HB 357

Department of Legislative Services

Maryland General Assembly
2007 Session

FISCAL AND POLICY NOTE

House Bill 357 (Delegate Hubbard)
Health and Government Operations

Maryland Fetal and Infant Mortality Review

This bill codifies the existing Fetal and Infant Mortality Review (FIMR) program under the Department of Health and Mental Hygiene (DHMH). It also establishes a State Fetal and Infant Mortality Review Team; adds confidentiality requirements specifically for FIMR information and records and makes it a misdemeanor for violating those requirements; provides legal protections for specified individuals in relation to FIMR; and requires an annual report.

Fiscal Summary

State Effect: The bill's changes to existing practice could be handled with existing budgeted DHMH resources.

Local Effect: None. This bill codifies existing local teams to prevent or reduce fetal and infant deaths.

Small Business Effect: None.

Analysis

Bill Summary: The bill establishes a State Fetal and Infant Mortality Review Team to prevent or reduce infant deaths by: (1) determining contributing factors to fetal and infant deaths and developing recommendations to address them; (2) implementing prevention or reduction strategies; (3) recommending legislative or budgetary initiatives to the Governor and the General Assembly to prevent or reduce those deaths; and (4)

advising the Governor, the General Assembly, and the public on necessary changes to prevent or reduce those deaths.

The State team may perform other functions including:

- conducting statistical analyses of the incidence and underlying factors for fetal and infant mortality in Maryland, including analyses that focus on jurisdictions and regions;
- analyzing reports from local teams;
- assisting local teams in developing, implementing, or evaluating community activities intended to reduce fetal and infant mortality; and
- evaluating the continued effectiveness and efficiency of the program and make appropriate changes.

The bill codifies the existing requirement for a multidisciplinary and multiagency local team in each county to prevent or reduce fetal and infant deaths by: (1) determining contributing factors to fetal and infant deaths and developing recommendations to address them; (2) implementing prevention or reduction strategies; and (3) advising the State team of necessary changes in law, policy, or practices to prevent or reduce fetal and infant deaths.

Actions a local team may take are also codified including evaluating fetal and infant deaths to determine the underlying or contributing factors and evaluating the continued effectiveness and efficiency of FIMR and make appropriate changes.

Annually, by October 1, each local team must submit to the State team an annual report regarding the local team's activities and recommendations.

Information Availability

The State team, a local team, or its staff must be provided access to information and records regarding the fetal or infant death and the health of the mother of the fetus or infant; and information and records maintained by any State or local government agency. A local team, or its staff, currently must be provided access to this information.

State and Local Team Meetings

State team and local team meetings are closed to the public. Either team, or a team's staff, may request an individual with relevant information to attend a team meeting.

Information and Record Confidentiality

All information and records obtained by the State team or a local team, and the team's staff, are confidential and are exempt from disclosure requirements under the State Government Article. Information may be disclosed only to carry out the team's duties. A team member or a team's staff must continue to keep confidential all discussions at and records used and addressed at meetings not open to the public.

Statistical data that does not contain individual identifying information must be public.

A violation of these confidentiality requirements is a misdemeanor and is subject to a maximum $500 fine, or maximum 90-days imprisonment, or both.

Civil or Criminal Proceedings

Members of the State team or a local team, or its staff, individuals attending a team meeting, and individuals presenting information to a team may not be questioned in any civil or criminal proceeding regarding the information presented in or opinions formed as a result of a meeting. This protection currently is not provided to local teams, their staff, or individuals attending a meeting or presenting information to a team.

With specified exceptions, these individuals may testify in a civil or criminal proceeding to information obtained independently of the State team or a local team or information that is publicly available.

A health care provider or health care facility may not be held liable for civil damages or subject to any criminal or disciplinary action for good faith efforts made to comply with the FIMR provisions.

Annual State Report

Annually, by December 1, the Secretary of Health and Mental Hygiene must submit a report to the Governor and the General Assembly on the State team's and local teams' activities and recommendations on fetal and infant mortality.

Current Law: FIMR, which began in fiscal 1998, is not codified in State law. Child fatality review teams are in statute but do not serve an identical purpose as FIMR teams.

There is a State Child Fatality Review Team and local child fatality review teams. The State Child Fatality Review Team's purpose is to prevent 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.

Local child fatality review teams: (1) promote cooperation and coordination among agencies involved in investigating child deaths or in providing services to surviving family members; (2) develop an understanding of the causes and incidence of child deaths in the county; (3) develop plans for and recommend changes within the agencies the members represent to prevent child deaths; and (4) advise the State team on changes to law, policy, or practice to prevent child deaths.

Background: In 2005, the infant mortality rate in Maryland was 7.3 deaths per 1,000 live births.

DHMH's Fetal and Infant Mortality Review Program assesses how infant morbidity and mortality occurs in specific local communities and creates a process for reducing the infant morbidity and mortality. There are 18 program teams, including two regional projects on the Eastern Shore, which conduct fetal and infant mortality reviews in all 24 jurisdictions. These teams have developed findings, recommendations, and proposed actions for improving systems of care for pregnant women and infants.

For example, Baltimore City's Helping Everyone After a Loss initiative provides services to women who experience a fetal or infant loss. Services include a medical assessment, assistance in accessing services, bereavement support, and a home visiting referral. In Allegany County, Kick Count was developed to teach women to detect fetal distress through counting kicks or other movement. As a result of the Southern Maryland Perinatal Partnership, which includes Anne Arundel, Calvert, Charles, Prince George's, and St. Mary's counties, local hospitals collaborating with the University System of Maryland developed the Maryland Advanced Perinatal Support System, a telemedicine project that provides high-risk obstetrics care, supports local physicians, and allows patients services within their community.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): Cecil County, Harford County, Department of Health and Mental Hygiene, Department of Legislative Services

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