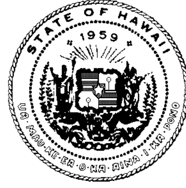
DAVID Y. IGE
GOVERNOR



RACHAEL WONG, DrPH
DIRECTOR

PANKAJ BHANOT
DEPUTY DIRECTOR

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

March 13, 2016

TO: The Honorable Della Au Bellatti, Chair
House Committee on Health

FROM: Rachael Wong, DrPH, Director

SUBJECT: SB 2317 SD2 - Relating to Health

Hearing: Monday, March 14, 2016 at 2:15 p.m.
Conference Room 329, State Capitol

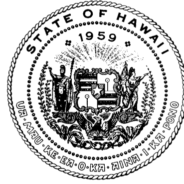
DEPARTMENT'S POSITION: The Department of Human Services (DHS) supports the bill, provided that its passage does not replace or adversely impact priorities indicated in the Executive Budget.

PURPOSE: The purpose of the bill is to provide ongoing funding to the Department of Health (DOH) to conduct both child and maternal death reviews.

The DHS has collaborated with the DOH on child death reviews in the past, and appreciates and recognizes the value and importance of the review process.

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

Testimony COMMENTING on S.B. 2317, S.D. 2
Relating to Health

REPRESENTATIVE DELLA BELATTI, CHAIR
HOUSE COMMITTEE ON HEALTH

Hearing Date: March 14, 2016 Room Number: 329

1 **Fiscal Implications:** The Department of Health (DOH) currently lacks resources to conduct
2 timely and meaningful child and maternal mortality reviews. A minimum estimated $150,000 is
3 required to temporarily establish minimum functionality over the next biennium.

4 The department defers to the Governor's Supplemental Budget Request for its fiscal priorities
5 regarding the general fund appropriation.

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

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

16 The department finds strong community consensus and is negotiating with stakeholders on a
17 proposal for a statutory and administrative framework. The proposed public health child and
18 maternal death review system does not duplicate or supplant reviews that healthcare providers

1 perform for internal purposes, but rather examines larger system issues including social
2 determinants of health that may inform coordinated improvements in local systems and policies
3 to improve maternal and child health.

4 DOH urges statute that assures pertinent information be provided to the department upon request
5 from the community and that those data be subject to appropriate privacy standards and
6 practices.

7 The department requests the indulgence of the Legislature by providing extra time to finalize
8 details of such a proposal.

9 Thank you for this opportunity to testify.

10 **Offered Amendments:**

11 SECTION 2. Chapter 321, Hawaii Revised Statutes, is amended by adding
12 a new section to part XXVII to be appropriately designated and to read
13 as follows:

14 "**§321- Child death reviews; reports.** (a) Upon written
15 request of the director, all providers of health care or social
16 services and state and county agencies shall disclose to the
17 department, and those individuals appointed by the director to
18 the panel, maternal mortality review information regarding the
19 circumstances of a maternal death so that the department may
20 conduct a multidisciplinary review of maternal mortality pursuant
21 to section 321- and this part. The department may request
22 information that includes but is not limited to medical records,
23 patient histories, social service records, medical examiner
24 records, or law enforcement records that are in electronic
25 format, paper copies, or provided through interviews. The

1 department shall not request findings of any hospital quality
2 committee review.

3 (b) The director shall submit an annual written report to
4 the legislature no later than twenty days prior to the convening
5 of each regular session on the status of child death reviews
6 conducted by the department pursuant to section 321-341. The
7 annual report shall include information about the department's
8 child death review activities, if any, in the twelve month period
9 prior to submission of the annual report; the total number of
10 child deaths in Hawaii and the causes of those deaths; and the
11 number of deaths of children in state custody and the causes of
12 those deaths, during the calendar year prior to the year of
13 submission of the annual report. The annual report may also
14 include discussion of identifiable trends in child deaths and
15 recommendations for system changes, including any proposed
16 legislation.

17 SECTION 3. Chapter 324, Hawaii Revised Statutes, is amended by
18 adding a new section to part I to be appropriately designated
19 and to read as follows:

20 "**§324- Maternal death review; reports.** (a) Upon
21 written request of the director, all providers of health care or
22 social services and state and county agencies shall disclose to
23 the department, and those individuals appointed by the director
24 to the panel, maternal mortality review information regarding
25 the circumstances of a maternal death so that the department may
26 conduct a multidisciplinary review of maternal mortality
27 pursuant to section 321- and this part. The department may
28 request information that includes but is not limited to medical

records, patient histories, social service records, medical examiner records, or law enforcement records that are in electronic format, paper copies, or provided through interviews. The department shall not request findings of any hospital quality committee review.

(b) The director of health shall submit an annual written report to the legislature no later than twenty days prior to the convening of each regular session on the status of reviews of maternal deaths conducted by the department. The annual report shall include information about the department's maternal death review activities, if any, in the twelve month period prior to submission of the annual report, the total number of deaths of women while pregnant or within one year after a pregnancy in Hawaii, the causes of those deaths, and whether the causes of death were pregnancy related. The annual report may also include discussion of identifiable trends in maternal deaths and recommendations for system changes, including any proposed legislation.

(c) The director of health shall submit a copy of any other maternal death review report published by the department of health, detailing findings and recommendations resulting from such a review, to the legislature upon the report's publication."

From: mailinglist@capitol.hawaii.gov
Sent: Friday, March 11, 2016 4:10 PM
To: HLTtestimony
Cc: laurie.field@ppvnh.org
Subject: *Submitted testimony for SB2317 on Mar 14, 2016 14:15PM*

SB2317
Submitted on: 3/11/2016
Testimony for HLT on Mar 14, 2016 14:15PM in Conference Room 329

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.

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96813

P: (808) 531-5502

March 14, 2016

To: Representative Della Au Belatti, Chair
Representative Richard P. Creagan, Vice Chair
House Committee on Health

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

Re: SB 2317 SD2 – Relating to Health - Support
Hawaii State Capitol, Room 329 – March 14, 2016, 2:15

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

March 4, 2016

To: Representative Della Au Belatti, Chair
Representative Richard Creagan, Vice Chair and
Members of the Committee on Health

From: Jeanne Y. Ohta, Co-Chair

RE: SB 2317 SD2 Relating to Health
Hearing: Monday, March 14, 2016, 2:15 p.m., Room 329

Position: SUPPORT

The Hawaii State Democratic Caucus writes in support of SB 2317 SD2 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 Hawaiʻi 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.

Hawaiʻi State Democratic Women's Caucus, 404 Ward Avenue Suite 200, Honolulu, HI 96814
hidemwomen@gmail.com

KAISER PERMANENTE®

Government Relations

Testimony of
John M. Kirimitsu
Legal and Government Relations Consultant

Before:
House Committee on Health
The Honorable Della Au Belatti, Chair
The Honorable Richard P. Creagan, Vice Chair

March 14, 2016
2:15 pm
Conference Room 329

Re: SB 2317 SD2 Relating to Health

Chair, Vice-Chair, and committee members thank you for this opportunity to provide testimony on SB 2317 SD2 relating to the implementation of a program for maternal death reviews and the reinstatement of the child death reviews.

Kaiser Permanente Hawaii supports this bill.

Estimates from the Centers for Disease Control and Prevention suggest that deaths related to pregnancy in the United States have more than doubled over the past 20 years. Today about 22 in 100,000 live births result in the mother's death.

Kaiser Permanente supports the implementation of a state-level maternity mortality review committee to review deaths of mothers while pregnant, as well as the reinstatement of Hawaii's child death review system, to improve mortality surveillance through the establishment of a statewide mortality review process. The child and maternal mortality review process is a method of understanding the diverse factors and issues that contribute to preventable deaths, and Kaiser Permanente supports their creation through SB 2317 SD2.

Thank you for your consideration.

711 Kapiolani Blvd
Honolulu, Hawaii 96813
Telephone: 808-432-5224
Facsimile: 808-432-5906
Mobile: 808-282-6642
E-mail: john.m.kirimitsu@kp.org

March 13, 2016 TESTIMONY: Written only

To: The Honorable Della Au Belatti, Chair
The Honorable Richard P. Creagan, Vice Chair
Members of the House Committee on Health

From: **Hawaii Public Health Association**

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

Hearing: March 14, 2016 at 2:15pm at State Capitol Room 329

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 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** 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 does 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**, 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

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

KAPI'OLANI
CHILD PROTECTION
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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 14, 2016

TO: The Honorable Della Au Belatti, Chair
The Honorable Richard Creagan, Vice Chair
House Committee on Health

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
Relating to Health

Good morning Chair Au Belatti, Vice Chair Creagan, and members of the House Committee on Health.

The Kapiolani Child Protection Center (KCPC) strongly supports S.B. 2317 S.D. 2, 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 providers release information for the Department of Health or others 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 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 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 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.

To: COMMITTEE ON HEALTH

From: Hawaii Medical Association
Dr. Scott McCaffrey, MD, President
Dr. Linda Rasmussen, MD, Legislative Co-Chair
Dr. Ronald Keinitz, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Date: March 14, 2016
Time: 2:15
Place: CR 329

Re: SB 2317, Relating to Health

Position: Strongly Support

The Hawaii Medical Association supports the position of the American Congress of Obstetricians and Gynecologists, Hawaii Section (Hawaii ACOG) in support of the establishment of a Hawaii Maternal Mortality Review Panel to conduct comprehensive, multidisciplinary reviews of maternal deaths towards improving pregnancy care in our state. This measure establishes the Hawaii maternal mortality review panel to conduct a comprehensive review of maternal deaths that have occurred in the State. The Centers for Disease Control and Prevention (CDC), American College of Obstetricians and Gynecologists, Association of Maternal and Child Health Programs, World Health Organization and many other organizations all strongly recommend that each state have a maternal mortality review panel.

Hawaii is one of only 13 states without a multi-disciplinary professional panel to review pregnancy-related deaths. Maternal mortality review panels are essential to improving pregnancy care for all patients and it is thought that up to half 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 identifying missed opportunities and remediable factors in cases of maternal death. Findings from review panels guide the creation of treatment protocols, education campaigns and standardization of pregnancy care. SB2317 creates this much needed review panel, made up of **volunteer** health providers and other members at very **minimal cost** to the State for a part-time administrative assistant. We are collaborating with and have received support from the State of Hawaii Department of Health (DOH) on this bill.

Despite advances in medical care, the U.S. maternal mortality continues to rise and we are the only developed nation with an increasing maternal mortality. The number of reported pregnancy-related deaths in the U.S. has increased from 8.4 deaths per 100,000 live births in 1997 to a high of 17.8 deaths per 100,000 live births in 2011 (CDC, 2015). In the 1990s, U.S.

officials had hoped to decrease this rate from 8.4 (1997) to 3.3 deaths per 100,000 live births by 2010 (Healthy People 2010), however the actual rate was five times that number. World Health Organization (WHO) estimates for 2013, reveal that 62 countries had lower maternal mortality ratios than the U.S. (WHO, Trends in Maternal Mortality: 1990-2013). According to Hawaii Department of Health data, there were 102 maternal deaths from 2001 through 2011, an average of 9 deaths per year.

For each maternal death, there are perhaps 100 times more “near misses”. Reviewing maternal deaths highlights areas for improvement in pregnancy care for all women.

The estimated cost of instituting the Hawaii Maternal Mortality Review Panel is only $10,000 annually for a part time administrative assistant/copying costs. The remainder of the professional panel committee members are volunteers and uncompensated. This is a very minimal cost for such a large benefit to all of Hawaii’s pregnant women.

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 14, 2016

To: Representative Della Au Belatti, Chair
Representative Richard Creagan, Vice Chair

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

Re: In support of
SB 2317 SD2
Hearing: Monday, March 14, 2016
Conference Room 329, State Capitol

Chair Belatti, Vice Chair Creagan, Members of the Committees:

I am writing to express strong support for SB 2317 SD2: 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 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 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.

From: mailinglist@capitol.hawaii.gov
Sent: Saturday, March 12, 2016 5:27 AM
To: HLTtestimony
Cc: leolinda@resqconsultants.com
Subject: *Submitted testimony for SB2317 on Mar 14, 2016 14:15PM*

SB2317
Submitted on: 3/12/2016
Testimony for HLT on Mar 14, 2016 14:15PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Leolinda Parlin	Family Voices of HI	Support	No

Comments:

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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

To: COMMITTEE ON HEALTH
Representative Della Au Bellati, Chair
Representative Richard P. Creagan, Vice Chair

DATE: Monday, March 14, 2016
TIME: 2:15 p.m.
PLACE: Conference Room 211
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 Relating to Health

Position: Strongly Support

Establishing the Maternal Mortality Review Panel

Dear Representative Bellati, Representative Creagen, 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.

1319 Punahou Street
Honolulu, Hawai'i 96826-1001

KAPI'OLANI
MEDICAL CENTER
FOR WOMEN & CHILDREN
An Affiliate of Hawai'i Pacific Health

808-983-6000
www.kapiolani.org

March 14, 2016 at 2:15 PM
Conference Room 329

House Committee on Health

To: Representative Della Au Belatti, Chair
Representative Richard Creagan, Vice Chair

From: Janet Burlingame, MD
Chair, Quality Council
Kapi'olani Medical Center for Women & Children

Re: SB 2317, SD2 - Testimony Supporting Intent

My name is Janet Burlingame, MD Obstetrician and Maternal-Fetal Medicine specialist at Kapi'olani Medical Center for Women & Children (KMCWC). Kapi'olani Medical Center is the state's only maternity, newborn and pediatric specialty hospital with 207 beds and 66 bassinets. Kapi'olani is also a tertiary care, medical teaching and research facility. The not-for-profit hospital is an affiliate of Hawai'i Pacific Health.

Kapi'olani **supports the intent** of SB 2317, SD2 which appropriates funds to the Department of Health to conduct comprehensive reviews of child and maternal deaths that have occurred in the State and report findings to the legislature**.** 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. *We are working with the Department of Health on language which will address concerns regarding patient privacy and liability issues*.

Program sustainability

I have some concern about the sustainability of a one-year appropriation and support all efforts to reinstate the maternal mortality review in a resource-conscientious, endurable manner.

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

55 Merchant Street
Honolulu, Hawai'i 96813-4333

HAWAIʻI PACIFIC HEALTH
Kapiʻolani · Pali Momi · Straub · Wilcox

www.hawaiipacifichealth.org

March 14, 2016 at 2:15 PM
Conference Room 329

House Committee on Health

To: Representative Della Au Belatti, Chair
Representative Richard Creagan, Vice Chair

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

Re: SB 2317, SD2 - Testimony Supporting Intent

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

HPH **strongly supports the intent** of SB 2317, SD2 which makes an appropriation to the Department of Health to conduct child death reviews and implement a program to perform maternal death reviews**.**

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. *We are working with the Department of Health on language which will address concerns regarding patient privacy and liability issues*.

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.

SB 2234 also provides a more adequate level of resources to ensure its goals are met.

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

March 14, 2016 at 2:15 PM
Conference Room 329

House Committee on Health

To: Chair Della Au Belatti
Vice Chair Richard P. Creagan

From: George Greene
President and CEO
Healthcare Association of Hawaii

Re: Submitting comments
SB 2317 SD 2, 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, 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 request of and use of data from health care facilities. We are particularly concerned that the liability language in this bill may not be strong enough to protect many of our members.

We would ask that your committee consider amendments to better clarify the type of data that the department would request, and ensure that any facilities or individuals involved in these reviews are protected. We look forwarding to engaging with the Department of Health and other stakeholders on this matter.

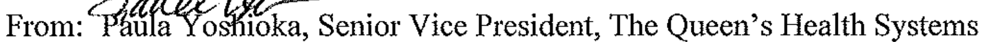
Thank you for your time and consideration of this matter.

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

Affiliated with the American Hospital Association, American Health Care Association, National Association for Home Care and Hospice,
American Association for Homecare and Council of State Home Care Associations

THE QUEEN'S HEALTH SYSTEMS

To: The Honorable Della Au Bellati, Chair, Committee on Health
The Honorable Richard P. Creagan, Vice Chair, Committee on Health
Members, Committee on Health



From: Paula Yoshioka, Senior Vice President, The Queen's Health Systems
Date: March 11, 2016
Hrg: House Committee on Health Hearing; Monday, March 14, 2016 at 2:15 p.m. in Room 329

Re: **Comments on SB 2317, SD2, Relating to Health**

My name is Paula Yoshioka, and I am a Senior Vice President at The Queen's Health Systems (QHS). I would like to submit comments on SB 2317, SD2, Relating to Health.

QHS supports the intent of this measure and would like to thank the committee for having the opportunity to provide comments on SB 2317, SD2, which would allow the Department of Health to carry out a report on child and maternal deaths in the state. For over 150 years, QHS has been committed to the mission of providing quality health care services in perpetuity to Native Hawaiians as well as all the people of Hawai'i. We believe the intent of this measure would improve the continuum of care for our woman and children. However, QHS concurs with the concerns raised by the Healthcare Association of Hawaii (HAH), with regards to the data that would be requested from our facilities and the limited liability language currently in the bill.

QHS humbly asks for the committee's consideration of amendments provided by HAH on SB 2317, SD2, which would clarify the type of data that the Department of Health would request and protect the facilities or individuals involved in the reviews.

Thank you for your time and attention to this important issue.

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 14, 2016 12:15 PM
To: HLTtestimony
Cc: dylanarm@hawaii.edu
Subject: *Submitted testimony for SB2317 on Mar 14, 2016 14:15PM*

SB2317
Submitted on: 3/14/2016
Testimony for HLT on Mar 14, 2016 14:15PM in Conference Room 329

Submitted By	Organization	Testifier Position	Present at Hearing
Dylan Armstrong	Individual	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.

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