2020 Regular Session

HOUSE CONCURRENT RESOLUTION NO. 68

BY REPRESENTATIVE HILFERTY

PUBLIC HEALTH: Requests a study concerning means by which to ensure that autopsies are conducted in all cases of maternal deaths occurring in hospitals

A CONCURRENT RESOLUTION

To urge and request the Louisiana Department of Health through the Commission on Perinatal Care and Prevention of Infant Mortality and the stakeholders listed therein to identify and explore means by which to conduct autopsies of all in-hospital maternal deaths and to standardize coroner and toxicology reporting on maternal deaths.

WHEREAS, a maternal death is generally defined as the death of an individual while pregnant or within forty-two days of pregnancy; and

WHEREAS, a current Center for Disease Control Foundation initiative entitled "Building U.S. Capacity to Review and Prevent Maternal Deaths" encourages states to complete a review process that identifies the underlying cause of maternal deaths; and

WHEREAS, according to a report released by the Louisiana Department of Health entitled "Louisiana Maternal Mortality Review Report 2011-2016", forty-three percent of maternal deaths in Louisiana do not have an autopsy performed, making determination of the cause of death difficult; and

WHEREAS, there are presently at least forty-one Maternal Mortality Review Committees (MMRC) in this country, many mandated or created by state legislation in their home states; and

WHEREAS, according to the MMRC in Washington State, "Because maternal deaths are relatively unusual, and may be associated with clinical and pathologic features not commonly evaluated by many autopsy pathologists, the development of guidelines and an

associated checklist was considered to be likely to improve the quality of death evaluation and in that way, improve maternal health in the state of Washington; and

WHEREAS, standardizing coroner and toxicology reporting on maternal deaths in Louisiana is likely to improve the quality of maternal death evaluation and therefore improve maternal health outcomes in Louisiana.

THEREFORE, BE IT RESOLVED that the Legislature of Louisiana does hereby urge and request the Louisiana Department of Health through the Commission on Perinatal Care and Prevention of Infant Mortality and the stakeholders listed therein to study the means by which to conduct autopsies of all in-hospital maternal deaths and to standardize coroner and toxicology reporting on maternal deaths.

BE IT FURTHER RESOLVED that in developing the study, the department shall seek to engage, collaborate with, and obtain information and perspective from stakeholder groups with appropriate expertise, including but not limited to the Louisiana Coroner's Association and the Louisiana Hospital Association.

BE IT FURTHER RESOLVED that the secretary of the Louisiana Department of Health shall take such actions as are necessary to ensure that the study committee convenes on or before September 1, 2020.

BE IT FURTHER RESOLVED that the Louisiana Department of Health through the Commission on Perinatal Care and Prevention of Infant Mortality shall provide the findings of this study in the form of a report outlining the identified or proposed mechanisms to the House Committee on Health and Welfare and the Senate Committee on Health and Welfare on or before June 30, 2021.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the secretary of the Louisiana Department of Health and the Commission on Perinatal Care and Prevention of Infant Mortality.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

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Urges and requests the La. Dept. of Health (LDH) through the Commission on Perinatal Care and Prevention of Infant Mortality to study ways to conduct autopsies of all maternal deaths that occur in-hospital and to standardize coroner and toxicology reporting on maternal deaths.

Requires LDH through the Commission on Perinatal Care and Prevention of Infant Mortality to submit a written report of findings resulting from the study to the legislative committees on health and welfare on or before June 30, 2021.