**HB 1112**

# Department of Legislative Services

Maryland General Assembly
2021 Session

## FISCAL AND POLICY NOTE
## First Reader

House Bill 1112 (Delegate Wivell)
Health and Government Operations

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**Public Health - Maternal and Child Mortality - Review and Perinatal Hospice Services**

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This bill authorizes both the State Child Fatality Review Team (State Team) and the Maternal Mortality Review Program to enter into a written agreement, as specified, with an entity to provide the secure storage of data based on information and records collected by either the State Team or program, including data that contains personal or incident identifiers. The bill also authorizes a physician or nurse practitioner who makes a diagnosis of a "lethal fetal anomaly" to refer a woman to or provide information regarding "perinatal hospice" services. Within 90 days of the bill becoming effective, the Maryland Department of Health (MDH) must (1) develop and publish on its website a list of perinatal hospice programs available in the State and nationally that is organized geographically and (2) publish on its website an information sheet on perinatal hospice programs, as specified.

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## Fiscal Summary

**State Effect:** MDH can likely handle the bill's requirements with existing budgeted resources. Revenues are not affected.

**Local Effect:** None.

**Small Business Effect:** None.

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## Analysis

**Bill Summary:**

*Data Storage Agreements*

An agreement that the State Team or program enters into with an entity to provide for secure data storage must (1) provide for the protection of the security and confidentiality of information and (2) address issues regarding limitations to access, storage, and destruction of information. In addition, an entity with an agreement to store data must comply with specified confidentiality requirements.

*Perinatal Hospice Services*

"Perinatal hospice" means comprehensive support to a pregnant woman and her family that includes support from the time of diagnosis through the time of birth and the death of the infant, and through the postpartum period. "Perinatal hospice" may include counseling and medical care by maternal-fetal medical specialists, obstetricians, neonatologists, anesthesia specialists, clergy, social workers, and specialty nurses focused on alleviating fear and ensuring that the woman and her family experience the life and death of their child in a comfortable and supportive environment.

A physician or nurse practitioner who diagnoses an unborn child as having a "lethal fetal anomaly" (a fetal condition diagnosed before birth that will, with reasonable certainty, result in the death of the unborn child within three months after birth) may (1) inform the pregnant woman, orally and in person, that perinatal hospice services are available; (2) offer or refer the pregnant woman for perinatal hospice services; and (3) provide the pregnant woman a specified information sheet as published by MDH.

MDH's information sheet on perinatal hospice programs must include (1) a statement indicating that perinatal hospice is an innovative and compassionate model of support for a pregnant woman who is informed that her unborn child has a lethal fetal anomaly and who chooses to continue her pregnancy; (2) a general description of the health care services available from perinatal hospice programs; and (3) appropriate contact information for perinatal hospice services, including 24-hour perinatal hospice services. MDH must make the information sheet available in both English and Spanish and in a format that can be printed and provided to a pregnant woman.

A perinatal hospice program may request that MDH include the program's informational material and contact information on the MDH website, and MDH may add the information as requested.

**Current Law:** 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.

Chapters 355 and 356 of 1999 established the State Child Fatality Review Team with the purpose of preventing child deaths by (1) developing an understanding of the causes and incidence of child deaths; (2) developing plans for and implementing changes within the agencies on the team to prevent child deaths; and (3) advising the Governor, the General Assembly, and the public on changes to law, policy, and practice to prevent child deaths. State Team members and staff may not disclose to any person or government official any identifying information about any child protection case.

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## Additional Information

**Prior Introductions:** None.

**Designated Cross File:** SB 891 (Senator Carozza) - Finance.

**Information Source(s):** Department of Legislative Services

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