Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

House Bill 796 (Delegate Wilkins, *et al.*)
Health and Government Operations Finance

Public Health - Maternal Mortality Review Program - Establishment of Local Teams

This bill authorizes the establishment of a multidisciplinary and multiagency maternal mortality review team in each county to prevent maternal deaths as specified. The bill establishes the membership and responsibilities of a local team, specifies confidentiality and disclosure provisions, and establishes penalties for violation of certain disclosure and confidentiality provisions. The Maryland Department of Health (MDH) is authorized to release specified data under specified circumstances. The Maternal Mortality Review Program and local maternal mortality review committees must be provided with specified information, to the extent allowed by law, regarding a woman whose death is under review.

Fiscal Summary

State Effect: Potential minimal increase in general fund revenues due to the bill's penalty provisions to the extent local teams are established. MDH can provide assistance to local teams with existing budgeted resources.

Local Effect: To the extent a county or counties elect to establish a local team, expenditures increase, as discussed below. Revenues are not affected.

Small Business Effect: None.

Analysis

Bill Summary: "Local team" means the multidisciplinary and multiagency maternal mortality review team established for a county. Two or more counties may establish a

single multicounty local team. A multicounty team must execute a specified memorandum of understanding.

Release of De-identified Data

On the approval of the Secretary of Health and with a signed data use agreement, MDH may release de-identified data and findings to the U.S. Centers for Disease Control and Prevention, local maternal mortality review teams, and other entities.

Provision of Information and Records

The Secretary of Health must provide the Maternal Mortality Review Program with information on maternal death cases when the records become available (including a copy of the death certificate) and medical information from the birth or fetal death record for any pregnancy that occurred within one year of the death of the woman (excluding specified information about infants).

On the request of the Secretary of Health, the Maternal Mortality Review Program must be provided access, to the extent allowed by law, to all information and records maintained by specified agencies that provided services to a woman whose death is being reviewed by the program.

Likewise, on request of the chair of a local team, the local team must be provided (1) access to all relevant information and records in accordance with the local team's data use agreement with MDH and (2) access, to the extent allowed by law, to all information and records maintained by specified agencies that provided services to a woman whose death is being reviewed by the local team.

Local Maternal Mortality Review Teams

If a local team is established, it must be convened by the local health officer and may include other specified representatives necessary to the work of the local team, recommended by the local team, and designated by the local health officer.

The purpose of a local team is to prevent maternal death as specified. A local team must (1) in consultation with the Maternal Mortality Review Program, establish and implement a protocol; (2) meet at least annually to review specified information; (3) enter into a data use agreement with MDH for the receipt of information necessary to carry out the local team's purpose and duties; and (4) provide specified reports to the Maternal Mortality Review Program.

A meeting of a local team must be closed to the public when discussing individual cases of maternal death, but otherwise must be open to the public. During a public meeting, information may not be disclosed (1) that identifies a deceased woman or a family member, guardian, or caretaker of a deceased woman or (2) regarding the involvement of any agency with a deceased woman or a family member, guardian, or caretaker of a deceased woman. A violation of these provisions is a misdemeanor subject to imprisonment for up to 90 days and/or a fine of up to $500.

Generally, the proceedings, records, and files of a local team are confidential and privileged and are not discoverable or admissible as evidence in any civil or criminal proceeding.

Miscellaneous

The bill also updates obsolete references to the Medical and Chirurgical Faculty's Maternal Child Health Committee, which is known as the Maternal Mortality Review Committee.

Current Law/Background:

Maryland Maternal Mortality Review Program

Chapter 74 of 2000 established Maryland's Maternal Mortality Review Program. The purpose of the program is to (1) identify maternal death cases; (2) review medical records and other relevant data; (3) determine preventability of death; (4) develop recommendations for the prevention of maternal deaths; and (5) disseminate findings and recommendations to policymakers, health care providers, health care facilities, and the public. Maternal mortality reviews are conducted by a committee of clinical experts from across the State, the Maternal Mortality Review Committee. The program must submit an annual report on findings, recommendations, and program actions to the Governor and the General Assembly.

Maternal Mortality Stakeholder Group

Chapter 308 of 2018 requires MDH to establish a Maternal Mortality Stakeholder Group. The stakeholder group is charged with examining issues resulting in disparities in maternal deaths, reviewing the status of implementation of previous recommendations, and identifying new recommendations with a focus on initiatives to address disparities in maternal deaths. The group will review the Maternal Mortality Review Program's 2018 annual report, and responses and recommendations from the stakeholders will be included in the 2019 annual report.

According to the program's 2018 annual report, in 2016, 39 pregnancy-associated deaths were identified (the death of a woman while pregnant or within one year of pregnancy

conclusion, irrespective of the duration and site of the pregnancy, and regardless of the cause of death). Of these cases, 9 (23%) were pregnancy-related (cause of death related to or aggravated by the pregnancy or its management). Non-cardiovascular medical conditions and homicide were the leading causes of pregnancy-related death. The remaining 30 cases were non-pregnancy-related deaths. The leading cause of non-pregnancy-related death for the fourth year in a row was substance use and unintentional overdose. Of all pregnancy-related deaths, 70% of non-pregnancy-related deaths and 89% of pregnancy-related deaths were considered preventable or potentially preventable.

The 9 pregnancy-associated deaths in 2016 were among residents of Baltimore City (2), and Baltimore (2), Prince George's (2), Carroll (1), Charles (1), and Somerset (1) counties. The 30 non-pregnancy-related deaths occurred among residents of Baltimore City (8) and Montgomery (4), Anne Arundel (3), Baltimore (3), Frederick (2), Prince George's (2), Wicomico (2), Allegany (1), Caroline (1), Carroll (1), Charles (1), Garrett (1), and Harford (1) counties.

Local Fatality Review Teams

Under Maryland law, there are three types of local fatality review teams: local child fatality review teams (Title 5, Subtitle 7 of the Health-General Article), local drug overdose fatality review teams (Title 5, Subtitle 9 of the Health-General Article), and local domestic violence fatality review teams (Title 4, Subtitle 7 of the Family Law Article). Each county is *required* to have a child fatality review team (or a multicounty local team), while counties are *authorized* to establish a drug overdose fatality review team or a domestic violence fatality review team. The Maryland Association of County Health Officers (MACHO) advises that counties also have fetal infant mortality review teams. The maternal mortality review teams required under the bill are modeled after the child fatality review teams.

Local Expenditures: The bill *authorizes* each county (or two or more counties jointly) to establish a local maternal mortality review team that will meet at least annually to review the status of maternal fatality cases, recommend actions to improve coordination of services and prevent maternal deaths, enter into data use agreements with MDH, and provide reports and recommendations to the Maternal Mortality Review Program. Currently, local health department (LHD) staff lead or support the existing fatality and overdose review committees. MACHO advises that LHDs are already operating at a resource deficit for the current mandated review teams.

As the local review teams are discretionary under the bill, expenditures increase only to the extent that a county or counties elect to establish a local team. For those counties that do, expenditures increase to establish and provide staff support to the teams, enter into data use agreements with MDH, and provide reports to the Maternal Mortality Review Program.

For example, Montgomery County advises that it would need to hire at least one full-time program specialist at an annual cost of approximately $87,000.

As noted earlier, based on 2016 data, the number of maternal deaths for most counties in any given year is low. Thus, with the exception of Baltimore City, no individual county is likely to have a significant caseload of maternal deaths to review in any given year and some counties (10 in 2016) will have no cases to review. Even so, establishment of a local review team is not required under the bill.

Additional Information

Prior Introductions: None.

Cross File: SB 602 (Senator Nathan-Pulliam) - Finance.

Information Source(s): Maryland Association of County Health Officers; Baltimore City; Harford and Montgomery counties; Maryland Department of Health; Department of Legislative Services

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Analysis by: Jennifer B. Chasse

Direct Inquiries to:
(410) 946-5510
(301) 970-5510