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State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 660

02/04/2021 Authored by Richardson; Hansen, R.; Becker-Finn; Youakim; Morrison and others
The bill was read for the first time and referred to the Committee on Health Finance and Policy
02/18/2021 Adoption of Report: Amended and re-referred to the Committee on Judiciary Finance and Civil Law
03/08/2021 Adoption of Report: Re-referred to the Committee on Health Finance and Policy

1.1 A bill for an act

1.2 relating to health; establishing the Dignity in Pregnancy and Childbirth Act;
1.3 requiring continuing education on anti-racism training and implicit bias; expanding
1.4 the maternal death studies conducted by the commissioner of health to include
1.5 maternal morbidity; appropriating money; amending Minnesota Statutes 2020,
1.6 section 145.901; proposing coding for new law in Minnesota Statutes, chapter
1.7 144.

1.8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.9 Section 1. **[144.1461] DIGNITY IN PREGNANCY AND CHILDBIRTH.**

1.10 Subdivision 1. **Citation.** This section may be cited as the "Dignity in Pregnancy and
1.11 Childbirth Act."

1.12 Subd. 2. **Continuing education requirement.** (a) Hospitals with obstetric care and birth
1.13 centers must provide continuing education on anti-racism training and implicit bias. The
1.14 continuing education must be evidence-based and must include at a minimum the following
1.15 criteria:

1.16 (1) education aimed at identifying personal, interpersonal, institutional, structural, and
1.17 cultural barriers to inclusion;

1.18 (2) identifying and implementing corrective measures to promote anti-racism practices
1.19 and decrease implicit bias at the interpersonal and institutional levels, including the
1.20 institution's ongoing policies and practices;

1.21 (3) providing information on the ongoing effects of historical and contemporary exclusion
1.22 and oppression of Black and Indigenous communities with the greatest health disparities
1.23 related to maternal and infant mortality and morbidity;

2.1 (4) providing information and discussion of health disparities in the perinatal health care
2.2 field including how systemic racism and implicit bias have different impacts on health
2.3 outcomes for different racial and ethnic communities; and

2.4 (5) soliciting perspectives of diverse, local constituency groups and experts on racial,
2.5 identity, cultural, and provider-community relationship issues.

2.6 (b) In addition to the initial continuing educational requirement in paragraph (a), hospitals
2.7 with obstetric care and birth centers must provide an annual refresher course that reflects
2.8 current trends on race, culture, identity, and anti-racism principles and institutional implicit
2.9 bias.

2.10 (c) Hospitals with obstetric care and birth centers must develop continuing education
2.11 materials on anti-racism and implicit bias that must be provided and updated annually for
2.12 direct care employees and contractors who routinely care for patients who are pregnant or
2.13 postpartum.

2.14 (d) Hospitals with obstetric care and birth centers shall coordinate with health care
2.15 licensing boards to obtain continuing education credits for the trainings and materials
2.16 required in this section. The commissioner of health shall monitor compliance with this
2.17 section. Initial training for the continuing education requirements in this subdivision must
2.18 be completed by December 31, 2022. The commissioner may inspect the training records
2.19 or require reports on the continuing education materials in this section from hospitals with
2.20 obstetric care and birth centers.

2.21 (e) A facility described in paragraph (d) must provide a certificate of training completion
2.22 to another facility or a training attendee upon request. A facility may accept the training
2.23 certificate from another facility for a health care provider that works in more than one
2.24 facility.

2.25 Subd. 3. **Midwife and doula care.** In order to improve maternal and infant health as
2.26 well as improving birth outcomes in groups with the most significant disparities that include
2.27 Black, Indigenous, and other communities of color; rural communities; and people with
2.28 low incomes, the commissioner of health in partnership with patient groups and culturally
2.29 based community organizations shall:

2.30 (1) develop procedures and services designed for making midwife and doula services
2.31 available to groups with the most maternal and infant mortality and morbidity disparities;

3.1 (2) propose changes to licensing of midwives in order to allow midwives with nationally
3.2 recognized credentials to practice to the full scope of competencies and education the
3.3 midwife has attained;

3.4 (3) promote racial, ethnic, and language diversity in the midwife and doula workforce
3.5 that better aligns with the childbearing population in groups with the most significant
3.6 maternal and infant mortality and morbidity disparities; and

3.7 (4) ensure that midwife and doula training and licensing are tailored to the specific needs
3.8 of groups with the most significant maternal and infant mortality and morbidity disparities,
3.9 including trauma-informed care, maternal mood disorders, intimate partner violence, and
3.10 systemic racism.

3.11 Sec. 2. Minnesota Statutes 2020, section 145.901, is amended to read:

3.12 **145.901 MATERNAL MORBIDITY AND DEATH STUDIES.**

3.13 Subdivision 1. **Purpose.** (a) The commissioner of health may conduct maternal morbidity
3.14 and death studies to assist the planning, implementation, and evaluation of medical, health,
3.15 and welfare service systems and to reduce the numbers of preventable adverse maternal
3.16 outcomes and deaths in Minnesota.

3.17 (b) For purposes of this section, "maternal morbidity" has the meaning given to severe
3.18 maternal morbidity by the Centers for Disease Control and Prevention, and includes an
3.19 unexpected outcome of labor or delivery that results in significant short- or long-term
3.20 consequences to a woman's health.

3.21 Subd. 2. **Access to data.** (a) The commissioner of health has access to medical data as
3.22 defined in section 13.384, subdivision 1, paragraph (b), medical examiner data as defined
3.23 in section 13.83, subdivision 1, and health records as defined in section 144.291, subdivision
3.24 2, paragraph (c), created, maintained, or stored by providers ~~as defined in section 144.291,~~
3.25 ~~subdivision 2, paragraph (i),~~ without the consent of the subject of the data, and without the
3.26 consent of the parent, spouse, other guardian, or legal representative of the subject of the
3.27 data, when the subject of the data is a woman who died or experienced morbidities during
3.28 a pregnancy or within 12 months of a fetal death, a live birth, or other termination of a
3.29 pregnancy.

3.30 The commissioner has access only to medical data and health records related to maternal
3.31 morbidities and deaths that occur on or after July 1, 2000, including the names of the
3.32 providers and clinics where care was received before, during, or related to the pregnancy
3.33 or death. The commissioner has access to records maintained by family home visiting

4.1 programs; the women, infants, and children (WIC) program; the prescription monitoring
4.2 program; behavioral health services programs; substance use treatment facilities; law
4.3 enforcement; the medical examiner; coroner; or hospitals for the purpose of providing the
4.4 name and location of any pre-pregnancy or prenatal care received by the subject of the data
4.5 or of any postpartum care received up to one year following the end of pregnancy by the
4.6 subject of the data.

4.7 (b) The provider or responsible authority that creates, maintains, or stores the data shall
4.8 furnish the data upon the request of the commissioner. The provider or responsible authority
4.9 may charge a fee for providing the data, not to exceed the actual cost of retrieving and
4.10 duplicating the data.

4.11 (c) The commissioner shall make a good faith reasonable effort to notify the subject of
4.12 the data, or the subject's parent, spouse, ~~other~~ guardian, or legal representative ~~of the subject~~
4.13 ~~of the data~~ before collecting data on the subject. For purposes of this paragraph, "reasonable
4.14 effort" means one notice is sent by certified mail to the last known address of the subject
4.15 of the data, or the subject's parent, spouse, guardian, or legal representative informing the
4.16 recipient of the data collection and offering a public health nurse support visit if desired.

4.17 (d) The commissioner does not have access to coroner or medical examiner data that
4.18 are part of an active investigation as described in section 13.83.

4.19 (e) The commissioner may request and receive from a coroner or medical examiner the
4.20 name of the health care provider that provided prenatal, postpartum, and other health services
4.21 to the subject of the data.

4.22 (f) The commissioner may access Department of Human Services data to identify sources
4.23 of care and services to assist with the evaluation of welfare systems to reduce preventable
4.24 maternal deaths.

4.25 (g) The commissioner may request and receive from a law enforcement agency law
4.26 enforcement reports or incident reports related to the subject of the data.

4.27 Subd. 3. **Management of records.** After the commissioner has collected all data about
4.28 a subject of a maternal morbidity or death study needed to perform the study, the data from
4.29 source records obtained under subdivision 2, other than data identifying the subject, must
4.30 be transferred to separate records to be maintained by the commissioner. Notwithstanding
4.31 section 138.17, after the data have been transferred, all source records obtained under
4.32 subdivision 2 possessed by the commissioner must be destroyed.

5.1 Subd. 4. **Classification of data.** (a) Data provided to the commissioner from source
5.2 records under subdivision 2, including identifying information on individual providers, data
5.3 subjects, or their children, and data derived by the commissioner under subdivision 3 for
5.4 the purpose of carrying out maternal morbidity and death studies, are classified as confidential
5.5 data on individuals or confidential data on decedents, as defined in sections 13.02, subdivision
5.6 3, and 13.10, subdivision 1, paragraph (a).

5.7 (b) Information classified under paragraph (a) shall not be subject to discovery or
5.8 introduction into evidence in any administrative, civil, or criminal proceeding. Such
5.9 information otherwise available from an original source shall not be immune from discovery
5.10 or barred from introduction into evidence merely because it was utilized by the commissioner
5.11 in carrying out maternal morbidity and death studies.

5.12 (c) Summary data on maternal morbidity and death studies created by the commissioner,
5.13 which does not identify individual data subjects or individual providers, shall be public in
5.14 accordance with section 13.05, subdivision 7.

5.15 (d) Data provided by the commissioner of human services to the commissioner of health
5.16 under this section retains the same classification the data held when retained by the
5.17 commissioner of human services, as required under section 13.03, subdivision 4, paragraph
5.18 (c).

5.19 Sec. 3. **APPROPRIATION; ANTI-RACISM AND IMPLICIT BIAS TRAINING;**
5.20 **MATERNAL MORBIDITY AND DEATH STUDIES.**

5.21 (a) $....... in fiscal year 2022 is appropriated from the general fund to the commissioner
5.22 of health to be used for grants for anti-racism and implicit bias training in accredited medical,
5.23 nursing, midwifery, and doula education curricula in obstetric clinical practice.

5.24 (b) $....... in fiscal year 2022 and $....... in fiscal year 2023 are appropriated from the
5.25 general fund to the commissioner of health for purposes of Minnesota Statutes, section
5.26 145.901.