FINAL BILL REPORT
SHB 1074

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Synopsis as Enacted

Brief Description: Concerning overdose and suicide fatality reviews.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Peterson, Rude, Leavitt, Wylie, Kloba, Ortiz-Self, Callan, Riccelli, Davis and Pollet).

House Committee on Health Care & Wellness
Senate Committee on Health & Long Term Care
Senate Committee on Behavioral Health Subcommittee to Health & Long Term Care

Background:

Maternal Mortality Review Panel.
The Maternal Mortality Review Panel conducts comprehensive, multidisciplinary reviews of maternal deaths in Washington, identifies factors associated with these deaths, and makes recommendations for system changes to improve health care services for women. Information, documents, proceedings, records, and opinions related to the panel are confidential and exempt from public inspection and copying, discovery, and introduction into evidence in civil or criminal actions.

Child Mortality Reviews.
Local health departments are authorized to conduct child mortality reviews. This process may include: a systemic review of medical, clinical, and hospital records; home interviews of parents and caretakers of children who have died; analysis of individual case information; and review by a team of professionals in order to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with the death.

Washington State Suicide Prevention Plan.
The Department of Health (DOH), with advice from the State Suicide Prevention Plan Steering Committee, oversees a statewide suicide prevention plan for people of all ages.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

The State Suicide Prevention Plan: examines data relating to suicide to recognize patterns and key demographic factors; identifies key risk and protective factors relating to suicide; and identifies goals, action areas, and implementation strategies relating to suicide prevention.

Washington State Opioid Response Plan.
The Washington State Opioid Response Plan was created to: prevent opioid misuse and abuse; identify and treat opioid use disorder; reduce morbidity and mortality from opioid use disorder; and use data and information to detect misuse and abuse, monitor morbidity and mortality, and evaluate interventions. The State Opioid Response Plan is implemented by state government agencies, local health departments, professional groups, and community organizations.

Uniform Health Care Information Act.
The state Uniform Health Care Information Act (UHCIA) governs the disclosure of health care information by health care providers and their agents or employees. The UHCIA provides that a health care provider may not disclose health care information about a patient unless there is a statutory exception or written authorization by the patient.

Prescription Monitoring Program.
The DOH maintains a prescription monitoring program (PMP) to monitor the prescribing and dispensing of all Schedule II, III, IV, and V controlled substances. Generally, prescription information submitted to the DOH is confidential; however, data in the PMP may be accessed by authorized individuals and entities.

Summary:

Local health departments may establish multidisciplinary overdose, withdrawal, and suicide fatality review teams (review teams) to review overdose, withdrawal, or suicide deaths and develop strategies to prevent future deaths. To aid in a review, local health departments may request and receive medical records relating to an overdose, withdrawal, or suicide, autopsy reports, medical examiner reports, coroner reports, school records, criminal justice records, law enforcement reports, and social services records. A local health department may request certain records from the following individuals and entities: health care providers; health care facilities; clinics; schools; criminal justice; law enforcement; laboratories; medical examiners; coroners; professions and facilities licensed by the Department of Health (DOH); local health jurisdictions; the DOH; the Health Care Authority and its licensees and providers; the Department of Social and Health Services and its licensees and providers; and the Department of Children, Youth, and Families and its licensees and providers. When requested, the above individuals and entities must provide the following records to the requesting local health department: all medical records related to the overdose, withdrawal, or suicide; autopsy results; medical examiner reports; coroner reports; criminal justice, law enforcement, and social services records; and other data requested for specific fatalities to perform an overdose, withdrawal, or suicide fatality

review.

The DOH must assist local health departments in collecting reports of overdose, withdrawal, or suicide fatality reviews conducted by local health departments, and entering the reports into a database to the extent the data is not protected, provide technical assistance to local health departments and review teams, and encourage communication among review teams. The DOH must respond to any requests for data from the database to the extent permitted under the Uniform Health Care Information Act (UHCIA) and the prescription monitoring program statutes.

All health care information collected by the review teams is confidential, subject to the restrictions on disclosure provided in the UHCIA, and may be used solely by the local health departments for purposes of the review. All information, documents, proceedings, records, and opinions collected or maintained by the review team or local department of health in support of a review team are confidential, not subject to public inspection and copying, and are not subject to discovery or introduction into evidence in any civil or criminal action. All meetings, proceedings, and deliberations of the review team must be confidential and may be conducted in executive session. Local health departments may publish statistical compilations and reports related to overdose, withdrawal, or suicide fatality review; however, any portions of these compilations and reports that identify individual cases and sources of information must be redacted. All overdose, withdrawal, or suicide fatality reviews must be shared with the DOH, subject to the same confidentiality provisions as described above.

Individuals who participate in activities relating to the review team may not be permitted or required to testify in any civil or criminal action as to the content of the review team's proceedings or the review team's information or records.

Any individual who, in substantial good faith, participates as a member of the review team or provides information to the review team for purposes of the review may not be subject to an action for civil damages or other relief as a result of the activity or its consequence.

"Overdose, withdrawal, and suicide fatality review" is defined as a confidential process to review minor or adult overdose, withdrawal, and suicide deaths. This process may include a systematic review of records, confidential interviews, analysis of individual case information, and review of this information by a team of professionals to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with each death.

Votes on Final Passage:

House	96	0	
House	97	0	
Senate	49	0	(Senate amended)

House 98 0 (House concurred)

Effective: June 9, 2022