HAWAII
STATE
COMMISSION
ON THE
STATUS
OF
WOMEN

Chair
LESLIE WILKINS

COMMISSIONERS:

SHERRY CAMPAGNA
CYD HOFFELD
JUDY KERN
MARILYN LEE
AMY MONK
LISA ELLEN SMITH

Executive Director
CATHY BETTS, JD

Email:
Catherine.a.betts@hawaii.gov
Visit us at:
humanservices.hawaii.gov
/hscsw/

235 S. Beretania #407
Honolulu, HI 96813
Phone: 808-586-5758
FAX: 808-586-5756

March 29, 2016

Testimony in Support, SB 2317, SD1, HD1 Relating to Health

To: Representative Sylvia Luke, Chair
Representative Scott Nishimoto, Vice Chair
Members of the House Committee on Finance

From: Cathy Betts, Executive Director
Hawaii State Commission on the Status of Women

Re: Testimony in Support, SB 2317, SD1, HD1, Relating to Health

On behalf of the Hawaii State Commission on the Status of Women, I would like to express my support for SB 2317, SD1, HD1, which would establish a maternal mortality review panel to review maternal deaths in Hawaii as well as reinstate child death reviews.

The Centers for Disease Control (CDC), the American Congress of Obstetricians and Gynecologists, the World Health Organization, and the Association of Maternal & Child Health Programs, among many other organizations, strongly recommend that all states have a formal review process of maternal deaths to decrease maternal mortality and morbidity. Hawaii does not review maternal deaths, despite having a maternal mortality ratio of anywhere between 9-14 deaths per 100,000 live births.

Maternal mortality reviews highlight possible areas for system improvements and changes that can lead to better pregnancy care for all women and have been proven to work in other states and countries. Establishing a maternal mortality review panel will undoubtedly save lives. The Commission strongly supports the establishment of a Hawaii Maternal Mortality Review Panel as well as the reinstatement of Child Death Review to conduct comprehensive, multidisciplinary reviews of maternal and child deaths towards improving maternal-child health in our state. The mortality reviews identify missed opportunities and remediable factors in cases of child and maternal deaths.

There currently is no allocation of resources to ensure the ongoing conduct of maternal and child death reviews. Establishment of a permanently funded unit within the MCH Branch at the DOH addresses program sustainability. Many factors responsible for infant mortality are shared with maternal mortality. These include socio-environmental factors, appropriate accessing of medical care and timely response by the healthcare system. In addition there is considerable overlap in the methodologies for determining factors contributing to deaths and preventability.

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. There are approximately 10 maternal deaths annually in the state of Hawaii. Maternal mortality rates are increasing and up to 50% of all maternal deaths may be preventable. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

Hawaii, as of 2013, is one of only two states not conducting child death reviews. Previous reviews have found that up to 75% of child deaths in Hawaii were preventable. There are approximately 170 child deaths per year in the state of Hawaii. A series of recommendations from prior Child Death Reviews launched policy changes in licensed daycares and stimulated public service campaigns directed at reducing sleep related deaths.

The appropriation for core fatality unit staffing at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews. The review panels for separate child and maternal death reviews will consist of voluntary expert members, allowing for significant in-kind support from health care providers and public health specialists. The Commission supports this measure and respectfully requests that you pass this bill with the appropriation of funds. Thank you for hearing this important measure.

March 30, 2016 at 3:00 PM
Conference Room 308

House Committee on Finance

To: Chair Sylvia Luke
Vice Chair Scott Y. Nishimoto

From: George Greene
President and CEO
Healthcare Association of Hawaii

Re: Submitting comments
SB 2317 SD 2 HD 1, Relating to Health

The Healthcare Association of Hawaii (HAH), established in 1939, serves as the leading voice of healthcare on behalf of 180 member organizations who represent almost every aspect of the health care continuum in Hawaii. Members include acute care hospitals, skilled nursing facilities, home health agencies, hospices, assisted living facilities and durable medical equipment suppliers. In addition to providing access to appropriate, affordable, high quality care to all of Hawaii's residents, our members contribute significantly to Hawaii's economy by employing over 20,000 people statewide.

The Healthcare Association of Hawaii would like to thank the committee for the opportunity to **submit comments** on SB 2317 SD 2 HD 1, which would require the Department of Health to submit reports on child and maternal deaths in the state. We support the intent of the legislation to improve public health efforts to prevent avoidable deaths in the state. However, we have some concerns regarding the data providers must disclose and the strength of the liability language in this measure.

We look forwarding to continuing our engagement with the Department of Health and other stakeholders on this measure to ensure that these reviews can be done effectively.

Thank you for your time and consideration of this matter.

Phone: (808) 521-8961 | Fax: (808) 599-2879 | HAH.org | 707 Richards Street, PH2 - Honolulu, HI 96813

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 28, 2016 2:22 PM
To: FINTestimony
Cc: laurie.field@ppvnh.org
Subject: *Submitted testimony for SB2317 on Mar 30, 2016 15:00PM*

SB2317
Submitted on: 3/28/2016
Testimony for FIN on Mar 30, 2016 15:00PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
Laurie Field	Planned Parenthood Votes Northwest and Hawaii	Support	No

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.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov

American Congress of Obstetricians and Gynecologists
District VIII, Hawaii (Guam & American Samoa) Section
Greigh Hirata, MD, FACOG, Chair
94-235 Hanawai Circle, #1B
Waipahu, Hawaii 96797

THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

To: COMMITTEE ON FINANCE
Representative Sylvia Luke, Chair
Representative Scott Nishimoto, Vice Chair

DATE: Wednesday, March 30, 2016
TIME: 3:00 p.m.
PLACE: Conference Room 308
State Capitol
415 S. Beretania St.

FROM: Hawaii Section, ACOG
Dr. Greigh Hirata, MD, FACOG, Chair
Dr. Jennifer Salcedo, MD, MPH, MPP, FACOG, Vice-Chai
Lauren Zirbel, Community and Government Relations

Re: SB 2317, SD2, HD1 Relating to Health

Position: Strongly Support

Establishing the Maternal Mortality Review Panel

Dear Representative Luke, Representative Nishimoto, and committee members:

The American Congress of Obstetricians and Gynecologists, Hawaii Section (Hawaii ACOG) strongly supports the establishment of a Hawaii Maternal Mortality Review Panel as well as the reinstatement of Child Death Review to conduct comprehensive, multidisciplinary reviews of maternal and deaths towards improving maternal-child health in our state. Deaths of a child or a pregnant woman are sentinel events that require proper investigations to understand the underlying causes and opportunities for prevention. The mortality reviews identify missed opportunities and remediable factors in cases of child and maternal deaths.

There currently is **no allocation of resources** to ensure the ongoing conduct of maternal and child death reviews. **Establishment of a permanently funded unit within the MCH Branch at the DOH addresses program sustainability. Many factors responsible for infant mortality are shared with maternal mortality.** These include socio-environmental factors, appropriate accessing of medical care and timely response by the healthcare system. In addition there is considerable overlap in the methodologies for determining factors contributing to deaths and preventability. **It just makes sense to combine resources for**

theses reviews. The Hawaii State Department of Health (DOH) is supportive of this legislation.

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. There are approximately 10 maternal daths in the state of Hawaii. Maternal mortality rates are increasing and up to 50% of all maternal deaths may be preventable. **We know that review panels work: unlike overall United States data with rising maternal death rates, the United Kingdom and the state of California have decreased their maternal mortality** by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

Hawaii, as of 2013, is one of only two states not conducting child death reviews. Previous reviews have found that up to 75% of child deaths in Hawaii were preventable. There are approximately 170 child deaths per year in the state of Hawaii. A series of recommendations from prior Child Death Reviews launched policy changes in licensed daycares and stimulated public service campaigns directed at reducing sleep related deaths. This summer's outbreak of infant deaths, with 7 being sleep related and another 5 also preventable, highlights the importance of ongoing surveillance and active responses to minimize preventable deaths.

The appropriation for core fatality unit staffing at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews. The review panels for separate child and maternal death reviews will consist of voluntary expert members, allowing for significant in-kind support from health care providers and public health specialists.

Mahalo for the opportunity to testify, and for your support of Hawaii Women's Health.

March of Dimes Foundation

Hawaii Chapter
1580 Makaloa Street, Suite 1200
Honolulu, HI 96814
Telephone (808) 973-2155
Inter-island 1-800-272-5240
Fax (808) 973-2160

marchofdimes.org/hawaii

Date: March 29, 2016

To: Representative Sylvia Luke, Chair
Representative Scott Nishimoto, Vice Chair

From: Lin Joseph
Director of Program Services
March of Dimes Hawaii Chapter

Re: In support of
SB 2317 SD2 HD1
Hearing: Monday, March 30, 2016
Conference Room 308, State Capitol

Chair Luke, Vice Chair Nishimoto, Members of the Committees:

I am writing to express strong support for SB 2317 SD2 HD1: Child and Maternal Death Review

For 75 years, the March of Dimes has been a leader in maternal and child health. Our mission is to *improve the health of babies by preventing birth defects, premature birth, and infant mortality*.

The death of a child or a pregnant woman is a sentinel event that requires proper investigation to understand the underlying causes and opportunities for prevention. Currently, Hawaii is one of only 13 states not conducting maternity reviews, and since 2013, one of only two states not conducting Child Death Reviews. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of care and have been shown to reduce child and maternal deaths.

The State of Hawaii reports in the Child Death Review Report 1997-2000 that there were 726 deaths of infants, children and adolescents up to age 18 during that period, approximately 200 deaths each year. Many of the deaths were preventable with the largest number due to motor vehicle incidents and sleep environment.

According to the Centers for Disease Control and Prevention (CDC), maternal mortality in the United States declined markedly during the 20th century. Unfortunately, this progress has stalled and the maternal mortality rate has steadily increased in recent years. The earlier, historic decline was led largely by medical and technological advances. In addition, interest and concern at the local, state, and federal levels led to developing systems for identifying, reviewing, and

analyzing maternal deaths. These systems have determined causes of deaths, identified gaps in services, and disseminated findings and recommendations.

Child and maternal death reviews should be part of every state's core public health function of assessment. The purpose of reviewing pregnancy-related and child deaths is to gain insight into the medical and social factors that lead to these events in order to decrease such deaths in the future.

Senate Bill SB 2317 SD2 HD1 provides for the Department of Health to begin again to conduct child death reviews and to implement maternal death reviews in Hawaii.

The March of Dimes strongly supports SB 2317 SD2 HD1 for its potential public health surveillance to improve monitoring of maternal and child health and better inform prevention and intervention strategies. Mahalo for your support.

Wednesday, March 30, 2016
3:00 PM
Conference Room 308

TO: House Committee on Finance
Representative Sylvia Luke, Chair
Representative Scott Nishimoto, Vice Chair

FROM: Lisa Kimura, Executive Director, Healthy Mothers Healthy Babies Coalition of Hawaii

RE: SB2317 SD2 HD1 - RELATING TO CHILD AND MATERNAL DEATH REVIEWS

POSITION: Strong Support

Dear Chair Luke, Vice Chair Nishimoto, and Committee Members:

As the leader of a maternal health organization that cares and advocates for pregnant women and new mothers, **I strongly support SB2317 SD2 HD1**, establishing a Hawaii Maternal Mortality Review Panel and an appropriation to perform comprehensive reviews of Hawaii maternal deaths, as well as reinstate the Child Death Reviews.

Whereas the Centers for Disease Control, American Congress of Obstetricians and Gynecologists, World Health Organization, Association of Maternal & Child Health Programs, and many other organizations strongly recommend that all states have a formal review process to decrease maternal mortality and morbidity, Hawaii does not review maternal deaths.

A woman should not have to fear for her life in the event of childbirth. Maternal mortality reviews highlight possible areas for system improvements and changes that can lead to better pregnancy care for all women and have been proven to work in other states and countries. Hawaii's maternal death rate is comparable to the overall U.S. rate, however, we are the only developed country with an increasing maternal death rate and Hawaii is one out of only 13 states in the nation that does not conduct maternal mortality reviews.

It has also been found that 75% of child deaths in Hawaii were preventable, however, Hawaii is one of only two states in the nation not conducting child death reviews. We need to be able to evaluate and work to improve our rates of maternal and infant deaths, as states and countries with an established mortality review panels have been able to make a sizable impact on standards of care and prevention efforts.

Many factors responsible for infant mortality coincide with maternal mortality. Deaths of a child or a pregnant woman are vital events that should be required by law to be investigated to find the primary causes and ensure the greatest opportunity for education and prevention for the future. Taking steps to evaluate the causes and implement steps to prevent maternal and infant mortality is vital to our health system of care.

Please support Hawaii's women and keiki with this bill. Thank you for the opportunity to submit testimony on this important women's health issue.

310 Paoakalani Ave., Suite 202A, Honolulu, Hawaii 96815
(808) 737-5805 lisak@hmhb-hawaii.org www.hmhb-hawaii.org

KAPIOLANI CHILD PROTECTION CENTER
55 Merchant St., 22nd Floor
Honolulu, HI 96813
Fax: 808.535.7722

KAPI'OLANI
CHILD PROTECTION
CENTER
An Affiliate of Hawai'i Pacific Health

TOLL FREE LINE: 888.535.7790
Tel: 808.535.7700
Fax: 808.535.7722
www.kapiolani.org/child-protection -center

DATE: March 30, 2016

TO: The Honorable Sylvia Luke, Chair
The Honorable Scott Nishimoto, Vice Chair
House Committee on Finance

FROM: The Kapi'olani Child Protection Center
A Program of Kapi'olani Medical Center for Women and Children

RE: Testimony in Strong Support of S.B. 2317 S.D. 2 H.D. 1
Relating to Health

Good afternoon Chair Luke, Vice Chair Nishimoto, and members of the House Committee on Finance.

The Kapiolani Child Protection Center (KCPC) strongly supports S.B. 2317 S.D. 2, H.D. 1, which appropriates funds to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews; requires the Department of Health to submit an annual report to the legislature relating to child and maternal deaths and death reviews in the State; and requires that health care and social service providers and state and county agencies release information for the Department of Health to conduct studies to reduce maternal morbidity or mortality.

Child and Maternal Death Reviews are processes in which multidisciplinary teams of professionals meet to share, discuss, and analyze case information on deaths in order to understand how and why children and mothers die, and make recommendations to prevent future deaths through well-informed, effective public policies and programs. These processes recognize that the deaths of children and mothers are sentinel events, and proper investigation can save lives as well as help to avoid severe non-lethal injury and life-long disability in the many other cases where would-be causes of death result in "near misses."

Conducting Child Death Reviews (CDR) is a nationally recognized best practice for approaching important child health issues, and programs for their consistent performance have been established in every state and the District of Columbia. Presently, Hawaii is the only state in which such reviews are not currently occurring on a regular basis in order to identify preventable deaths and their specific causes, and develop countermeasures. This is deeply troubling, given that as many as 75% of child deaths from external causes in Hawaii are likely preventable, and the fact that an average of 170 child deaths are occurring in Hawaii each year.

Act 369, Session Laws of Hawai'i 1997, granted the Department of Health the authority to conduct CDR, and reports were generated covering all child deaths in the State between 1996 and 2006. However, despite achieving such successes as initiating safe sleep requirements for licensed childcare providers and assisting in the development of a state plan for suicide prevention, the program lapsed in 2013. The last report was published in December 2011 and covered child deaths from 2001 through 2006.

This represents a significant deficit in Hawaii's understanding of what has been killing and injuring our children and young people for the past decade, and lost opportunities to design programs to prevent deaths and serious harm from a range of sources, including but not limited to child abuse, unsafe sleep practices, drowning, and other emerging health and safety issues.

Likewise, Hawaii is one of only 13 states that are not currently conducting Maternal Death Reviews (MDR) for women who pass away during pregnancy or in the year following pregnancy, even though such maternal mortality is increasing nationwide and it is recognized that up to 50% of maternal deaths are preventable. In Hawaii, approximately 9 maternal deaths are identified each year, corresponding to an average of 19,000 births per year. Unfortunately, it is our understanding that although Hawaii law authorizes the performance of MDRs and Hawaii once possessed a program to conduct such reviews, that program has also been defunct for many years.

S.B. 2317 S.D. 2 H.D. 1 would allow the Department of Health to establish a funded unit with its Maternal and Child Health Branch to ensure the ongoing performance of maternal and child death reviews through a sustainable program, while keeping the Legislature and the public reasonably informed of the unit's activities and the progress of the review processes.

Moreover, it is our understanding, based on ongoing discussions with Department of Health personnel and other agency and community stakeholders, that the combined child and maternal death review unit envisioned by S.B. 2317 S.D. 2 H.D. 1 makes sense for several important reasons. Many factors responsible for infant death and serious injury are shared with maternal mortality, and so there is subject matter overlap between the two review processes. Moreover, coordination and medical abstracting skills and knowledge can be cross applied to both types of death review; there is overlap between the internal Department of Health and other state agency resources which would likely be called upon for consultation and assistance in both processes; and the number of maternal deaths (about 9 per year) relative to child deaths (about 170 per year) supports establishing and sustaining a shared unit that is empowered to organize the performance of both review processes.

With the resumption of consistent, comprehensive multidisciplinary reviews of child and maternal deaths, Hawaii will be empowered to make well-informed, responsible decisions regarding how to allocate limited resources and create effective programs, treatment protocols, education campaigns, and standardized care. Over time, this will accomplish the ultimate goal of meaningfully reducing child and maternal deaths in our state.

Therefore, we respectfully urge you to join us in strongly supporting S.B. 2317 S.D. 2 H.D. 1.

From: mailinglist@capitol.hawaii.gov
Sent: Tuesday, March 29, 2016 9:06 AM
To: FINTestimony
Cc: jfarnsworth@hawaii.rr.com
Subject: Submitted testimony for SB2317 on Mar 30, 2016 15:00PM

SB2317
Submitted on: 3/29/2016
Testimony for FIN on Mar 30, 2016 15:00PM in Conference Room 308

Submitted By	Organization	Testifier Position	Present at Hearing
JoAnn Farnsworth	Individual	Support	No

Comments: strong support

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.

Do not reply to this email. This inbox is not monitored. For assistance please email webmaster@capitol.hawaii.gov

Autumn Broady, MD, MPH
1259 Laukahi St.
Honolulu, HI 96821

To: House Committee on Finance
Representative Sylvia Luke, Chair
Representative Scott Nishimoto, Vice Chair

DATE: Wednesday, March 30th
TIME: 3:00 PM
PLACE: Conference Room 308

FROM: Autumn Broady, MD, MPH

Re: SB2317 Relating to Child and Maternal Death Reviews

Position: Strongly Support

Dear Representatives Luke, Nishimoto and Committee Members:

As a provider of high-risk obstetrics and an advocate of maternal-child health, I strongly support the establishment of a Hawaii Maternal Mortality Review Panel as well as the reinstatement of Child Death Review to conduct comprehensive, multidisciplinary reviews of maternal and child deaths towards improving maternal-child health in our state. Deaths of a child or a pregnant woman are sentinel events that require proper investigations to understand the underlying causes and opportunities for prevention. The mortality reviews identify missed opportunities and remediable factors in cases of child and maternal deaths.

There currently is **no allocation of resources** to ensure the ongoing conduct of maternal and child death reviews. **Establishment of a permanently funded unit within the MCH Branch at the DOH addresses program sustainability. Many factors responsible for infant mortality are shared with maternal mortality.** These include socio-environmental factors, appropriate accessing of medical care and timely response by the healthcare system. In addition there is considerable overlap in the methodologies for determining factors contributing to deaths and preventability. **It just makes sense to combine resources for theses reviews. The Hawaii State Department of Health (DOH) is supportive of this legislation.**

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. There are approximately 10 maternal deaths annually in the state of Hawaii. Maternal mortality rates are increasing and up to 50% of all maternal deaths may be preventable. **We know that review panels work: unlike overall United States data with rising maternal death rates, the**

United Kingdom and the state of California have decreased their maternal mortality by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

Hawaii, as of 2013, is one of only two states not conducting child death reviews. Previous reviews have found that up to 75% of child deaths in Hawaii were preventable. There are approximately 170 child deaths per year in the state of Hawaii. A series of recommendations from prior Child Death Reviews launched policy changes in licensed daycares and stimulated public service campaigns directed at reducing sleep related deaths. This summer's series of infant deaths, with 7 being sleep related and another 5 also preventable, highlights the importance of ongoing surveillance and active responses to minimize preventable deaths.

The appropriation for core fatality unit staffing at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews. The review panels for separate child and maternal death reviews will consist of voluntary expert members, allowing for significant in-kind support from health care providers and public health specialists.

Mahalo for the opportunity to testify, and for your support of Hawaii Maternal and Child Health.

March 4, 2016

To: Representative Sylvia Luke, Chair
Representative Scott Nishimoto, Vice Chair and
Members of the Committee on Finance

From: Jeanne Y. Ohta, Co-Chair

RE: SB 2317 SD2 HD1 Relating to Health
Hearing: Wednesday, March 30, 2016, 3:00 p.m., Room 308

Position: SUPPORT

The Hawaii State Democratic Caucus writes in support of SB 2317 SD2 HD1 Relating to Health. Deaths of a child or a pregnant woman are sentinel events that require proper investigations to understand the underlying causes and opportunities for prevention. The mortality reviews identify missed opportunities and remediable factors in cases of child and maternal deaths.

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. Maternal mortality rates are increasing and up to 50% of all maternal deaths may be preventable. We know that review panels work to reverse these bad outcomes. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

The Hawai‘i State Democratic Women’s Caucus is a catalyst for progressive, social, economic, and political change through action on critical issues facing Hawaii’s women and girls. Thank you for the opportunity to provide testimony in support of this important healthcare measure.

Hawai‘i State Democratic Women’s Caucus, 404 Ward Avenue Suite 200, Honolulu, HI 96814
hidemwomen@gmail.com

Lauren Wilson,
Maui, Hawai`i

To: House Committee on Finance
Representative Sylvia Luke, Chair
Representative Scott Nishimoto, Vice Chair

FROM: Lauren Wilson

Re: SB2317 Relating to Child and Maternal Death Reviews

Position: Strongly Support

Dear Representatives Luke, Nishimoto and Committee Members:

As a parent of a child who died in Hawai`i, I strongly support the establishment of a Hawaii Maternal Mortality Review Panel as well as the reinstatement of Child Death Review to conduct comprehensive, multidisciplinary reviews of maternal and child deaths towards improving maternal-child health in our state. It pains me to think what could have been different had, we as a state, still been providing resources and conducting Child and Maternal Death Reviews. Could the systemic failures that we faced have been avoided? One could never know. However, it is my hope, with your support of SB 2234 and full appropriation that other parents will not have to wonder. That future parents who face a child or maternal death will know that all stones have been overturned to ensure as many unnecessary deaths are prevented as possible.

There currently is no allocation of resources to ensure the ongoing conduct of maternal and child death reviews. Establishment of a permanently funded unit within the MCH Branch at the DOH addresses program sustainability. Many factors responsible for infant mortality are shared with maternal mortality. These include socio-environmental factors, appropriate accessing of medical care and timely response by the healthcare system. In addition there is considerable overlap in the methodologies for determining factors contributing to deaths and preventability. It just makes sense to combine resources for theses reviews. The Hawaii State Department of Health (DOH) is supportive of this legislation.

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. There are approximately 10 maternal deaths annually in the state of Hawaii. Maternal mortality rates are increasing and up to 50% of all maternal deaths may be preventable. We know that review panels work: unlike overall United States data with rising maternal death rates, the United Kingdom and the state of California have decreased their maternal mortality by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

Hawaii, as of 2013, is one of only two states not conducting child death reviews. Previous reviews have found that up to 75% of child deaths in Hawaii were preventable. There are approximately 170 child deaths per year in the state of Hawaii. A series of recommendations from prior Child Death Reviews launched policy changes in licensed daycares and stimulated public service campaigns directed at reducing sleep related deaths. This summer's series of infant deaths, with 7 being sleep related and another 5 also preventable, highlights the importance of ongoing surveillance and active responses to minimize preventable deaths.

The appropriation for core fatality unit staffing at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews. The review panels for separate child and maternal death reviews will consist of voluntary expert members, allowing for significant in-kind support from health care providers and public health specialists.

Mahalo for the opportunity to testify, and for your support of Hawaii Maternal and Child Health.

Lauren Wilson
Maui

DAVID Y. IGE
GOVERNOR

RACHAEL WONG, DrPH
DIRECTOR

PANKAJ BHANOT
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

LATE

March 30, 2016

TO: The Honorable Sylvia Luke, Chair
House Committee on Finance

FROM: Rachael Wong, DrPH, Director

SUBJECT: **SB 2317 SD2 HD1 Relating to Health**

Hearing: Wednesday, March 30, 2016 at 3:00 p.m.
Conference Room 308, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) is committed to improving the health and safety of Hawaii's children and families and offers comments.

PURPOSE: The purpose of the bill requires the Department of Health (DOH) to submit annual reports to the Legislature of child and maternal deaths and death reviews in the State. It also requires all health care and social services providers, and county and state agencies to disclose child death review information and information or other materials for studies to reduce morbidity or mortality; and appropriates fund to DOH to conduct child death reviews and implement a program to perform maternal death reviews.

DHS has collaborated with DOH on child death reviews in the past, and appreciates and recognizes the value and importance of the review process. However, DHS has concerns with amendments of HD1 due to the confidentiality of the information DHS will be providing to DOH. DHS would like to be certain that any DHS information maintained or produced by DOH in any form such as notes, emails, work product and reports will be protected from disclosure under any circumstance, including litigation related discovery.

Thank you for the opportunity to testify.

DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

STATE OF HAWAII
DEPARTMENT OF HEALTH
P. O. Box 3378
Honolulu, HI 96801-3378
doh.testimony@doh.hawaii.gov

LATE

Testimony COMMENTING on SB2317 SD2 HD1
RELATING TO HEALTH

REPRESENTATIVE SYLVIA LUKE, CHAIR
HOUSE COMMITTEE ON FINANCE

Hearing Date: March 30, 2016 Room Number: 308

Fiscal Implications: The Department of Health (DOH) currently lacks resources to conduct timely and meaningful child and maternal mortality reviews. A minimum estimated $150,000 is required to temporarily establish minimum functionality over the next biennium; roughly half of which is for personnel and the other half for purchase of service contracts and other operational expenses. General funds would be requested to support operations going forward in subsequent biennia. The department defers to the Governor's Supplemental Budget Request for its fiscal priorities regarding the general fund appropriation.

Department Testimony: The Department agrees that comprehensive multidisciplinary reviews are needed to improve systems of care and prevent child and maternal deaths, which is an essential public health service in the State.

The proposed public health child and maternal death review system does not duplicate or supplant reviews that healthcare providers perform for internal purposes, but rather examines larger system issues including social determinants of health that may inform coordinated improvements in local systems and policies to improve maternal and child health.

According to department vital records, there are approximately 170 child deaths and up to 10 maternal deaths per year, out of an average 19,000 annual births. In the last Hawaii child death review report 2001-2006, out of 1,079 child deaths, 34% of both residents and non-residents were comprehensively reviewed and **73% of them were determined to be preventable**. Since this report, fewer deaths have been reviewed with no reviews occurring since 2013 when

resources to oversee these reviews ended; no maternal mortality reviews have been conducted in the past.

The department finds strong community consensus and is negotiating with stakeholders on a proposal for a statutory and administrative framework, specifically refinements to the access to and handling of confidential patient information. DOH respectfully requests this measure be passed out largely as drafted for further conversation.

Thank you for this opportunity to testify.

Offered Amendments: None

Hawaii Children's Action Network
Building a unified voice for Hawaii's children

LATE

Address
850 Richards Street
Suite 201
Honolulu, HI
96813

P: (808) 531-5502

March 30, 2016

To: Representative Sylvia Luke, Chair
Representative Scott Y. Nishimoto, Vice Chair
House Committee on Finance

From: Deborah Zysman, Executive Director
Hawaii Children's Action Network

Re: SB 2317 SD2 HD1 – Relating to Health - Support
Agenda #2 – Hawaii State Capitol, Room 308 – March 30, 2016, 3 PM

On behalf of Hawaii Children's Action Network (HCAN), formerly Good Beginnings Alliance, we are writing in support of SB 2317 SD2, HD1 Relating to Health.

HCAN is committed to improving lives and being a strong voice advocating for Hawai'i's children. Last fall, HCAN convened input in person and online from more than 50 organizations and individuals that came forward to support or express interest for a number of issues affecting children and families in our state that resulted in the compilation of 2016 Hawai'i Children's Policy Agenda, which can be accessed at http://www.hawaii-can.org/2016policyagenda.

SB 2317 SD2 HD1 would authorize an appropriation for and establish a Hawaii Maternal Mortality Review Panel within the Department of Health (DOH) to conduct a comprehensive review of maternal deaths that have occurred in this state.

Hawaii is one of 13 states not conducting maternal mortality reviews; and as of 2013, is one of only two states not conducting Child Death Reviews. Up to 50 percent of maternal mortality is preventable and 75 percent of child deaths in Hawaii were found to be preventable.

The lack of mortality reviews for maternal and child deaths are missed opportunities to remedy the causes by taking preventative actions to educate our community. Securing data on the causes helps to address and prevent unnecessary deaths from happening.

For these reasons, HCAN respectfully requests that the committee vote to pass this bill.

LATE

March 30, 2016 TESTIMONY: Written only

To: The Honorable Sylvia Luke, Chair
The Honorable Scott Y. Nishimoto, Vice Chair
Members of the House Committee on Finance

From: **Hawaii Public Health Association**

Subject: **SUPPORT – SB2317 SD2 HD1** RELATING TO HEALTH: CHILD DEATH AND MATERNAL MORTALITY REVIEWS

Hearing: March 30, 2016 at 3pm, State Capitol Conference Room 308

The Hawaii Public Health Association (HPHA) is an association of over 600 community members, public health professionals, and organizations statewide dedicated to improving public health. HPHA also serves as a voice for public health professionals and as a repository for information about public health in the Pacific.

HPHA **supports the passage of SB2317 SD2 HD1** which appropriates funds to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews.

The Hawaii Child Death Review (CDR) system was established in 1997 by the Legislature through Hawaii Revised Statute §321-345. The CDR teams conducted comprehensive and multidisciplinary reviews of child deaths 0-17 years to understand risk factors of child deaths. The reviews focused on prevention of future child deaths and have also led to recommendations in ensuring child safety and providing optimal child health. CDRs require adequate resources to conduct the reviews and passage of this bill would enable this process to resume, since it has been inactive since 2011.

The United States maternal mortality ratio has increased and the Centers for Disease Control and Prevention (CDC) states that maternal mortality review committees are necessary for ensuring all pregnancy-related deaths are identified and reviewed, and that effective prevention actions are developed. The Association of Maternal and Child Health Programs also supports a maternal mortality review process as pregnancy-related deaths are an indicator of the overall health of women of reproductive age. Many of these deaths

are preventable. According to the American Congress of Obstetricians and Gynecologists, state-level maternal mortality review committees are an important obstetric care and maternal public health function. Hawaii is one of fourteen states that do not conduct maternal mortality review in a comprehensive statewide system.

Child death and maternal death reviews would provide critical data to support prevention efforts to reduce child and maternal mortality and morbidity in Hawaii.

Thank you for the opportunity to testify in support of **SB2317 SD2 HD1**, which would allow funding to resume child death reviews and implement a program to conduct maternal death reviews.

Respectfully submitted,

Hoce Kalkas, MPH
HPHA Legislative and Government Relations Committee Chair

LATE

Sara Christine Harris, MD
1448 Young Street #1810
Honolulu, HI 96814

To: House Committee on Finance
Representative Sylvia Luke, Chair
Representative Scott Nishimoto, Vice Chair

DATE: Wednesday, March 30th
TIME: 3:00 PM
PLACE: Conference Room 308

FROM: Sara Christine Harris, MD

Re: SB2317 Relating to Child and Maternal Death Reviews

Position: Strongly Support

Dear Representatives Luke, Nishimoto and Committee Members:

As a provider of obstetrics and an advocate of maternal-child health, I strongly support the establishment of a Hawaii Maternal Mortality Review Panel as well as the reinstatement of Child Death Review to conduct comprehensive, multidisciplinary reviews of maternal and child deaths towards improving maternal-child health in our state. Deaths of a child or a pregnant woman are sentinel events that require proper investigations to understand the underlying causes and opportunities for prevention. The mortality reviews identify missed opportunities and remediable factors in cases of child and maternal deaths.

There currently is **no allocation of resources** to ensure the ongoing conduct of maternal and child death reviews. **Establishment of a permanently funded unit within the MCH Branch at the DOH addresses program sustainability. Many factors responsible for infant mortality are shared with maternal mortality.** These include socio-environmental factors, appropriate accessing of medical care and timely response by the healthcare system. In addition there is considerable overlap in the methodologies for determining factors contributing to deaths and preventability. **It just makes sense to combine resources for theses reviews. The Hawaii State Department of Health (DOH) is supportive of this legislation.**

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. There are approximately 10 maternal deaths annually in the state of Hawaii. Maternal mortality rates are increasing and up to 50% of all maternal deaths may be preventable. **We know that review panels work: unlike overall United States data with rising maternal death rates, the**

United Kingdom and the state of California have decreased their maternal mortality by instituting programs aimed at preventable causes of death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care.

Hawaii, as of 2013, is one of only two states not conducting child death reviews. Previous reviews have found that up to 75% of child deaths in Hawaii were preventable. There are approximately 170 child deaths per year in the state of Hawaii. A series of recommendations from prior Child Death Reviews launched policy changes in licensed daycares and stimulated public service campaigns directed at reducing sleep related deaths. This summer's series of infant deaths, with 7 being sleep related and another 5 also preventable, highlights the importance of ongoing surveillance and active responses to minimize preventable deaths.

The appropriation for core fatality unit staffing at the DOH is fundamental to ensuring the sustainability of child and maternal death reviews. The review panels for separate child and maternal death reviews will consist of voluntary expert members, allowing for significant in-kind support from health care providers and public health specialists.

Mahalo for the opportunity to testify, and for your support of Hawaii Maternal and Child Health.

Sincerely,

Sara Harris

LATE

55 Merchant Street
Honolulu, Hawai'i 96813-4333

HAWAI'I PACIFIC HEALTH
Kapi'olani · Pali Momi · Straub · Wilcox

www.hawaiipacifichealth.org

March 30, 2016 at 3:00 PM
Conference Room 308

House Committee on Finance

To: Representative Sylvia Luke, Chair
Representative Scott Nishimoto, Vice Chair

From: Michael Robinson
Vice President, Government Relations & Community Affairs

Re: SB 2317, SD2, HD1 - Testimony Supporting Intent and Requesting Amendments

---

My name is Michael Robinson, Vice President, Government Relations and Community Affairs at Hawai'i Pacific Health (HPH). Hawai'i Pacific Health is a not-for-profit health care system, and the state's largest health care provider and non-governmental employer. Hawai'i Pacific Health is committed to providing the highest quality medical care and service to the people of Hawai'i and the Pacific Region through its four hospitals, more than 50 outpatient clinics and service sites, and over 1,600 affiliated physicians. Hawai'i Pacific Health's hospitals are Kapi'olani Medical Center for Women & Children, Pali Momi Medical Center, Straub Clinic & Hospital and Wilcox Memorial Hospital.

We support the objective of this bill to integrate the efforts and resources of both the infant and maternal mortality review boards and to provide adequate resources needed to enable comprehensive multidisciplinary reviews of maternal and child deaths under a single piece of legislation. However, as the information sought is highly sensitive and confidential, we respectfully request an amendment which will address concerns regarding patient privacy and liability issues. Our suggested language is provided below:

Page 7, lines 3-5: "The department of health may request information stored in electronic format or in paper copies, [~~or gathered through interviews~~]…. "

Page 7, lines 14-15: "The department of health shall not request findings of any hospital [~~quality~~] committee review."

Given the likelihood of commonly shared socially determined risk factors related to both infant and maternal mortality, we appreciate the effect this bill will have in creating a sound and coordinated systems approach to establish accountability and awareness of this public health issue. By addressing the issue from a combined infant and maternal

mortality framework, this approach will also better facilitate the ongoing dialogue and effort occurring between maternal and pediatric medical specialists.

Thank you very much for the opportunity to testify on this measure.