

BILL ANALYSIS

Senate Research Center

S.B. 1599
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Health & Human Services
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Texas' maternal mortality rates nearly doubled between 2010 and 2014. The Maternal Mortality and Morbidity Task Force is charged with reducing the incidence of pregnancy-related deaths and severe maternal morbidity in Texas. The 2016 Maternal Mortality and Morbidity Task Force and Department of State Health Services (DSHS) Joint Biennial Report found significant variations in how these deaths are investigated depending on the investigating system involved, and that some deaths that should have been investigated by a medical examiner were not appropriately routed to the medical examiner system. The task force recommended the promotion of best practices for improving the quality of maternal death reporting and investigation and improving the quality of death certificate data.

S.B. 1599 directs DSHS to develop best practices for reporting pregnancy-related deaths and when they should be investigated by the medical examiner. The information should also include how to correctly complete the death certificate of a person whose death was related to a pregnancy.

S.B. 1599 amends current law relating to maternal mortality reporting and investigation information.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 1 (Section 1001.241, Health and Safety Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 1001, Health and Safety Code, by adding Subchapter J, as follows:

SUBCHAPTER J. MATERNAL MORTALITY REPORTING AND INVESTIGATION INFORMATION

Sec. 1001.241. MATERNAL MORTALITY REPORTING AND INVESTIGATION INFORMATION. (a) Requires the Department of State Health Services (DSHS) to post on the DSHS Internet website information regarding 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.

(b) Requires that the information provided under Subsection (a) include guidelines for:

(1) determining when a comprehensive toxicology screening should be performed on a person whose death was related to pregnancy;

(2) determining when a death should be reported to or investigated by a medical examiner or justice of the peace under Chapter 49 (Inquests Upon Dead Bodies), Code of Criminal Procedure; and

(3) correctly completing the death certificate of a person whose death was related to pregnancy.

(c) Requires the executive commissioner of the Health and Human Services Commission to adopt rules as necessary to implement this section.

SECTION 2. Effective date: September 1, 2017.