health Committee Members:

I strongly support SB1238 SD2, which establishes a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in Hawaii for the purpose of identifying factors associated with those deaths towards improving services for all women in our state. I urge you to support Women's Health and amend the effective date from July 1, 2050 that effectively defeats this bill, to January 1, 2014.

As you may know, Hawaii's Maternal and Perinatal Mortality Review Committee was an active group until about 15 or more years ago when this committee ceased to exist due to lack of administrative support. During that time, protections for patients, and from discovery or legal action of the review process was provided by Hawaii Revised Statutes 324-1 to 4, and this law is still current today. This law requires updating and revision to establish the Maternal Mortality Review Panel. The review panel's clinical health professionals, such as physicians and nurses, are all non-compensated volunteers dedicated to improving Hawaii's maternal and perinatal care.

Hawaii is one of only 14 states in the nation that does not have an active Maternal Mortality Review Committee (ACOG Annual Clinical Meeting, May 2011) and there are currently several states in the process of establishing a maternal mortality review.

Despite advances in medical care, the maternal mortality rate in the U.S. appears to be rising, and has reached a rate that is now four times higher than the federal government's Healthy People 2010 goal. The U.S. pregnancy-related mortality ratio was 14.5 per 100,000 live births during 1998-2005 (Centers for Disease Control and Prevention-CDC).

This is higher than any other period in the past 20 years. U.S. officials had hoped to decrease this rate from 8.4 in 1997 to 3.3 deaths per 100,000 live births by 2010 (Healthy People 2010), and instead the actual rate was 4 times that number. According to World Health Organization (WHO) estimates for 2008, 47 countries had lower maternal mortality ratios than the U.S. (WHO, Trends in Maternal Mortality: 1990-2008)

The CDC estimated Hawaii's maternal mortality ratio from 2001 through 2006 as 13.9 deaths per 100,000 live births (CDC, National Center for Health Statistics-NCHS, 2001-2006 data). According to Hawaii Department of Health data, there were 102 maternal deaths from 2001 through 2011, or an average of 9 deaths per year. These numbers are thought to be under-reported not only in Hawaii, but also across the nation. Many experts caution that there is a 30% to 100% under-reporting of maternal deaths. Experts also estimate that only 30-40% of the rise in national maternal deaths can be attributed to new data collection techniques and better reporting.

Nationally, women of color, particularly African American women, have a higher maternal mortality ratio than white women in the U.S. (CDC, NCHS, 2010). No current similar data are publicly available or analyzed for our multiethnic state.

As an example of how comprehensive maternal mortality reviews can contribute to improved quality of care, the United Kingdom noted that certain ethnic populations had comparatively increased maternal mortality rates. Using this information, they targeted particular pregnant populations for earlier prenatal care, education campaigns for care providers and other interventions based on their maternal mortality review data with a subsequent decrease in maternal mortality (Saving Mothers' Lives, Reviewing maternal deaths to make motherhood safer: 2006-2008. British Journal of Obstetrics and Gynaecology. Volume 118, Supplement 1, March 2011). In the United States, the Illinois Maternal Mortality Review Committee (MMRC) found that obstetric hemorrhage was the leading cause of death, with 69% thought to be potentially avoidable. The Illinois MMRC was instrumental in mandating that every obstetric hospital in their state undergo mandatory Obstetric Hemorrhage training which benefits all pregnant women [Reducing Maternal Deaths through State Maternal Mortality Review. Kilpatrick SJ, etal. 2012 Sep;21(9):905-9. Journal of Womens Health (Larchmont)]

For every woman who dies of a pregnancy-related cause, many more suffer morbidity related to pregnancy. Comprehensive review of maternal death can therefore lead to improvement in general women's care and decrease morbidity, in addition to decreasing mortality. This morbidity and mortality place a significant burden on women, their children and families, and on society in personal, social and economic terms.

The HHS-HRSA Maternal and Child Health Bureau, Centers for Disease Control and Prevention (CDC), the Association of Maternal and Child Health Programs (AMCHP), and the American Congress of Obstetricians and Gynecologists (ACOG), all recommend that maternal deaths in each state be investigated by a multidisciplinary peer review protected Maternal Mortality Review Panel. Review

of every maternal death by a qualified, multidisciplinary committee in each state is critical to understanding the role in maternal death of geography, age, preexisting conditions, access to appropriate care, as well as race, ethnicity, community education, and services.

I urge you to support the establishment of the Hawaii Maternal Mortality Review Panel and to amend the effective date to January 1, 2014. Reviewing maternal mortality can guide us towards system changes unique to Hawaii's population, which lead to decreased maternal mortality as well as improvement of services to all of Hawaii's women.

Thank you for the opportunity to present this testimony. Please contact me if you have any questions regarding this important bill.