SUBJECT: Requiring DSHS to post guidelines for reporting maternal mortality rates

COMMITTEE: Public Health — favorable, without amendment

VOTE: 8 ayes — Price, Sheffield, Arévalo, Burkett, Guerra, Klick, Oliverson, Zedler

0 nays

3 absent — Coleman, Collier, Cortez

SENATE VOTE: On final passage, May 4 — 31-0, on Local and Uncontested Calendar

WITNESSES: For — (*Registered, but did not testify*: Juliana Kerker, American Congress of Obstetricians and Gynecologists - Texas District, Texas Association of Obstetricians and Gynecologists; Stacey Pogue, Center for Public Policy Priorities; Mandi Kimball, Children at Risk; Liz Garbutt, Children's Defense Fund - Texas; Wendy Wilson, Consortium of Texas Certified Nurse Midwives; Leah Gonzalez, Healthy Futures of Texas; Grace Chimene, League of Women Voters of Texas; Nora Del Bosque, March of Dimes; Jason Sabo, Mental Health America of Greater Houston; Gyl Switzer, Mental Health America of Texas; Sebastien Laroche, Methodist Healthcare Ministries of South Texas, Inc.; Greg Hansch, National Alliance on Mental Illness Texas; Will Francis, National Association of Social Workers - Texas Chapter; Jessica Schleifer, Teaching Hospitals of Texas; Adriana Kohler, Texans Care for Children; Joshua Houston, Texas Impact; Michelle Romero, Texas Medical Association; Clayton Travis, Texas Pediatric Society; Bryan Hebert, United Ways of Texas; Maggie Jo Buchanan, Young Invincibles; Nancy Sheppard)

Against — None

On — (*Registered, but did not testify*: Evelyn Delgado, Department of State Health Services)

BACKGROUND: Health and Safety Code, sec. 34.001(12) defines a pregnancy-related

death as the death of a woman while pregnant or within one year of delivery or end of pregnancy, regardless of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management, but not from accidental or incidental causes.

Observers have suggested that there are variations in how pregnancy-related deaths are investigated, depending on the investigating system involved, and contend that some deaths that should have been investigated by a medical examiner were not appropriately directed to the medical examiner system. Some suggest developing best practices for maternal mortality reporting and investigations and for death certificate data.

DIGEST:

SB 1599 would require the Department of State Health Services (DSHS) to post on its website information on the systematic protocol for pregnancy-related death investigations and the best practices for reporting pregnancy-related deaths to the medical examiner or justice of the peace of each county, as applicable. The posted information would have to include guidelines for:

- determining when a comprehensive toxicology screening should be performed on a person whose death was related to pregnancy;
- determining when a death should be reported to or investigated by a medical examiner or justice of the peace in the county where the death occurred; and
- correctly completing the death certificate of a person whose death was related to pregnancy.

The Health and Human Services Commission executive commissioner would adopt rules to implement its provisions.

The bill would take effect September 1, 2017.