2019-21 Biennium Budget
Decision Package

Agency: 303 - Department of Health
Decision Package Code-Title: 1P - Continue Maternal Mortality Reviews
Budget Session: 2019-21 Regular
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Agency Recommendation Summary

Maternal mortality is on the rise in the United States, with minority communities experiencing disparities compared to the general population. Maternal mortality is also under- reported, leaving Washington without critical data to inform policy recommendations to reduce the rate of occurence. The Department of Health (DOH) requests funding to continue the biennial Maternal Mortality Review Report and align state policy with national best practices.

Fiscal Summary

Dollars in Thousands

Operating Expenditures	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Fund 001 - 1	$408	$399	$399	$399
Total Expenditures	**$408**	**$399**	**$399**	**$399**
Biennial Totals		**$807**		**$798**
Staffing	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
FTEs	3.4	3.4	3.4	3.4
Average Annual		**3.4**		**3.4**
Object of Expenditure	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**
Obj. A	$262	$261	$261	$261
Obj. B	$91	$91	$91	$91
Obj. E	$20	$20	$20	$20
Obj. G	$7	$7	$7	$7
Obj. J	$8	$0	$0	$0

Object of Expenditure	FY 2020	FY 2021	FY 2022	FY 2023
Obj. T	$20	$20	$20	$20

Package Description

What is the problem, opportunity or priority you are addressing with the request?

Maternal mortality is on the rise in the United States, with minority communities experiencing substantial disparities compared to the general population (Figure 1). For every maternal death, 20 or more women have a near death experience or severe maternal morbidity, which results in social, physical, emotional, and economic burdens on families and communities. Best estimates say that half of these deaths could be prevented and half the injuries reduced or eliminated with better care. To understand and address underlying reasons for these disparities and worsening health outcomes in Washington, DOH must have access to accurate data surrounding the deaths of mothers and pregnant women.

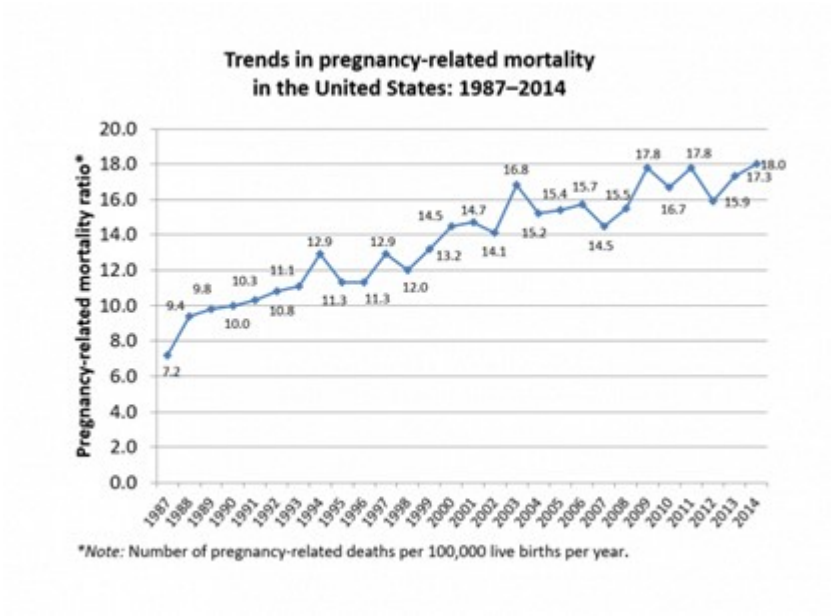

Figure 1: Division of Reproductive Health. (2018). Pregnancy Mortality Surveillance System. National Center for Chronic Disease Prevention and Health Promotion. Centers for Disease Control and Prevention

Under current statute, providers are only required to report deaths related to low-risk pregnancies to DOH via Adverse Event Reporting. This results in significant under-reporting of maternal deaths, since providers are not required to report maternal deaths related to high-risk pregnancies. For example, in Washington in 2014 and 2015, only one of sixty-nine deaths was reported, since most were considered "high risk" pregnancies. A wide variety of factors may result in a woman's pregnancy being classified as "high-risk." The Centers for Disease Control and Prevention (CDC) has identified the following criteria as presenting an elevated risk for pregnancy-related death:[i]

- Lack of maternal access to prenatal care;
- A woman has previously given birth to five or more children;

- Pregnancy to a woman 35 years of age or older;
- A pregnant woman is of African American or Hispanic heritage.

Under current statute, if a woman met any of these criteria and died during childbirth, her death is not required to be reported.

The Maternal Mortality Review Panel uses data from a variety of state and local government entities to determine whether pregnancy or childbirth were a direct cause or contributing factor in each maternal death reviewed. The information gained from these reviews is then aggregated to identify patterns or commonalities among the maternal deaths reviewed, and whether policy, systems, or environmental changes may improve future health outcomes for women. The panel submits its recommendations to address these identified issues to DOH, the legislature, and relevant stakeholder groups in a biennial report, which is then used to inform maternal health policies and programs.

Since implementation of this law, DOH has identified quality improvement efforts to align our state with CDC best practices. These include:

- Reporting deaths from suicide, opioids and other injuries.
- Existing law does not allow DOH to share de-identified information with the CDC, counties, or health systems, thereby hindering the ability for federal or local-level public health organizations to accurately formulate data-driven responses and quality improvement strategies when patterns are observed in the data.
- Capturing complete maternal health data by requiring hospitals and birthing centers to report all maternal deaths which occur within 42 days of giving birth, so valuable information is collected related to cause of death, pregnancy or childbirth, and whether they were preventable. Because only deaths related to low-risk pregnancies are currently reported to DOH, the panel is unable to develop reports that accurately reflect maternal mortality in the state, or policy recommendations that fully address factors that contribute to maternal deaths.
- The statute mandating the completion of the report expires in June 2020. Improving the health-care system overall is a critical component to reducing maternal mortality. Knowing the level of maternal mortality is not enough; we need to understand the underlying factors that led to the deaths. Each maternal death can provide indications on practical ways of addressing its causes and determinants. Without the mortality report as a permanent requirement, as well as funding to conduct maternal mortality reviews, the state will lose a vital source of information that shows us where the state is improving and where it is not so that strategies and policy interventions to prevent maternal deaths can be developed.

What is your proposed solution?

DOH proposes revising RCW 70.54.450 to: extend the law, which is currently set to expire June 2020; require hospitals and birthing centers to report the deaths of pregnant women and women who die within 42 days after the end of pregnancy to local county coroners or medical examiners, and fund autopsies for those deaths; allow DOH to consider, and upon approval, share deidentified data related to the review with the CDC, regional maternal mortality review efforts, and local health jurisdictions; and annual funding for the cost of completing reviews, coordinating quality improvement, and publishing biennial reports that align with best practices.

These revisions will allow DOH and the panel to continue to review these deaths and track state trends to understand the issues that contribute to poor maternal healthoutcomes. The report will also enable providers and facilities to address risk factors to prevent maternal mortality and morbidities.

The total cost to complete the reviews and reports, and support implementation of the panel's recommendations is $410,000 per year, or $820,000 for the biennium.

The proposed changes would strengthen the law and the work that is being done and ensure the information collected for the review process results in concrete activities to address root causes of maternal mortality. The changes would also help align Washington with federal efforts to reduce maternal mortality.

What are you purchasing and how does it solve the problem?

The costs for this proposal are ongoing costs to staff and facilitate an ongoing maternal mortality review, associated quality improvement coordination, and produce a biennial report with recommendations to reduce maternal deaths and improve maternal and infant health outcomes. Maternal death investigations and autopsies are paid for under a designated account. Additional fiscal detail is provided in the attached cost models.

What alternatives did you explore and why was this option chosen?

Alternative methods that do not require legislative changes have been explored and some have been attempted, including:

- Implementing panel recommendations on preventing maternal mortality without the ability to share key data and within the constraints of the law and current resources;
- Passively participating in local, regional, and federal efforts without sharing data;

- Completing a maternal mortality review and report based on the current timeline;
- Performing maternal mortality reviews without key records that must be obtained from the Department of Children, Youth, and Families, which is not mentioned in the current law.
- Performing maternal mortality reviews without key mental health records that must be obtained from the Health Care Authority. Currently law prevents DOH from accessing these records.

[i] Centers for Disease Control and Prevention. Gateway to Health Communication & Social Marketing Practice: Pregnancy and Prenatal Care. https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/PregnancyPrenatalCare.html

Assumptions and Calculations

Expansion or alteration of a current program or service:

This proposal is a continuation of the current program that is scheduled to sunset. In addition, we are requesting increased state funding to cover the actual costs we incur annually to conduct the reviews and develop the reports. In 2017, 2018, and 2019 we covered the gap between our state funding and actual costs using other funds.

Additional fiscal detail is attached to this decision package.

Year	General Fund State – MMR	Maternal Child Health Block Grant	Total Program Allocation
2016	$0	$0	$0
2017	$230,000	$197,000	$427,000
2018	$227,000	$197,000	$427,000
2019	$227,000	$197,000	$427,000
2020	$227,000	$0	$227,000
2021	$227,000	$0	$227,000

Detailed assumptions and calculations:

This mandate requires 2.5 FTE per year, including 0.80 FTE of a Health Services Consultant 3, 0.50 FTE of a Public Health Nurse, 0.55 FTE of an Epidemiologist 3, 0.40 FTE of an Epidemiologist 2, 0.10 FTE of a

Health Services Consultant 4, 0.10 FTE of a Research Investigator 3 and 0.05 FTE of a Senior Epidemiologist. In addition, estimated expenditures include .40 and .60 FTE in the 19-21 biennium to assist with increased division and agency workload.

There are four aspects to this mandate, including: identification of maternal deaths and hospital/vital records linkages; data collection, analyses, and preparation for the panel to review; convening the Maternal Mortality Review Panel and preparing the required report; and initiating implementation of the panel recommendations. Below are the activities by type of staff needed to complete this work.

Aspect 1 - Identification of Maternal Deaths and Hospital/Vital Records Linkages

0.1 FTE Research Investigator 3 to provide quality assurance of data, clarify cause of death, and conduct follow-up to confirm maternal deaths

0.35 FTE Epidemiologist 3 to link data from the birth records database with the death records database and the Comprehensive Hospital Abstract Reporting System (CHARS) data, and to conduct data review and analysis for the report

0.05 FTE Senior Epidemiologist to supervise staff and provide quality assurance of the data

FTE = 0.5

Salaries = $48,000

Benefits = $17,000

Goods & Services = $1,000

Equipment = $1,550

Intra-Agency Reimbursement = $4,000

Total Direct Costs = $72,000

Indirects = $17,000

Total cost associated with the identification of maternal deaths: $89,000

Aspect 2 - Data collection, analyses, and preparation for panel review

0.2 FTE Health Services Consultant (HSC)3 to request, collect, and manage all necessary records

0.2 FTE Nurse consultant to review medical records, identify records sources, summarize records for the panel, and make clinical decisions related to data elements for data collection

0.2 FTE MCH Epidemiologist 2 to identify medical facilities and other sources of data, review all sources of data, enter key data elements into the CDC database system, clean and prepare data, conduct data analyses, prepare charts and tables for report and presentations.

0.1 FTE MCH Epidemiologist 3 to provide subject matter expertise, supervise data analysis activities, and oversee the development of the data analysis and development of the surveillance system.

Counties will incur a small cost due to expanding reporting and autopsy requirements. The amount added to the Forensic Investigation Council dedicated account is $25,000 per fiscal year based on an estimate from WACME of $2,500 per autopsy and 10 additional autopsies per year. This will be passed thru to counties to absorb any new additional costs.

FTE = 0.7

Salaries = $61,000

Benefits = $21,000

Goods & Services = $1,000

Equipment = $2,000

Intra-Agency Reimbursement = $6,000

Total Direct Costs = $91,000

Indirects = $25,000

Total cost for data collection, analyses, and preparation for panel review: $116,000 per year.

Aspect – 3 Convene the Maternal Mortality Review Panel and Prepare the Report

0.1 FTE MCH Epidemiologist 2 to compile key data elements from various data sources to organize for review by the panel and visual representation in the report, present data to the the panel and other audiences, participate in review proceedings, analyze contributing factors to deaths, and assist with development of a biennial report for legislators and other stakeholders.

0.1 FTE MCH Epidemiologist 3 to provide subject matter expertise and work with the MCH Epidemiologist 2 and the DOH team in implementing panelreviews, participate in review proceedings, and report writing.

0.1 FTE Public Health Nurse Consultant to provide expert consultation to DOH staff implementing the review, participate in all review proceedings, and to make key clinical decisions related to the review process.

0.3 FTE HSC 3 to manage administrative and logistical tasks related to the review preparation and meetings, to recruit and facilitate appointment of panel members, to keep panel members informed of review processes and upcoming meetings and responsibilities, and to facilitate maternal mortality

review meetings

0.1 FTE HSC4 to supervise program and review proceedings and assist with troubleshooting internal and external barriers.

FTE = 0.7

Salaries = $57,000

Benefits = $20,000

Goods & Services = $11,000(Including Non-Employee travel to convene meeting and publication of report)

Equipment = $2,000

Intra-Agency Reimbursement = $6,000

Total Direct Costs = $96,000

Indirects = $26,000

Total cost to convene the the panel and complete the legislative report: $122,000

Aspect 4 - Initiate Implementation of Panel Recommendations

0.2 HSC 3 to assist with the implementation of the panel recommendations as quality improvement efforts; disseminate information related to the review findings as well as general information about maternal mortality and review processes at the DOH.

0.2 FTE Public Health Nurse Consultant to guide the overall implementation of the review process and to initiate and provide guidance for state-wide efforts to reduce maternal mortality in Washington.

0.1 FTE MCH Epidemiologist 2 to participate in state-wide efforts related to the implementation of the review and general guidance around recommendations and best practices, and to collaboratively develop an evaluation plan.

FTE = 0.5

Salaries = $42,000

Benefits = $15,000

Goods & Services = $1,000 (Including Non-Employee travel to convene meeting and publication of report)

Equipment = $2,000

Intra-Agency Reimbursement = $4,000

Total Direct Costs = $64,000

Indirects = $17,000

Total cost to initiate implementation of the recommendations: $81,000

Workforce Assumptions:
Please see attached Financial Calculator.

Strategic and Performance Outcomes

Strategic framework:
The proposed changes support the governor's priority of healthy and safe communities and the Heathiest Next Generation Initiative, as well as the Agency Strategic Plan. Nationally, maternal mortality rates have been on the rise. In Washington, rates have remained more stable than the rest of the country, however the same inequities in outcomes among populations seen in other parts of the US are also present in Washington. The law requiring the maternal mortality review and report was created to identify those disparities and make policy, systems, and environment recommendations to improve outcomes for mothers and babies, and to identify ways to implement these recommendations. Protecting women and improving maternal healthcare has an immediate and long-lasting impact on not only a mother's infant and children, but also on her family and community. Investing in mothers is an investment in communities and in the state. This proposal strengthens existing law and allows the information gleaned from the review to be more effectively used to reduce maternal deaths.

Performance outcomes:
Funding and staffing changes, the ability to access all records and data needed, the ability to share key information and data with key stakeholders, and supporting and coordinating quality improvement efforts with providers, facilities, and larger health systems, have the potential to greatly reduce the maternal mortality rate in Washington, and, more significantly, the maternal morbidity rate, which is a huge economic burden on families, communities, and healthcare and social systems, as well as a physical and emotional burden on women and their families. This work addresses several of the Healthy Washington performance outcomes and objectives, including:

1. **Healthy babies and mothers:** The health of a mother directly impacts the health of her baby. Work to improve and expand access to maternal care for mothers during and after pregnancy will help these women to be healthier. In turn, mothers can help their babies be healthier. When mothers and babies are healthy, they have the potential to impact the health of communities. Potential outcomes overall include improved infant health and decreased rates of maternal mortality and morbidity. Outcomes related to Healthy People include the potential to decrease

infant mortality, decrease the number of infants born with low birth weight among all populations, and decrease the rate of unintended pregnancies.

2. **Healthy youth and adults:** The panel made recommendations related to several key issues identified as contributing to maternal mortality in Washington related to the Healthy Washington Performance Outcomes for healthy youth and adults, including obesity and mental health care and treatment.

    a. Maternal deaths related to substance use and mental health accounted for nearly 25% of all maternal deaths in Washington. The panel recommended that pregnant women and mothers with mental health and substance use disorders need better access to high quality mental health care services. The ability to coordinate quality improvement efforts that support the development and/or expansion of these services would have a significant impact on maternal health outcomes, and would decrease the state's maternal mortality rate. This could also impact outcomes related to Healthy People, including improving retention rates for outpatient mental health services, improving the rate of service for people discharged from mental health care, and reducing the number of suicide and opioid-related overdose deaths in the state

    b. For those deaths that were found to be directly related to pregnancy, the panel found that obesity directly contributed to the deaths in 31% of cases; 94% of the women who died from pregnancy-related causes were overweight or obese. The panel recommended that healthcare facilities, providers, and service providers need to improve maternal care for women who are overweight and obese. The ability to identify this as an issue in maternal health care and implement, support, and coordinate efforts to address maternal care for this population has the potential to help the state meet several Healthy Washington objectives related to chronic disease, including decreasing the percentage of adults who report fair or poor health and increasing the number of people who maintain healthy weights.

3. **Access/Pay for quality**: The findings of the maternal mortality review indicated that 100% of the women who died from pregnancy related causes were covered by some form of health insurance; 75% were covered by Medicaid. The panel found that expanding healthcare coverage and the services covered under insurance plans has the potential to reduce maternal mortality and morbidity rates and prevent maternal deaths. Continued investigation into healthcare coverage among pregnant women and mothers allows DOH to focus attention on areas and populations where issues related to health care coverage and access remain. This information, combined with collaborative efforts to address these issues, has the potential to increase Medicaid enrollment and perhaps the percentage of residents who report they have a primary care provider.

Other Collateral Connections

Intergovernmental:
The work in this proposal will have a minimal impact on tribal and local governments. DOH is requesting tribal representation in the proposed legislation.DOH also requests expanding the maternal deaths that must be investigated and autopsied to include deaths that occur within 42 days of giving birth. Counties will incur a small cost due to expanding reporting and autopsy requirements. DOH asks that these costs be reimbursed at 100%. Reimbursement will come from the Forensic Investigation Council dedicated account, from which all autopsies are currently funded. DOH, in conjunction with the Washington Association of Coroners and Medical Examiners (WACME), determined this request would result in up to 10 more death investigations per year. Additional funding for these costs has been included in this request. The amount added to the Forensic Investigation Council dedicated account is $25,000 per fiscal year based on an estimate from WACME of $2,500 per autopsy and 10 additional autopsies per year.

Stakeholder response:
A wide variety of stakeholders will be impacted by the proposed changes. DOH has worked extensively with stakeholders. Concerns expressed by stakeholders include the following, which are each addressed in turn.

1. Maternal deaths are relatively rare. The legislature may have a difficulty justifying investing state funds to review an estimated 30 deaths per year. However, for every death, there are 50-100 or more near deaths that result in severe maternal morbidity and have a heavy physical, emotional, and socioeconomic burden on families and communities. Currently, there is just enough funding to conduct the reviews themselves; however, this funding does not account for the quality improvement activities that must be done as a result of the review. Stakeholders and advocates rely on DOH to lead the efforts related to the recommendations of the panel. Developing and carrying out concrete steps to reduce maternal deaths and improve women's healthcare in the state is the crux of the maternal mortality review.

2. Hospitals and providers may be reluctant to comply with additional reporting requirements, which may be perceived as additional regulatory requirements. Mandatory reporting of maternal deaths will ensure the data collected is accurate and that sufficient information is available to develop preventive strategies.

3.County officials involved in death investigations may have concerns about completing additional autopsies without guaranteed reimbursements to complete the work. This proposal requests that required autopsies be 100% reimbursed to providers who perform them.

4. Data and identity theft are pressing concerns that must be addressed if data is to be shared between agencies. Only de-identified aggregated data will be shared. The data will be shared with a few key public health agencies, including CDC, local health jurisdictions (LHJ) and regional maternal mortality efforts. DOH will also require a data user agreement with each entity outlining how the data can be used and how it must be protected

5. The need for access to behavioral health care records is not readily apparent. Legislators concerned with privacy will likely require justification for access to these records. Mental health-related issues are key to understanding deaths related to suicide and overdose, and how mental health is affecting maternal mortality as a whole.

Legal or administrative mandates:
N/A

Changes from current law:
RCW 70.54.450 – see language changes in the document

This proposal expands the definition of when autopsies are performed in maternal mortality cases to all incidences of maternal mortality within 42 days of the end of pregnancy, and requires counties be reimbursed for 100% of associated costs.This change requires amending RCW 68.50.104 to disburse funds from the death investigations account to the forensic investigation council sufficient to reimburse counties for 100% of associated costs of autopsies.

State workforce impacts:
N/A

State facilities impacts:
N/A

Puget Sound recovery:
N/A

Agency Questions

Did you include cost models and backup assumptions?
See attached backup.

Reference Documents

- Continue Marternal Mortality Reviews - FnCal.xlsm
- Federal Efforts to Address Maternal Mortality.docx
- Maternal Mortality update-Fact Sheet Content Template.docx

IT Addendum

Does this Decision Package include funding for any IT-related costs, including hardware, software, (including cloud-based services), contracts or IT staff?
No