SB 602

Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
First Reader

Senate Bill 602 (Senator Nathan-Pulliam)
Finance

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

This bill requires that there be 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 disclosure and confidentiality provisions.

Fiscal Summary

State Effect: Potential minimal increase in general fund revenues due to the bill's penalty provisions. The Maryland Department of Health can provide assistance to local teams with existing budgeted resources.

Local Effect: Expenditures increase for local jurisdictions (particularly local health departments (LHDs) and for larger jurisdictions) to establish local maternal mortality review teams. **This bill imposes a mandate on a unit of local government.**

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.

A local team must include, when available (1) the local health officer; (2) the director of the local department of social services; (3) the director of the county substance use treatment program; (4) the director of the county mental health agency or core service agency; (5) an obstetrician-gynecologist; (6) a direct-entry midwife; (7) a birth doula; (8) a member of the public with specified expertise; and (9) any other individual necessary to the work of the local team. Certain members of the team may designate representatives from their respective departments or office to represent them on the local team.

The purpose of a local team is to prevent maternal death as specified. A local team must, in consultation with the Maternal Mortality Review Program, (1) establish and implement a protocol; (2) set as its goal the review of maternal deaths in accordance with national standards; (3) meet at least quarterly to review specified information; (4) collect and maintain data on fetal deaths; (5) provide specified reports to the Maternal Mortality Review Program; and (6) in consultation with the American College of Obstetricians and Gynecologists' guidelines, define "severe maternal mortality."

On request of the chair of the local team, the Maternal Mortality Review Program must immediately provide the team with access to specified information and records regarding a maternal death under review or the family of a woman whose death is under review.

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. Generally, all information and records acquired by a local team are confidential and exempt from public disclosure under the Public Information Act, nor may such records be subject to subpoena, discovery, or introduction into evidence in any civil or criminal proceeding. A violation of the bill's confidentiality provisions is a misdemeanor subject to imprisonment for up to 90 days and/or a fine of up to $500.

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 the Maryland Department of Health 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 requires each county (or two or more counties jointly) to establish a local maternal mortality review team that will meet at least four times per year to review the status of maternal fatality cases, recommend actions to improve coordination of services and prevent maternal deaths, collect and maintain data, and provide reports and recommendations to the Maternal Mortality Review Program. Currently, 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 mandatory under the bill, expenditures increase for local jurisdictions to establish and provide staff support to the teams, collect required data, 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 the local review team is required.

Additional Information

Prior Introductions: None.

Cross File: HB 796 (Delegate Wilkins, *et al.*) - Health and Government Operations.

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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