



Senate

General Assembly

File No. 345

February Session, 2018

Substitute Senate Bill No. 304

Senate, April 9, 2018

The Committee on Public Health reported through SEN. GERRATANA of the 6th Dist. and SEN. SOMERS of the 18th Dist., Chairpersons of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT ESTABLISHING A MATERNITY MORTALITY REVIEW COMMITTEE WITHIN THE DEPARTMENT OF PUBLIC HEALTH.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. (NEW) (*Effective October 1, 2018*) (a) As used in this
2 section, "maternal death" means the death of a woman while pregnant
3 or not later than one year after the date on which the woman ceases to
4 be pregnant, regardless of whether the woman's death is related to her
5 pregnancy.

6 (b) There is established, within the Department of Public Health, a
7 maternal mortality review panel to conduct comprehensive,
8 multidisciplinary reviews of maternal deaths in the state for purposes
9 of identifying factors associated with maternal death and making
10 recommendations for improvements to the provision of health care
11 services to women. The panel shall include, but need not be limited to,
12 the Chief Medical Examiner, or his or her designee, the Commissioner
13 of Public Health, or his or her designee, and the following members,

14 who shall be appointed by the Commissioner of Public Health:

15 (1) A physician licensed pursuant to chapter 370 of the general
16 statutes, who specializes in obstetrics;

17 (2) A physician licensed pursuant to chapter 370 of the general
18 statutes, who specializes in maternal fetal medicine;

19 (3) A physician licensed pursuant to chapter 370 of the general
20 statutes, who is a pediatrician who specializes in neonatology;

21 (4) A nurse-midwife licensed pursuant to chapter 377 of the general
22 statutes;

23 (5) An epidemiologist affiliated with the epidemiology and
24 emerging infections program administered by the Department of
25 Public Health, who has experience analyzing perinatal data;

26 (6) A representative of the Department of Public Health, who
27 participates in the maternal and child health needs assessment
28 administered by the department;

29 (7) A representative of a community mental health center;

30 (8) A representative of a community or regional program or facility
31 providing services for persons with psychiatric disabilities or persons
32 with substance use disorders; and

33 (9) A relative of a woman in the state who died of a maternal death.

34 (c) Members of the maternal mortality review panel shall serve not
35 more than three consecutive years. The review panel shall meet at least
36 biannually and shall select its chairperson from among its members.
37 Members shall serve without compensation, but shall be reimbursed
38 for reasonable and necessary expenses incurred in the performance of
39 their duties.

40 (d) The maternal mortality review panel shall perform the following
41 functions:

- 42 (1) Identify maternal death cases in the state;
- 43 (2) Review medical records and other relevant data related to each
44 maternal death case;
- 45 (3) Contact family members of each woman who died of a maternal
46 death and any other affected persons to collect additional data relevant
47 to the maternal death case;
- 48 (4) Consult with relevant experts to evaluate information obtained
49 in the panel's review of each maternal death case; and
- 50 (5) Make recommendations regarding the prevention of maternal
51 death.

52 (e) Not later than January 1, 2019, and annually thereafter, the
53 review panel shall report its findings and recommendations to the
54 Department of Public Health and, in accordance with the provisions of
55 section 11-4a of the general statutes, to the joint standing committee of
56 the General Assembly having cognizance of matters relating to public
57 health.

58 Sec. 2. (NEW) (*Effective October 1, 2018*) (a) Licensed health care
59 providers, health care facilities and pharmacies shall provide
60 reasonable access to the maternal mortality review panel established
61 under section 1 of this act to all relevant medical records associated
62 with a maternal death case under review by the panel.

63 (b) If there is a maternal death and the health care provider or
64 health care facility has knowledge of the circumstances of the death,
65 the health care provider or health care facility shall report the death to
66 the maternal mortality review panel. Every report made under this
67 subsection shall (1) be confidential, (2) not be open to public inspection
68 or subject to disclosure, and (3) not be subject to subpoena or discovery
69 or introduced into evidence in any judicial proceeding, except as
70 otherwise specifically provided by law and upon sealing of the court
71 record containing the information included in the report.

72 (c) No health care provider, health care facility or pharmacy that
 73 provides reasonable access to medical records under this section shall
 74 disclose personally identifiable information to the maternal mortality
 75 review panel if such disclosure would constitute a violation of federal
 76 law, including, but not limited to, the Health Insurance Portability and
 77 Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from
 78 time to time.

79 (d) No health care provider, health care facility or pharmacy shall be
 80 subject to civil or criminal liability or disciplinary action for good faith
 81 efforts made to comply with the provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	October 1, 2018	New section
Sec. 2	October 1, 2018	New section

Statement of Legislative Commissioners:

In Section 1(b), subdivisions (7) and (11) were deleted and "the Chief Medical Examiner, or his or her designee" and "the Commissioner of Public Health, or his or her designee" were inserted in the second sentence for accuracy and clarity.

PH *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note***State Impact:*** None***Municipal Impact:*** None***Explanation***

This bill, which establishes a Maternity Mortality Review Panel, does not result in a fiscal impact as PA 17-236 prohibits transportation allowances for task force members.

The Out Years***State Impact:*** None***Municipal Impact:*** None

OLR Bill Analysis**SB 304*****AN ACT ESTABLISHING A MATERNITY MORTALITY REVIEW COMMITTEE WITHIN THE DEPARTMENT OF PUBLIC HEALTH.*****SUMMARY**

This bill establishes a Maternity Mortality Review Panel within the Department of Public Health (DPH) to review maternal deaths in Connecticut, identify associated factors, and make recommendations for improving women's health care services. Starting January 1, 2019, and annually thereafter, the panel must annually report its findings and recommendations to DPH and the Public Health Committee.

Under the bill, a "maternal death" is the death of a woman (1) while pregnant or (2) within one year after the date when the woman ceases to be pregnant, regardless of whether the death is related to her pregnancy.

The bill establishes related reporting and medical records requirements for licensed health care providers, health care facilities, and pharmacies. It also grants these individuals and entities immunity from civil or criminal liability or disciplinary action for good faith efforts to comply with the bill's provisions.

The bill also makes technical changes.

EFFECTIVE DATE: October 1, 2018

MATERNAL MORTALITY REVIEW PANEL***Membership***

Under the bill, the Maternity Mortality Review Panel must include at least the following 11 members:

1. three licensed physicians, one each who specializes in obstetrics,

- maternal fetal medicine, and neonatology;
2. one licensed nurse-midwife;
 3. one epidemiologist affiliated with DPH's Epidemiology and Emerging Infections Program, who has experience analyzing perinatal data;
 4. one DPH representative who participates in the department's maternal and child health needs assessment;
 5. the Chief Medical Examiner, or his designee;
 6. one community mental health center representative;
 7. one representative of a community or regional program or facility that provides services to individuals with psychiatric disabilities or substance use disorders;
 8. a relative of a Connecticut resident who died of a maternal death; and
 9. the DPH commissioner, or his designee.

Panel members serve three-year terms without compensation, but may be reimbursed for related reasonable and necessary expenses. The bill requires the panel to meet at least biannually and select its chairperson from among its members.

Duties

Under the bill, the panel must:

1. identify maternal death cases in Connecticut and review related medical records and other relevant data;
2. contact family members of each woman who died of a maternal death and any other affected persons to collect additional relevant data;

3. consult with relevant experts to evaluate information obtained in the panel’s review of each maternal death case; and
4. make recommendations on preventing such deaths.

MEDICAL RECORDS AND REPORTING REQUIREMENTS

Under the bill, licensed health care providers, health care facilities, and pharmacies must provide the Maternal Mortality Review Panel reasonable access to all relevant medical records associated with maternal death cases the panel reviews. But they cannot disclose personally identifiable information if doing so would violate federal law (e.g., HIPAA).

Additionally, if a provider or facility knows the circumstances of a maternal death, the bill requires them to report the death to the panel. These reports are (1) confidential, (2) not subject to disclosure or public inspection, and (3) not subject to subpoena or discovery or introduction into evidence in a judicial proceeding, unless it is specifically provided by law and the court record is sealed.

COMMITTEE ACTION

Public Health Committee

Joint Favorable
Yea 20 Nay 7 (03/19/2018)