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Gov. Murphy signs legislation to establish maternal mortality review committee
NJBIZ (New Brunswick, NJ) - May 1, 2019

RWH/JA

Title 26.
Chapter 6C.
(New)
Maternal
Mortality
§§ 1-12, 14-17 -
C.26:6C-1 to
26:6C-16

(CORRECTED COPY)

P.L. 2019, CHAPTER 75, *approved May 1, 2019*
Assembly, No. 1862 (*Third Reprint*)

1 AN ACT concerning maternal ²**[deaths]** mortality and morbidity²,
2 supplementing Title 26 of the Revised Statutes, and amending
3 R.S.26:8-24.

4
5 **BE IT ENACTED** by the Senate and General Assembly of the State
6 of New Jersey:

7
8 ¹1. (New section) The Legislature finds and declares that:

9 a. Most nations across the globe have successfully reduced
10 their maternal mortality rates over the past two and a half decades,
11 in response to a United Nations' call to action; however, the U.S. is
12 one of only a handful of countries where maternal mortality rates
13 have continued to rise (increasing by 27% between 2000 and 2014);

14 b. The U.S. is currently ranked 50th in the world in maternal
15 mortality, with a rate of maternal death that is ²**[more than]** ²**nearly**²
16 three times the rate that exists in the United Kingdom, and about
17 ²**[eight]** ²**six**² times the rate that exists in the Netherlands, Norway,
18 and Sweden;

19 c. In New Jersey, there is currently a Maternal Mortality Case
20 Review Team that operates ²**[informally]**² out of the Department of
21 Health (DOH), and which periodically reviews and provides
22 statistics on maternal deaths occurring in the State.

23 d. ²**[According to the DOH Maternal Mortality Case Review**
24 Team's latest report, which covers the period from 2009 to 2013,
25 New Jersey ranks 35th of the 50 states in pregnancy-related deaths;
26 however, it is important to note that pregnancy-related deaths make
27 up only a single subset of the total maternal deaths that have
28 occurred in the State, and a] ²**A**² document produced by Every
29 Mother Counts shows that New Jersey is ranked ²**[47th]** ²**46th**² of
30 the 50 states in total maternal mortality, with a rate of 37.3 maternal
31 deaths per every 100,000 live births ²and African-American women

EXPLANATION – Matter enclosed in bold-faced brackets **[thus]** in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows:

¹Assembly AWC committee amendments adopted March 12, 2018.

²Senate SBA committee amendments adopted February 7, 2019.

³Senate floor amendments adopted February 21, 2019.

1 in New Jersey are five times more likely than their white
2 counterparts to die from pregnancy-related complications²;

3 e. While the DOH Maternal Mortality Case Review Team
4 produces important statistical data, the team is not permanently
5 established by statute, does not meet regularly, produces only
6 periodic reports on maternal mortality, and uses varying datasets in
7 those periodic reports, making the ²**[amalgamation]** aggregation²
8 and comparison of data by interested parties more difficult;

9 ²f. There is a need to coordinate and expand the multiple,
10 fractionalized maternal mortality and morbidity reduction efforts
11 being conducted by caring and committed individuals and
12 organizations across the State. Further, it is essential to house these
13 myriad efforts in the Department of Health, the state designated
14 agency responsible for public health protection and services. The
15 DOH can uniquely leverage the weight and power of the State to
16 effectuate critical changes in the delivery of care and the
17 implementation of Statewide strategies to reduce maternal mortality
18 and morbidity and to eliminate the racial and ethnic disparities in
19 maternal outcomes;

20 g. To coordinate and support a Statewide strategy to reduce
21 maternal morbidity and mortality, the State should establish a New
22 Jersey Maternal Care Quality Collaborative (NJMCQC);

23 h. To improve data collection and to improve and assist quality
24 improvement efforts by health care facilities and the State, a
25 Maternal Data Center should be established within the Healthcare
26 Quality and Informatics Unit in the DOH;

27 **[f.] i.² United States Senate Bill No. 1112, introduced in the**
28 115th Congress, would establish a federal grant program to assist
29 states in establishing and sustaining state-level maternal mortality
30 review committees; however, a state will only be eligible to obtain a
31 grant under this bill if the state's maternal mortality review
32 committee satisfies certain specific requirements, as articulated in
33 S.1112; ²and

34 **[g.] j.² In order to ensure that the entity reviewing maternal**
35 deaths in the State ²**[is operating on a permanent basis]** may
36 operate permanently and sustainably², with full statutory authority,
37 in adherence to certain specified powers and responsibilities, and in
38 a manner that would enable the State to obtain federal grant funds
39 under S.1112 or other similar federal legislation, it is both
40 reasonable and necessary for the Legislature to replace the existing
41 informal DOH Maternal Mortality Case Review Team with a
42 statutorily-established Maternal Mortality Review ²**[Commission]**
43 Committee², situated in the Department of Health ²and overseen by
44 the NJMCQC², which ²**[commission]** committee² will incorporate
45 the membership of the current Maternal Mortality Case Review
46 Team, but will have formal statutory authority, broader powers, and
47 specific goals and directives, as necessary to ensure that it is able to

1 continuously engage in the comprehensive, regular, and uniform
 2 review and reporting of maternal deaths throughout the State.¹

3

4 ¹**[1.] 2.**¹ (New section) As used in this act:

5 ²**["Commission"]** "Committee"² means the Maternal Mortality
 6 Review ²**[Commission]** Committee², established pursuant to
 7 section ¹**[2]** ²**[3¹]** ⁴² of this act, which is responsible for annually
 8 reviewing and reporting on maternal death rates and the causes of
 9 maternal death in the State, and which is further responsible for
 10 providing recommendations to improve maternal care and reduce
 11 adverse maternal outcomes.

12 ²**["Commissioner"]** means the Commissioner of Health. ²

13 "Department" means the Department of Health.

14 "Maternal death" means a pregnancy-associated death ²**[**, or a
 15 pregnancy-related death²**]**.

16 ¹"Maternal Mortality Case Review Team" means the
 17 interdisciplinary team of experts that is operating in the Department
 18 of Health as of the effective date of this act, and which is being
 19 replaced by the ²**[commission]** committee² established pursuant to
 20 this act.¹

21 ²"NJMCQC" means the New Jersey Maternal Care Quality
 22 Collaborative, established pursuant to section 3 of P.L. ,
 23 c. (C.) (pending before the Legislature as this bill).²

24 "Pregnancy-associated death" means the death of a woman,
 25 which occurs while the woman is pregnant, or during the one-year
 26 period following the date of the end of the pregnancy, irrespective
 27 of the cause of death.

28 "Pregnancy-related death" means the death of a woman, which
 29 occurs while the woman is pregnant, or during the one-year period
 30 following the date of the end of the pregnancy, regardless of the
 31 duration of the pregnancy, and which results from any cause related
 32 to, or aggravated by, the pregnancy or its management, but
 33 excluding any accidental or incidental cause.

34 "Report of maternal death" means a report of ²**[actual or**
 35 **perceived]** a suspected² maternal death, which is filed with the
 36 department, pursuant to the processes established under subsection
 37 a. of section ¹**[5]** ²**[6¹]** ⁷² of this act, and which is to be forwarded
 38 to the ²**[commission]** committee² for the purposes of investigation,
 39 as provided by subsection b. of that section.

40 "Severe maternal morbidity" means the physical and
 41 psychological conditions that result from, or are aggravated by,
 42 pregnancy, and which have an adverse effect on the health of a
 43 woman.

44 "State registrar" means the State registrar of vital statistics, who
 45 is responsible for supervising the registration of, and maintaining,
 46 death records in the State, in accordance with the provisions of
 47 R.S.26:8-1 et seq.

1 23. (New section) a. There is hereby established in the
2 Department of Health the New Jersey Maternal Care Quality
3 Collaborative (NJMCQC) that shall work with the Governor's
4 office to coordinate all efforts and strategies to reduce maternal
5 mortality, morbidity, and racial and ethnic disparities in the State,
6 including supervision and oversight of the Maternal Mortality
7 Review Committee.

8 b. The NJMCQC shall work collaboratively with current
9 organizations that are developing and implementing maternal
10 mortality and morbidity reduction strategies, including the New
11 Jersey Hospital Association's Perinatal Quality Care Collaborative.

12 c. The NJMCQC shall be composed of 34 members, including
13 nine ex-officio members and 25 public members appointed by the
14 Governor.

15 (1) The ex officio members shall include the following persons
16 or their designees:

17 the Commissioner of Health;

18 the Commissioner of Human Services;

19 the Commissioner of Banking and Insurance;

20 the Commissioner of Children and Families;

21 the Deputy Commissioner of Health Systems in the Department
22 of Health;

23 the Deputy Commissioner of Public Health Services in the
24 Department of Health;

25 the Director of the Office of Minority and Multicultural Health
26 in the Department of Health;

27 the Director of the Division of Medical Assistance and Health
28 Services in the Department of Human Services; and

29 the Assistant Commissioner of Health and Life Insurance Plans
30 in the Department of Banking and Insurance.

31 (2) The public members appointed by the Governor shall include
32 members representing each of the following groups:

33 the New Jersey Hospital Association;

34 the New Jersey Health Care Quality Institute;

35 the Catholic HealthCare Partnership of New Jersey;

36 the Hospital Alliance of New Jersey;

37 the Fair Share Hospitals Collaborative;

38 the New Jersey section of the American College of Obstetricians
39 and Gynecologists;

40 the New Jersey Affiliate of the American College of Nurse
41 Midwives;

42 the New Jersey Medical Society;

43 three medical directors of health plans in the State, as
44 recommended to the commissioner by the President of the New
45 Jersey Association of Health Plans;

46 the New Jersey Section of the Association of Women's Health
47 Obstetric and Neonatal Nurses;

- 1 the New Jersey Chapter of the American College of Emergency
2 Physicians;
3 Planned Parenthood of New Jersey;
4 the New Jersey Association of Osteopathic Physicians and
5 Surgeons;
6 the New Jersey Primary Care Association;
7 the Partnership for Maternal and Child Health of Northern New
8 Jersey;
9 the Central Jersey Family Health Consortium;
10 the Southern New Jersey Perinatal Cooperative;
11 each of the three Accountable Care Organizations established
12 pursuant to P.L.2011, c. 114 or any successor organization to that
13 Accountable Care Organization; and
14 three additional public members appointed on the
15 recommendation of the Commissioner of Health, one who is
16 engaged in maternal health advocacy; one who is engaged in health
17 equity advocacy; and one who is engaged in healthcare consumer
18 advocacy.
- 19 d. The public members of the NJMCQC shall serve without
20 compensation and shall each serve for a term of three years. Each
21 public member shall serve for the term of appointment and shall
22 serve until a successor is appointed and qualified, except that a
23 public member may be reappointed to the NJMCQC upon the
24 expiration of their term. Any vacancy in the membership shall be
25 filled, for the unexpired term, in the same manner as the original
26 appointment.
- 27 e. The NJMCQC shall adopt and implement the strategic plan
28 for the State of New Jersey to reduce maternal mortality, morbidity
29 and racial and ethnic disparities. The NJMCQC shall meet quarterly
30 to coordinate activities that forward the strategic plan, strategize on
31 future activities, solicit funding opportunities, focus on translating
32 the data collected by, the Maternal Data Center, the Healthcare
33 Quality and Informatics Unit, the Maternal Mortality Review
34 Committee, the Department of Health, and its partners into action
35 items, and communicate goals and achievement of these goals with
36 stakeholders.
- 37 f. The NJMCQC shall:
- 38 (1) Employ an Executive Director, a Program Manager, and any
39 other personnel as authorized by the Commissioner of Health. The
40 Department of Health shall provide such administrative staff
41 support to the NJMCQC as shall be necessary for the NJMCQC to
42 carry out its duties. The director shall be appointed by the
43 commissioner and shall serve at the pleasure of the commissioner
44 during the commissioner's term of office and until the appointment
45 and qualification of the director's successor;
- 46 (2) Apply for and accept any grant of money from the federal
47 government, private foundations or other sources, which may be

1 available for programs related to maternal mortality, morbidity and
 2 racial and ethnic disparities;

3 (3) Serve as the designated State entity for receipt of federal
 4 funds specifically designated for programs concerning maternal
 5 mortality, morbidity and racial and ethnic disparities;

6 (4) Enter into contracts with individuals, organizations, and
 7 institutions necessary for the performance of its duties under
 8 P.L. , c. (C.) (pending before the Legislature as this bill);
 9 and

10 (5) Work with the Center for Healthcare Quality and Informatics
 11 to develop and publicize statistical information on maternal
 12 mortality, morbidity and racial and ethnic disparities and
 13 information as provided for pursuant to P.L.2018, c.82 (C.26:2H-
 14 5j).

15 g. The NJMCQC is entitled to call to its assistance, and avail
 16 itself of, the services of employees of any State, county or
 17 municipal department, board, bureau, commission or agency as it
 18 may require and as may be available to it for its purposes. All
 19 departments, agencies and divisions are authorized and directed, to
 20 the extent not inconsistent with law, to cooperate with the
 21 NJMCQC.

22

23 ¹~~[2.]~~ ²~~[3.]~~ ^{4.} (New section) a. There is hereby established, in
 24 the Department of Health, the Maternal Mortality Review
 25 ²~~[Commission]~~ Committee², which shall be tasked with annually
 26 reviewing and reporting on maternal death rates and the causes of
 27 maternal death in the State, and providing recommendations to
 28 improve maternal care and reduce ²~~severe~~² adverse outcomes related
 29 to, or associated with, pregnancy. ¹~~The~~ ²~~[commission]~~ committee²
 30 shall replace and supersede the Maternal Mortality Case Review
 31 Team that is currently constituted in the department.¹ The
 32 ²~~[commission]~~ committee² shall be composed of ¹~~[31]~~ ²~~[38]~~¹ ²⁴~~24~~²
 33 members, including ¹~~[18]~~ ²~~[25]~~¹ ⁴~~4~~² ex officio members ²~~[or their~~
 34 ~~designees,]~~² as provided in subsection b. of this section, and ²~~[13]~~
 35 ²⁰~~20~~² public members, as provided in subsection c. of this section.

36 b. The ex officio members of the ²~~[commission]~~ committee²
 37 shall include the following persons, or their designees: ²~~[(1) the~~
 38 ~~State registrar]~~

39 ²~~[(2)]~~² the State Medical Examiner;

40 ²~~[(3)]~~² the Director of the Division of Family Health Services in
 41 the Department of Health;

42 ²~~[(4)]~~² the Director of the Office of Emergency Medical Services
 43 in the Department of Health;

44 ²~~[(5)]~~² the Director of the Office of Minority and Multicultural
 45 Health in the Department of Health; ²~~]~~ the Director of the Maternal
 46 Data Center established by section 14 of P.L. , c. (C.)
 47 (pending before the Legislature as this bill); and²

- 1 ²[(6)]² the ²Medical² Director of the Division of Medical
2 Assistance and Health Services in the Department of Human
3 Services;
- 4 ²[(7) the President of the New Jersey Hospital Association;
5 (8) the President of the New Jersey Health Care Quality Institute;
6 (9) the Chief Executive Officer of the Medical Society of New
7 Jersey;
8 (10) the Executive Director of the New Jersey Chapter of the
9 National Association of Social Workers;
10 (11) the Chair of the New Jersey section of the American
11 ¹[(Congress)] College¹ of Obstetricians and Gynecologists
12 ¹(ACOG)¹;
13 (12) the President of the New Jersey Affiliate of the American
14 College of Nurse Midwives;
15 (13) ¹the Chair of the New Jersey Section of the Association of
16 Women’s Health Obstetric and Neonatal Nurses (AWHONN);
17 (14) the President of the New Jersey Chapter of the American
18 College of Emergency Physicians;
19 (15) the President of the New Jersey Association of Osteopathic
20 Physicians and Surgeons;
21 (16) the President of the New Jersey Academy of Family
22 Physicians;
23 (17) the President of the New Jersey Chapter of the American
24 Academy of Pediatrics;
25 (18) the President of the New Jersey Health Officers
26 Association;
27 (19) the President of the New Jersey Primary Care Association;
28 (20)¹ the Executive Director of the Partnership for Maternal and
29 Child Health of Northern New Jersey;
30 ¹[(14)] (21)¹ the Chief Executive Officer of the Central Jersey
31 Family Health Consortium;
32 ¹[(15)] (22)¹ the Executive Director of the Southern New Jersey
33 Perinatal Cooperative;
34 ¹[(16)] (23)¹ the Director of the City of Newark Department of
35 Health and Community Wellness;
36 ¹[(17)] (24)¹ the Director of the City of Trenton Health and
37 Human Services Department; and
38 ¹[(18)] (25)¹ the Director of the Camden County Department of
39 Health and Human Services.]²
- 40 c. ²(1) Seven of the public members shall be appointed by the
41 Governor to represent the following groups:
42 the New Jersey section of the American College of Obstetricians
43 and Gynecologists (ACOG);
44 the New Jersey Affiliate of the American College of Nurse
45 Midwives;
46 the New Jersey Section of the Association of Women’s Health
47 Obstetric and Neonatal Nurses (AWHONN);

1 the New Jersey Chapter of the American College of Emergency
2 Physicians;

3 the Partnership for Maternal and Child Health of Northern New
4 Jersey;

5 the Central Jersey Family Health Consortium; and
6 the Southern New Jersey Perinatal Cooperative.

7 (2)² The additional 13² public members of the ²**[commission]**
8 committee² shall be appointed by the ²**[Governor]** Commissioner
9 of Health, to reflect the diversity in the state's geographic regions
10 and perinatal designations² and shall include:

11 ²**[(1) five]** seven² licensed and practicing health care
12 practitioners, one of whom specializes in obstetrics or gynecology,
13 one of whom specializes in maternal and fetal medicine, ²**[one of**
14 **whom specializes in family planning,]**² one of whom specializes in
15 critical care medicine, ²**[and]**² one of whom specializes in perinatal
16 pathology ², two of whom serve in clinical roles providing pre or
17 post-natal care at Federally Qualified Health Centers operating in
18 the State, and one anesthesiologist²;

19 ²**[(2)]²** one licensed and practicing health care practitioner ²**[,]**
20 or² mental health care practitioner ²**[, or]** ;

21 one² substance use disorder treatment professional who
22 specializes in perinatal addiction;

23 ²**[(3)]²** one certified nurse midwife;

24 ²**[(4)]²** one registered professional nurse or advanced practice
25 nurse who specializes in hospital-based obstetric nursing;

26 ²**[(5)]²** one licensed practical nurse, registered professional
27 nurse, or advanced practice nurse who participates in, and
28 represents, the Nurse-Family Partnership operating in New Jersey;

29 ²**[(6)]** one health care administrator who has experience in
30 overseeing the operations of maternity wards or birthing centers;

31 (7) one private citizen who is engaged in maternal health
32 advocacy;

33 (8) one private citizen who is engaged in minority health
34 advocacy; and

35 (9) one private citizen who is engaged in patient advocacy **]** ; and
36 one Certified Midwife or Certified Professional Midwife².

37 d. Of the 13² public members appointed to the ²**[commission]**
38 committee by the Commissioner of Health², not more than seven
39 shall be of the same political party.

40 e. Each public member of the ²**[commission]** committee² shall
41 serve for a term of four years; however, of the public members first
42 appointed, four shall serve an initial term of two years, four shall
43 serve an initial term of three years, and five shall serve an initial
44 term of four years. Each public member shall serve for the term of
45 their appointment, and until a successor is appointed and qualified,
46 except that a public member may be reappointed to the

1 ²[commission] committee² upon the expiration of their term. Any
2 vacancy in the membership shall be filled, for the unexpired term,
3 in the same manner as the original appointment.

4 f. All initial appointments to the ²[commission] committee²
5 shall be made within 60 days after the effective date of this act.
6 ¹Upon the appointment of a majority of the ²[commission]
7 committee² members, the Maternal Mortality Case Review Team,
8 which is constituted in the Department of Health as of the effective
9 date of this act, shall be disbanded.¹

10 g. Any member of the ²[commission] committee² may be
11 removed by the ²[Governor] Commissioner of Health², for cause,
12 after a public hearing.

13
14 ¹[3.] ²[4.1] 5.² (New section) a. The ²[commission]
15 committee² shall organize as soon as practicable following the
16 appointment of a majority of its members, and shall annually elect a
17 chairperson and vice-chairperson from among its members. The
18 chairperson may appoint a secretary, who need not be a member of
19 the ²[commission] committee².

20 b. The ²[commission] committee² shall meet pursuant to a
21 schedule to be established at its first meeting, and it shall
22 additionally meet at the call of its chairperson or the Commissioner
23 of Health; however, in no case shall the ²[commission] committee²
24 meet less than ¹[four] ²[two¹] four² times a year.

25 c. A majority of the total number of members appointed to the
26 ²[commission] committee² shall constitute a quorum for the
27 conducting of official ²[commission] committee² business. A
28 vacancy in the membership of the ²[commission] committee² shall
29 not impair the right of the ²[commission] committee² to exercise
30 its powers and duties, provided that a majority of the currently
31 appointed members are available to conduct business. Any
32 recommendations of the ²[commission] committee² shall be
33 approved by a majority of the members present.

34 d. The members of the ²[commission] committee² shall serve
35 without compensation, but shall be reimbursed for travel and other
36 necessary expenses incurred in the discharge of their official duties,
37 within the limits of funds appropriated or otherwise made available
38 for such purposes.

39 e. ²The Department of Health shall employ, at a minimum, the
40 following support staff for the committee: a program manager, a
41 clinical nurse case abstractor; two maternal child health
42 epidemiologists, a case abstraction manager, and any other staff the
43 Commissioner of Health shall deem necessary.² The Department of
44 Health shall ²also² provide such administrative staff support to the
45 ²[Commission] committee² as shall be necessary for the
46 ²[commission] committee² to carry out its duties.

- 1 ¹[4.] ²[5. ¹] 6.² (New section) a. The Maternal Mortality
2 Review ²[Commission] Committee² shall have the power to:
- 3 (1) carry out any power, duty, or responsibility expressly
4 granted by this act;
- 5 (2) adopt, amend, or repeal suitable bylaws for the management
6 of its affairs;
- 7 (3) maintain an office at such place or places as it may
8 designate;
- 9 (4) apply for, receive, and accept, from any federal, State, or
10 other public or private source, grants, loans, or other moneys that
11 are made available for, or in aid of, the ²[commission's]
12 committee's² authorized purposes, or that are made available to
13 assist the ²[commission] committee² in carrying out its powers,
14 duties, and responsibilities under this act;
- 15 (5) enter into any and all agreements or contracts, execute any
16 and all instruments, and do and perform any and all acts or things
17 necessary, convenient, or desirable to further the purposes of the
18 ²[commission] committee²;
- 19 (6) call to its assistance, and avail itself of the services of, such
20 employees of any State entity or local government unit as may be
21 required and available for the ²[commission's] committee's²
22 purposes;
- 23 (7) review and investigate reports of maternal death; conduct
24 witness interviews, and hear testimony provided under oath at
25 public or private hearings, on any material matter; and request ¹[,
26 or compel through the issuance of a subpoena,]^{1 2} or compel
27 through the issuance of a subpoena,² the attendance of relevant
28 witnesses and the production of relevant documents, records, and
29 papers;
- 30 (8) solicit and consider public input and comment on the
31 ²[commission's] committee's² activities by periodically holding
32 public hearings or conferences, and by providing other
33 opportunities for such input and comment by interested parties; and
- 34 (9) identify, and promote the use of, best practices in maternal
35 care, and encourage and facilitate cooperation and collaboration
36 among health care facilities, health care professionals,
37 administrative agencies, and local government units for the
38 purposes of ensuring the provision of the highest quality maternal
39 care throughout the State.
- 40 b. The Maternal Mortality Review ²[Commission] Committee²
41 shall have the duty and responsibility to:
- 42 (1) develop mandatory and voluntary maternal death reporting
43 processes, in accordance with the provisions of section ²[5] 7²
44 of this act ²and, at a minimum meet or exceed current federal Centers
45 for Disease Control and Prevention reporting methodologies²;
- 46 (2) conduct an investigation of each reported case of maternal
47 death, and prepare a de-identified case summary for each such case,

1 in accordance with the provisions of section ¹[6] ²[7¹] 8² of this
2 act;

3 (3) review the statistical data on maternal deaths that is
4 forwarded by the ²[State registrar, pursuant to section ¹[10] 11¹ of
5 this act] Maternal Data Center pursuant to section 14 of this act²,
6 and the reports of maternal death that are forwarded by the
7 department, pursuant to subsection b. of section ¹[5] ²[6¹] 7² of
8 this act, in order to identify Statewide and regional maternal death
9 rates; trends, patterns, and disparities in adverse maternal outcomes;
10 and medical, non-medical, and system-related factors that may have
11 contributed to maternal deaths and treatment disparities; and

12 (5) annually report its findings and recommendations on
13 maternal mortality to the department, the Governor, and the
14 Legislature, in accordance with section ¹[7] ²[8¹] 9² of this act.
15

16 ¹[5.] ²[6.¹] 7.² (New section) a. Within 90 days after the
17 ²[commission's] committee's² organizational meeting, the
18 ²[commission] committee² shall:

19 (1) develop a mandatory maternal death reporting process,
20 pursuant to which health care practitioners, medical examiners,
21 hospitals, birthing centers, and other relevant professional actors
22 and health care facilities will be required to confidentially report to
23 the Department of Health on individual cases of maternal death ¹.
24 In developing a mandatory maternal death reporting process
25 pursuant to this paragraph, the ²[commission] committee² may, as
26 deemed to be appropriate, review and incorporate elements of the
27 maternal death reporting process that is used by the Maternal
28 Mortality Case Review Team as of the effective date of this act¹;
29 and

30 (2) develop a voluntary maternal death reporting process,
31 pursuant to which the family members of a deceased woman, and
32 any other interested members of the public, will be permitted, but
33 not required, to confidentially report to the Department of Health on
34 individual cases of perceived maternal death. At a minimum, the
35 process developed pursuant to this paragraph shall require the
36 department to: (a) post on its Internet website a hyperlink, a toll-
37 free telephone number, and an email address, which may each be
38 used for the voluntary submission of public reports of maternal
39 death; and (b) publicize the availability of these resources to
40 professional organizations, community organizations, social service
41 agencies, and members of the public.

42 b. The department shall keep a record of all reports of maternal
43 death that are submitted thereto through the reporting processes that
44 are established by the ²[commission] committee² pursuant to
45 paragraphs (1) and (2) of subsection a. of this section. The
46 department shall also ensure that a copy of each such report of
47 maternal death is promptly forwarded to the ²[commission]

1 committee², so that the ²[commission] committee² may properly
2 execute its investigatory functions and other duties and
3 responsibilities under this act.

4
5 ¹[6.] ²[7.1] 8.² (New section) a. Upon receipt of a report of
6 maternal death, which has been forwarded to the ²[commission]
7 committee² pursuant to subsection b. of section ¹[5.] ²[6.1] 7² of
8 this act, the ²[commission] committee² shall investigate the
9 reported case in accordance with the provisions of this section. In
10 conducting the investigation, the ²[commission] committee² shall
11 consider:

12 (1) the information contained in the forwarded report of
13 maternal death;

14 (2) any relevant information contained in the deceased woman's
15 autopsy report or death record, or in a certificate of live birth or
16 fetal death for the woman's child, or in any other vital records
17 pertaining to the woman;

18 (3) any relevant information contained in the deceased woman's
19 medical records, including: (a) records related to the health care
20 that was provided to the woman prior to her pregnancy; (b) records
21 related to the woman's prenatal and postnatal care, labor and
22 delivery care, emergency room care, and any other care delivered
23 up until the time of the woman's death; and (c) the woman's
24 hospital discharge records ¹and ²[other] all² hospital records
25 ²including all emergency room and outpatient records² from the
26 one-year period following the end of the pregnancy¹;

27 (4) information obtained through the oral and written interviews
28 of individuals who were directly involved in the care of the woman
29 either during, or immediately following, her pregnancy, including
30 interviews with relevant health care practitioners, mental health
31 care practitioners, and social service providers, and, as deemed to
32 be appropriate and necessary, interviews with the woman's family
33 members;

34 (5) background information about the deceased woman,
35 including, but not limited to, information regarding the woman's
36 age, race, and socioeconomic status; and

37 (6) any other information that may shed light on the maternal
38 death, including, but not limited to, reports from social service or
39 child welfare agencies.

40 b. At the conclusion of an investigation conducted pursuant to
41 this section, the ²[commission] committee² shall prepare a case
42 summary, which shall include the ²[commission's] committee's²
43 findings with regard to the cause of, or the factors that contributed
44 to, the maternal death, and recommendations for actions that should
45 be undertaken, or policies that should be implemented, to mitigate
46 or eliminate those factors and causes in the future. Any case
47 summary prepared pursuant to this subsection shall omit the

1 ¹**[personally]**¹ identifying information of the deceased woman and
2 her family members ¹, the health care providers who provided care,
3 and the hospitals where care was provided¹.

4 c. The ²**[commission]** committee² may present its findings and
5 recommendations on each individual case, or on groups of
6 individual cases, as deemed appropriate, to the health care facility
7 or facilities where relevant care was provided in the case or group
8 of cases, and to the individual health care practitioners who
9 provided such care, or to any relevant professional organization, for
10 the purposes of instituting or facilitating policy changes,
11 educational activities, or improvements in the quality of care
12 provided; or for the purposes of exploring, facilitating, or
13 establishing regional projects or other collaborative projects that are
14 designed to reduce instances of maternal death.

15
16 ¹**[7.]** ²**[8.1]** 9.² (New section) a. Within one year after its
17 organization, and annually thereafter, the ²**[commission]**
18 committee² shall prepare, and submit to the Department of Health,
19 to the Governor, and, pursuant to section 2 of P.L.1991, c.164
20 (C.52:14-19.1), to the Legislature, a report containing the
21 ²**[commission's]** committee's² findings on the rates and causes of
22 maternal deaths occurring in the State during the preceding year,
23 and providing recommendations for legislative or other action that
24 can be undertaken to: (a) improve the quality of maternal care and
25 reduce adverse maternal outcomes in the State; (b) increase the
26 availability of, and improve access to, social and health care
27 services for pregnant women; and (c) reduce or eliminate ¹racial
28 and other¹ disparities in maternal care and treatment, both during,
29 and in the year after, pregnancy. Each annual report, with the
30 exception of the first report prepared under this section, shall
31 additionally identify the extent to which the ²**[commission's]**
32 committee's² prior recommendations have been successfully
33 implemented in practice, and the apparent impact that the
34 implementation of such recommended changes has had on maternal
35 care in the preceding year.

36 b. The report that is annually prepared pursuant to this section
37 shall be based on:

38 (1) the case summaries that were prepared by the
39 ²**[commission]** committee² over the preceding year, pursuant to
40 subsection b. of section ¹**[6]** ²**[7.1]** 8² of this act;

41 (2) the statistical data that was forwarded to the ²**[commission]**
42 committee², during the preceding year, by the ²**[State registrar]**
43 Maternal Data Center², pursuant to section ¹**[10]** ²**[11.1]** 14² of this
44 act; and

45 (3) any other relevant information, including ¹information from
46 the ²**[commission's]** committee's² prior annual reports, or¹

1 information on any collaborative maternal health arrangements that
2 have been established by health care providers, professional
3 organizations, local government units, or other relevant actors or
4 entities in the preceding year, in response to the ²[commission]
5 committee² outreach authorized by subsection c. of section ¹[6.]
6 ²[7.1] 8 of this act², or by paragraph (9) of subsection a. of section
7 ¹[4.] ²[5.1] 6², of this act.

8 c. Upon receipt of the ²[commission's] committee's² annual
9 report pursuant to this section, the department shall post a copy of
10 the report at a publicly accessible location on its Internet website,
11 and shall take appropriate steps to otherwise broadly publicize the
12 ²[commission's] committee's² findings and recommendations. The
13 Commissioner of Health shall also adopt rules and regulations,
14 pursuant to the "Administrative Procedure Act," P.L.1968, c.410
15 (C.52:14B-1 et seq.), to implement the recommendations contained
16 in the report, to the extent that such recommendations can be
17 implemented through administrative rule-making action.

18
19 ¹[8.] ²[9.1] 10² (New section) a. Upon receipt of the
20 ²[commission's] committee's² first annual report, issued pursuant
21 to section ¹[7.] ²[8.1] 9² of this act, the department, working in
22 consultation with the ²[commission] committee², ¹[as well as
23 with] the Perinatal Quality Collaborative, the Maternal Child
24 Health Consortia, and other¹ relevant professional organizations
25 and patient advocacy groups, shall develop an ongoing maternal
26 health educational program for health care practitioners, as may be
27 necessary to improve the quality of maternal care and reduce
28 adverse outcomes related to, or associated with, pregnancy. The
29 educational program established pursuant to this section shall
30 initially be based on, and shall reflect, the findings and
31 recommendations identified in the ²[commission's] committee's²
32 first report. However, once the educational program is established,
33 the department shall, on at least ¹[a biennial] an annual¹ basis
34 thereafter, review the program and make necessary changes to
35 ensure that the ongoing education provided thereunder accurately
36 reflects, and is consistent with, the latest data, findings, and
37 recommendations of the ²[commission] committee², as reflected in
38 the ²[commission's] committee's² most recent annual report.

39 b. ¹[Each of the State's professional licensing boards, as
40 appropriate, shall adopt rules and regulations, pursuant to the
41 "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et
42 seq.), which are applicable to the health care practitioners under
43 each board's respective jurisdiction, and which require the
44 practitioners involved in the provision of care to pregnant women to
45 satisfactorily complete the educational program established
46 pursuant to this section. Each licensing board shall require the
47 relevant practitioners under its jurisdiction to complete this

1 educational program as a condition of initial licensure, or, in the
 2 case of practitioners who are already licensed as of the effective
 3 date of this act, within 180 days after the program is established
 4 under this section; and shall additionally require practitioners to
 5 complete the program on at least a biennial basis thereafter, as a
 6 condition of license renewal. **]** Each hospital and birthing facility in
 7 the State shall require its health care practitioners involved in labor,
 8 delivery, and postpartum care to complete a standardized maternal
 9 patient discharge education module, pursuant to which such health
 10 care practitioners will be educated in the complications of
 11 childbirth, and the warning signs of complications in women who
 12 have just given birth. This educational module may be
 13 implemented in each facility before the department finalizes the
 14 Statewide educational program that is to be established under
 15 subsection a. of this section; however, after the Statewide
 16 educational program is finalized under subsection a. of this section,
 17 the educational modules implemented pursuant to this subsection
 18 shall be modified as necessary to conform to the department's
 19 educational program. Any modules implemented before the
 20 department's Statewide educational program is finalized shall
 21 address the most frequent causes of maternal mortality, including
 22 but not limited to, hemorrhage, hypertension, preeclampsia, heart
 23 failure and chest pain, infection, embolism, and postpartum
 24 depression. Each facility shall additionally provide this
 25 information, both orally and in writing, to any woman who has
 26 given birth at the facility, prior to discharge. The educational
 27 module implemented under this subsection shall be completed by
 28 all relevant health care practitioners at the facility, as a condition of
 29 their practice or employment in the facility, and may be used to
 30 satisfy relevant continuing education requirements applicable to
 31 each such health care practitioner.

32 c. Within 90 days after the effective date of this act, the
 33 Commissioner of Health shall adopt rules and regulations, pursuant
 34 to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-
 35 1 et seq.), as necessary to implement the provisions of this section.¹
 36

37 ¹[9.] ²[10.1] 11.² (New section) a. (1) Except as otherwise
 38 provided by subsection b. of this section, all proceedings and
 39 activities of the Maternal Mortality Review ²[Commission]
 40 Committee²; all opinions of the members of the ²[commission]
 41 committee², which are formed as a result of the ²[commission's]
 42 committee's² proceedings and activities; and all records obtained,
 43 created, or maintained by the ²[commission] committee², including
 44 written reports and records of interviews or oral statements, shall be
 45 confidential, and shall not be subject to public inspection,
 46 discovery, subpoena, or introduction into evidence in any civil,
 47 criminal, legislative, or other proceeding.

1 (2) In no case shall the ²[commission] committee² disclose any
2 personally identifiable information to the public, or include any
3 personally identifiable information in a case summary that is
4 prepared pursuant to subsection b. of section ¹[6.] ²[7¹] 8² of this
5 act, or in an annual report that is prepared pursuant to section ¹[7.]
6 ²[8¹] 9² of this act.

7 (3) Members of the ²[commission] committee² shall not be
8 questioned in any civil, criminal, legislative, or other proceeding
9 regarding information that has been presented in, or opinions that
10 have been formed as a result of, a meeting or communication of the
11 ²[commission] committee²; however, nothing in this paragraph
12 shall prohibit a ²[commission] committee² member from being
13 questioned, or from testifying, in relation to publicly available
14 information or information that was obtained independent of the
15 member's participation on the ²[commission] committee².

16 b. Nothing in this section shall be deemed to prohibit the
17 ²[commission] committee² from publishing, or from otherwise
18 making available for public inspection, ¹[case summaries,]¹
19 statistical compilations ²[,]² or reports that are based on
20 confidential information, provided that those ¹[summaries,]¹
21 compilations ¹[,]¹ and reports do not contain personally identifying
22 information or other information that could be used to ultimately
23 identify the individuals concerned.

24

25 ¹[10.] ²[11¹] 12² (New section) a. (1) On an annual basis, and
26 using the death records that have been filed during the preceding
27 year, the ²[State registrar] Maternal Mortality Review Committee²
28 shall ²work collaboratively with the Maternal Data Center in the
29 Healthcare Quality and Informatics Unit, NJMCQC's Maternal
30 Health epidemiologists and other staff to² identify: (a) the total
31 number of maternal deaths that have occurred in the State during
32 the year, and during each quarter of the year; (b) the average
33 Statewide rate of maternal death occurring during the year; (c) the
34 number and percentage of maternal deaths that occurred during the
35 year in each of the Northern, Central, and Southern regions of the
36 State; (d) the number and percentage of maternal deaths, on a
37 Statewide and regional basis, that constituted pregnancy-associated
38 deaths, and the number and percentage of maternal deaths, on a
39 Statewide and regional basis, that constituted pregnancy-related
40 deaths; ¹[and]¹ (e) the areas of the State where the rates of
41 maternal death are significantly higher than the Statewide average ¹;
42 and (f) the rate of racial disparities in maternal deaths occurring on
43 a Statewide and regional basis¹ .

44 (2) The results of the annual analysis that is conducted pursuant
45 to this subsection shall be posted at a publicly accessible location
46 on the Internet website of the ²[Office of Vital Statistics and

1 Registry, in² the Department of Health, and shall also be promptly
2 forwarded to the ²【commission】 NJMCQC².

3 b. In order to accomplish its duties under this section, the
4 ²【State registrar】 Maternal Mortality Review Committee² shall:

5 (1) for the purposes of determining the total number of
6 pregnancy-associated deaths, review each woman's death record,
7 and match the death record with a certificate of live birth, or with a
8 fetal or infant death record, for the woman's child, in order to
9 confirm whether the woman died during pregnancy, or within one
10 year after the end of pregnancy; and

11 (2) for the purposes of determining the total number of
12 pregnancy-related deaths, review each woman's death record, and
13 identify each such death record in which the death is reported to
14 have resulted from an underlying or contributing cause related to
15 pregnancy, regardless of the amount of time that has passed
16 between the end of the pregnancy and the death.

17 The ²【State registrar】 Maternal Mortality Review Committee²
18 may also use any other appropriate means or methods to identify
19 maternal deaths ¹【, including, but not limited to, reviewing a
20 random sample of reported deaths to ascertain cases of pregnancy-
21 related death and pregnancy-associated death that are not
22 discernable from a review of death records alone】. Such means or
23 methods may include, but need not be limited to, use of the case
24 ascertainment system devised by the federal Centers for Disease
25 Control and Prevention¹.

26

27 ¹【11.】 ²【12¹】 13.² R.S.26:8-24 is amended to read as follows:

28 26:8-24. The State registrar shall:

29 a. Have general supervision throughout the State of the
30 registration of vital records;

31 b. Have supervisory power over local registrars, deputy local
32 registrars, alternate deputy local registrars, and subregistrars, in the
33 enforcement of the law relative to the disposal of dead bodies and
34 the registration of vital records;

35 c. Prepare, print, and supply to all registrars, upon request
36 therefor, all blanks and forms used in registering the records
37 required by said law, and provide for and prescribe the use of the
38 NJ-EDRS ²or any successor vital reporting system². The blanks
39 and forms supplied under this subsection, and any electronic blanks
40 and forms that are used in the NJ-EDRS, shall require the person
41 registering a birth or death record, at a minimum, to provide the
42 same information as is required by the National Center for Vital
43 Health Statistics in its standardized U.S. certificates of live birth,
44 death, and fetal death. No 【other】 blanks, forms, or methods of
45 registration shall be used, other than those that satisfy the
46 requirements of this subsection, and which are supplied or approved
47 by the State registrar;

1 d. Carefully examine the certificates or electronic files received
2 periodically from the local registrars or originating from their
3 jurisdiction; and, if any are incomplete or unsatisfactory, require
4 such further information to be supplied as may be necessary to
5 make the record complete and satisfactory;

6 e. Arrange or bind, and permanently preserve the certificates of
7 vital records, or the information comprising those records, in a
8 systematic manner and in a form that is deemed most consistent
9 with contemporary and developing standards of vital statistical
10 archival record keeping;

11 f. Prepare and maintain a comprehensive and continuous index
12 of all vital records registered, the index to be arranged
13 alphabetically:

14 1. In the case of deaths, by the name of the decedent;

15 2. In the case of births, by the name of child, if given, and if
16 not, then by the name of father or mother;

17 3. In the case of marriages, by the surname of the husband and
18 also by the maiden name of the wife;

19 4. In the case of civil unions, by the surname of each of the
20 parties to the civil union;

21 5. In the case of domestic partnerships, by the surname of each
22 of the partners;

23 g. Mark the birth certificate of a missing child when notified by
24 the Missing Persons Unit in the Department of Law and Public
25 Safety pursuant to section 3 of P.L.1995, c.395 (C.52:17B-9.8c);

26 h. Develop and provide to local registrars an education and
27 training program, which the State registrar may require each local
28 registrar to complete as a condition of retaining that position, and
29 which may be offered to deputy local registrars, alternate deputy
30 local registrars and subregistrars at the discretion of the State
31 registrar, that includes material designed to implement the NJ-
32 EDRS and to familiarize local registrars with the statutory
33 requirements applicable to their duties and any rules and regulations
34 adopted pursuant thereto, as deemed appropriate by the State
35 registrar; **[and]**

36 i. Facilitate the electronic notification, upon completion of the
37 death record and issuance of a burial permit, of the decedent's
38 name, Social Security number and last known address to the
39 Department of Labor and Workforce Development and the
40 Department of Human Services to safeguard public benefit
41 programs and diminish the criminal use of a decedent's name and
42 other identifying information; and

43 j. Facilitate the provision of relevant statistical data on
44 maternal deaths to the Maternal Mortality Review ²[Commission]
45 Committee², in accordance with the provisions of section ¹[10.]
46 ²[11¹] ¹² of P.L. , c. (C.) (pending before the Legislature
47 as this act).

48 (cf: P.L.2013, c.274, s.1)

1 ²14. (New section) a. The Department of Health shall establish
2 a Maternal Data Center in the Healthcare Quality and Informatics
3 Unit that shall develop protocols and requirements for the
4 submission of maternal mortality, morbidity and racial and ethnic
5 disparity data indicators ³[.]; ³ collect this information from
6 relevant health care facilities in the State ³[.]; ³ conduct rapid-cycle
7 data analytics; develop reports and a public facing dashboard; and
8 disseminate the information collected to the NJMCQC, the Maternal
9 Mortality Review Committee, participating health care facilities,
10 and other stakeholders as identified by the NJMCQC. ³Each
11 participating facility shall have full access to data reported to the
12 Maternal Data Center, provided that any data accessible to
13 participating facilities shall be de-identified, and further provided
14 that nothing in this subsection shall authorize the disclosure of any
15 confidential or personal identifying information for any patient. ³

16 b. The Maternal Data Center shall employ a director, three
17 research scientists; a technical assistant; and other staff as necessary
18 to implement the requirements pursuant to subsection a. of this
19 section. ²

20
21 ²15. (New section) The Commissioner of Health shall establish
22 and collect maternal data center membership fees from health care
23 facilities, as defined by the Commissioner of Health, that ³are
24 licensed to ³ provide maternal care services in the State ³and that
25 enter into a written agreement with the Department of Health to
26 participate in the Maternal Data Center pursuant to section 14 of
27 this act. The membership fee shall be required of each licensed
28 facility participating in the Maternal Data Center, and in no case
29 shall the amount of the fee exceed \$10,000 per facility per year.
30 Each participating facility shall pay its annual membership fee on a
31 date as shall be required by the commissioner ³. The revenue from
32 these fees shall be used to fund the Maternal Data Center to
33 implement the requirements pursuant to section 14 of this act. ²

34 ³The commissioner shall be authorized to seek out and accept such
35 other sources of funding as may be available from appropriate
36 public and private sources for the purposes of the Maternal Data
37 Center. ³

38
39 ³16. (New section) a. There is established the "Maternal Data
40 Center Fund" as a nonlapsing, revolving fund in the Department of
41 Health. The fund shall be comprised of membership fees collected
42 from facilities licensed to provide maternal care services that enter
43 into a written agreement with the Department of Health to
44 participate in the Maternal Data Center pursuant to section 15 of
45 this act as well as any other funds collected by the department
46 pursuant to section 15 of this act.

1 b. The Commissioner of Health shall deposit all membership
2 fees and other funds collected pursuant to section 15 of this act into
3 the fund. Monies credited to the fund may be invested in the same
4 manner as assets of the General Fund, and any investment earnings
5 on the fund shall accrue to the fund and shall be available subject to
6 the same terms and conditions as other monies in the fund.

7 c. Commencing July 1, 2019, and annually thereafter, monies
8 in the fund shall be appropriated by the Legislature to the
9 Department of Health for the purposes of operating and maintaining
10 the Maternal Data Center pursuant to section 14 of this act.³

11
12 ³~~[²16.]~~ ³17.³ (New section) The Commissioner of Health shall
13 adopt rules and regulations pursuant to the “Administrative
14 Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate
15 the purposes of this act.²

16
17 ¹[12.] ²[13.1] ³[17.2] ³18.³ This act shall take effect
18 immediately.

19
20
21
22

23 Establishes Maternal Mortality Review Committee to annually
24 review and report on rates and causes of maternal mortality and
25 morbidity in New Jersey, and to recommend improvements in
26 maternal care.

ASSEMBLY, No. 1862

STATE OF NEW JERSEY 218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:

Assemblywoman PAMELA R. LAMPITT

District 6 (Burlington and Camden)

Assemblyman RAJ MUKHERJI

District 33 (Hudson)

Assemblywoman VALERIE VAINIERI HUTTLE

District 37 (Bergen)

Co-Sponsored by:

Assemblywoman Pinkin

SYNOPSIS

Establishes Maternal Mortality Review Commission to annually review and report on rates and causes of maternal death in New Jersey, and to recommend improvements in maternal care.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



(Sponsorship Updated As Of: 2/16/2018)

1 AN ACT concerning maternal deaths, supplementing Title 26 of the
2 Revised Statutes, and amending R.S.26:8-24.

3

4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6

7 1. (New section) As used in this act:

8 “Commission” means the Maternal Mortality Review
9 Commission, established pursuant to section 2 of this act, which is
10 responsible for annually reviewing and reporting on maternal death
11 rates and the causes of maternal death in the State, and which is
12 further responsible for providing recommendations to improve
13 maternal care and reduce adverse maternal outcomes.

14 “Commissioner” means the Commissioner of Health.

15 “Department” means the Department of Health.

16 “Maternal death” means a pregnancy-associated death, or a
17 pregnancy-related death.

18 “Pregnancy-associated death” means the death of a woman,
19 which occurs while the woman is pregnant, or during the one-year
20 period following the date of the end of the pregnancy, irrespective
21 of the cause of death.

22 “Pregnancy-related death” means the death of a woman, which
23 occurs while the woman is pregnant, or during the one-year period
24 following the date of the end of the pregnancy, regardless of the
25 duration of the pregnancy, and which results from any cause related
26 to, or aggravated by, the pregnancy or its management, but
27 excluding any accidental or incidental cause.

28 “Report of maternal death” means a report of actual or perceived
29 maternal death, which is filed with the department, pursuant to the
30 processes established under subsection a. of section 5 of this act,
31 and which is to be forwarded to the commission for the purposes of
32 investigation, as provided by subsection b. of that section.

33 “Severe maternal morbidity” means the physical and
34 psychological conditions that result from, or are aggravated by,
35 pregnancy, and which have an adverse effect on the health of a
36 woman.

37 “State registrar” means the State registrar of vital statistics, who
38 is responsible for supervising the registration of, and maintaining,
39 death records in the State, in accordance with the provisions of
40 R.S.26:8-1 et seq.

41

42 2. (New section) a. There is hereby established, in the
43 Department of Health, the Maternal Mortality Review Commission,
44 which shall be tasked with annually reviewing and reporting on
45 maternal death rates and the causes of maternal death in the State,

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 and providing recommendations to improve maternal care and
2 reduce adverse outcomes related to, or associated with, pregnancy.
3 The commission shall be composed of 31 members, including 18 ex
4 officio members or their designees, as provided in subsection b. of
5 this section, and 13 public members, as provided in subsection c. of
6 this section.

7 b. The ex officio members of the commission shall include the
8 following persons, or their designees:

9 (1) the State registrar;

10 (2) the State Medical Examiner;

11 (3) the Director of the Division of Family Health Services in the
12 Department of Health;

13 (4) the Director of the Office of Emergency Medical Services in
14 the Department of Health;

15 (5) the Director of the Office of Minority and Multicultural
16 Health in the Department of Health;

17 (6) the Director of the Division of Medical Assistance and
18 Health Services in the Department of Human Services;

19 (7) the President of the New Jersey Hospital Association;

20 (8) the President of the New Jersey Health Care Quality
21 Institute;

22 (9) the Chief Executive Officer of the Medical Society of New
23 Jersey;

24 (10) the Executive Director of the New Jersey Chapter of the
25 National Association of Social Workers;

26 (11) the Chair of the New Jersey section of the American
27 Congress of Obstetricians and Gynecologists;

28 (12) the President of the New Jersey Affiliate of the American
29 College of Nurse Midwives;

30 (13) the Executive Director of the Partnership for Maternal and
31 Child Health of Northern New Jersey;

32 (14) the Chief Executive Officer of the Central Jersey Family
33 Health Consortium;

34 (15) the Executive Director of the Southern New Jersey Perinatal
35 Cooperative;

36 (16) the Director of the City of Newark Department of Health and
37 Community Wellness;

38 (17) the Director of the City of Trenton Health and Human
39 Services Department; and

40 (18) the Director of the Camden County Department of Health
41 and Human Services.

42 c. The public members of the commission shall be appointed
43 by the Governor, and shall include:

44 (1) five licensed and practicing health care practitioners, one of
45 whom specializes in obstetrics or gynecology, one of whom
46 specializes in maternal and fetal medicine, one of whom specializes
47 in family planning, one of whom specializes in critical care
48 medicine, and one of whom specializes in perinatal pathology;

- 1 (2) one licensed and practicing health care practitioner, mental
2 health care practitioner, or substance use disorder treatment
3 professional who specializes in perinatal addiction;
4 (3) one certified nurse midwife;
5 (4) one registered professional nurse or advanced practice nurse
6 who specializes in hospital-based obstetric nursing;
7 (5) one licensed practical nurse, registered professional nurse, or
8 advanced practice nurse who participates in, and represents, the
9 Nurse-Family Partnership operating in New Jersey;
10 (6) one health care administrator who has experience in
11 overseeing the operations of maternity wards or birthing centers;
12 (7) one private citizen who is engaged in maternal health
13 advocacy;
14 (8) one private citizen who is engaged in minority health
15 advocacy; and
16 (9) one private citizen who is engaged in patient advocacy.
17 d. Of the public members appointed to the commission, not
18 more than seven shall be of the same political party.
19 e. Each public member of the commission shall serve for a
20 term of four years; however, of the public members first appointed,
21 four shall serve an initial term of two years, four shall serve an
22 initial term of three years, and five shall serve an initial term of four
23 years. Each public member shall serve for the term of their
24 appointment, and until a successor is appointed and qualified,
25 except that a public member may be reappointed to the commission
26 upon the expiration of their term. Any vacancy in the membership
27 shall be filled, for the unexpired term, in the same manner as the
28 original appointment.
29 f. All initial appointments to the commission shall be made
30 within 60 days after the effective date of this act.
31 g. Any member of the commission may be removed by the
32 Governor, for cause, after a public hearing.
33
34 3. (New section) a. The commission shall organize as soon as
35 practicable following the appointment of a majority of its members,
36 and shall annually elect a chairperson and vice-chairperson from
37 among its members. The chairperson may appoint a secretary, who
38 need not be a member of the commission.
39 b. The commission shall meet pursuant to a schedule to be
40 established at its first meeting, and it shall additionally meet at the
41 call of its chairperson or the Commissioner of Health; however, in
42 no case shall the commission meet less than four times a year.
43 c. A majority of the total number of members appointed to the
44 commission shall constitute a quorum for the conducting of official
45 commission business. A vacancy in the membership of the
46 commission shall not impair the right of the commission to exercise
47 its powers and duties, provided that a majority of the currently
48 appointed members are available to conduct business. Any

1 recommendations of the commission shall be approved by a
2 majority of the members present.

3 d. The members of the commission shall serve without
4 compensation, but shall be reimbursed for travel and other
5 necessary expenses incurred in the discharge of their official duties,
6 within the limits of funds appropriated or otherwise made available
7 for such purposes.

8 e. The Department of Health shall provide such administrative
9 staff support to the commission as shall be necessary for the
10 commission to carry out its duties.

11

12 4. (New section) a. The Maternal Mortality Review
13 Commission shall have the power to:

14 (1) carry out any power, duty, or responsibility expressly
15 granted by this act;

16 (2) adopt, amend, or repeal suitable bylaws for the management
17 of its affairs;

18 (3) maintain an office at such place or places as it may
19 designate;

20 (4) apply for, receive, and accept, from any federal, State, or
21 other public or private source, grants, loans, or other moneys that
22 are made available for, or in aid of, the commission's authorized
23 purposes, or that are made available to assist the commission in
24 carrying out its powers, duties, and responsibilities under this act;

25 (5) enter into any and all agreements or contracts, execute any
26 and all instruments, and do and perform any and all acts or things
27 necessary, convenient, or desirable to further the purposes of the
28 commission;

29 (6) call to its assistance, and avail itself of the services of, such
30 employees of any State entity or local government unit as may be
31 required and available for the commission's purposes;

32 (7) review and investigate reports of maternal death; conduct
33 witness interviews, and hear testimony provided under oath at
34 public or private hearings, on any material matter; and request, or
35 compel through the issuance of a subpoena, the attendance of
36 relevant witnesses and the production of relevant documents,
37 records, and papers;

38 (8) solicit and consider public input and comment on the
39 commission's activities by periodically holding public hearings or
40 conferences, and by providing other opportunities for such input
41 and comment by interested parties; and

42 (9) identify, and promote the use of, best practices in maternal
43 care, and encourage and facilitate cooperation and collaboration
44 among health care facilities, health care professionals,
45 administrative agencies, and local government units for the
46 purposes of ensuring the provision of the highest quality maternal
47 care throughout the State.

- 1 b. The Maternal Mortality Review Commission shall have the
2 duty and responsibility to:
- 3 (1) develop mandatory and voluntary maternal death reporting
4 processes, in accordance with the provisions of section 5 of this act;
5 (2) conduct an investigation of each reported case of maternal
6 death, and prepare a de-identified case summary for each such case,
7 in accordance with the provisions of section 6 of this act;
8 (3) review the statistical data on maternal deaths that is
9 forwarded by the State registrar, pursuant to section 10 of this act,
10 and the reports of maternal death that are forwarded by the
11 department, pursuant to subsection b. of section 5 of this act, in
12 order to identify Statewide and regional maternal death rates;
13 trends, patterns, and disparities in adverse maternal outcomes; and
14 medical, non-medical, and system-related factors that may have
15 contributed to maternal deaths and treatment disparities; and
16 (4) annually report its findings and recommendations on
17 maternal mortality to the department, the Governor, and the
18 Legislature, in accordance with section 7 of this act.

19
20 5. (New section) a. Within 90 days after the commission's
21 organizational meeting, the commission shall:

- 22 (1) develop a mandatory maternal death reporting process,
23 pursuant to which health care practitioners, medical examiners,
24 hospitals, birthing centers, and other relevant professional actors
25 and health care facilities will be required to confidentially report to
26 the Department of Health on individual cases of maternal death; and
27 (2) develop a voluntary maternal death reporting process,
28 pursuant to which the family members of a deceased woman, and
29 any other interested members of the public, will be permitted, but
30 not required, to confidentially report to the Department of Health on
31 individual cases of perceived maternal death. At a minimum, the
32 process developed pursuant to this paragraph shall require the
33 department to: (a) post on its Internet website a hyperlink, a toll-
34 free telephone number, and an email address, which may each be
35 used for the voluntary submission of public reports of maternal
36 death; and (b) publicize the availability of these resources to
37 professional organizations, community organizations, social service
38 agencies, and members of the public.

39 b. The department shall keep a record of all reports of maternal
40 death that are submitted thereto through the reporting processes that
41 are established by the commission pursuant to paragraphs (1) and
42 (2) of subsection a. of this section. The department shall also
43 ensure that a copy of each such report of maternal death is promptly
44 forwarded to the commission, so that the commission may properly
45 execute its investigatory functions and other duties and
46 responsibilities under this act.

1 6. (New section) a. Upon receipt of a report of maternal death,
2 which has been forwarded to the commission pursuant to subsection
3 b. of section 5 of this act, the commission shall investigate the
4 reported case in accordance with the provisions of this section. In
5 conducting the investigation, the commission shall consider:
6 (1) the information contained in the forwarded report of
7 maternal death;
8 (2) any relevant information contained in the deceased woman's
9 autopsy report or death record, or in a certificate of live birth or
10 fetal death for the woman's child, or in any other vital records
11 pertaining to the woman;
12 (3) any relevant information contained in the deceased woman's
13 medical records, including: (a) records related to the health care
14 that was provided to the woman prior to her pregnancy; (b) records
15 related to the woman's prenatal and postnatal care, labor and
16 delivery care, emergency room care, and any other care delivered
17 up until the time of the woman's death; and (c) the woman's
18 hospital discharge records;
19 (4) information obtained through the oral and written interviews
20 of individuals who were directly involved in the care of the woman
21 either during, or immediately following, her pregnancy, including
22 interviews with relevant health care practitioners, mental health
23 care practitioners, and social service providers, and, as deemed to
24 be appropriate and necessary, interviews with the woman's family
25 members;
26 (5) background information about the deceased woman,
27 including, but not limited to, information regarding the woman's
28 age, race, and socioeconomic status; and
29 (6) any other information that may shed light on the maternal
30 death, including, but not limited to, reports from social service or
31 child welfare agencies.

32 b. At the conclusion of an investigation conducted pursuant to
33 this section, the commission shall prepare a case summary, which
34 shall include the commission's findings with regard to the cause of,
35 or the factors that contributed to, the maternal death, and
36 recommendations for actions that should be undertaken, or policies
37 that should be implemented, to mitigate or eliminate those factors
38 and causes in the future. Any case summary prepared pursuant to
39 this subsection shall omit the personally identifying information of
40 the deceased woman and her family members.

41 c. The commission may present its findings and
42 recommendations on each individual case, or on groups of
43 individual cases, as deemed appropriate, to the health care facility
44 or facilities where relevant care was provided in the case or group
45 of cases, and to the individual health care practitioners who
46 provided such care, or to any relevant professional organization, for
47 the purposes of instituting or facilitating policy changes,
48 educational activities, or improvements in the quality of care

1 provided; or for the purposes of exploring, facilitating, or
2 establishing regional projects or other collaborative projects that are
3 designed to reduce instances of maternal death.

4 d. In addition to investigating reports of maternal death, as
5 provided by this section, the Maternal Mortality Review
6 Commission may additionally elect to investigate alleged cases of
7 severe maternal morbidity, using data and information obtained
8 through patient registries, or the oral or written interviews of
9 pregnant women and their families.

10
11 7. (New section) a. Within one year after its organization, and
12 annually thereafter, the commission shall prepare, and submit to the
13 Department of Health, to the Governor, and, pursuant to section 2
14 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature, a report
15 containing the commission's findings on the rates and causes of
16 maternal deaths occurring in the State during the preceding year,
17 and providing recommendations for legislative or other action that
18 can be undertaken to: (a) improve the quality of maternal care and
19 reduce adverse maternal outcomes in the State; (b) increase the
20 availability of, and improve access to, social and health care
21 services for pregnant women; and (c) reduce or eliminate disparities
22 in maternal care and treatment, both during, and in the year after,
23 pregnancy. Each annual report, with the exception of the first
24 report prepared under this section, shall additionally identify the
25 extent to which the commission's prior recommendations have been
26 successfully implemented in practice, and the apparent impact that
27 the implementation of such recommended changes has had on
28 maternal care in the preceding year.

29 b. The report that is annually prepared pursuant to this section
30 shall be based on:

31 (1) the case summaries that were prepared by the commission
32 over the preceding year, pursuant to subsection b. of section 6 of
33 this act;

34 (2) the statistical data that was forwarded to the commission,
35 during the preceding year, by the State registrar, pursuant to section
36 10 of this act; and

37 (3) any other relevant information, including information on any
38 collaborative maternal health arrangements that have been
39 established by health care providers, professional organizations,
40 local government units, or other relevant actors or entities in the
41 preceding year, in response to the commission outreach authorized
42 by subsection c. of section 6, or by paragraph (9) of subsection a. of
43 section 4, of this act.

44 c. Upon receipt of the commission's annual report pursuant to
45 this section, the department shall post a copy of the report at a
46 publicly accessible location on its Internet website, and shall take
47 appropriate steps to otherwise broadly publicize the commission's
48 findings and recommendations. The Commissioner of Health shall

1 also adopt rules and regulations, pursuant to the “Administrative
2 Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.), to implement
3 the recommendations contained in the report, to the extent that such
4 recommendations can be implemented through administrative rule-
5 making action.

6
7 8. (New section) a. Upon receipt of the commission’s first
8 annual report, issued pursuant to section 7 of this act, the
9 department, working in consultation with the commission, as well
10 as with relevant professional organizations and patient advocacy
11 groups, shall develop an ongoing maternal health educational
12 program for health care practitioners, as may be necessary to
13 improve the quality of maternal care and reduce adverse outcomes
14 related to, or associated with, pregnancy. The educational program
15 established pursuant to this section shall initially be based on, and
16 shall reflect, the findings and recommendations identified in the
17 commission’s first report. However, once the educational program
18 is established, the department shall, on at least a biennial basis
19 thereafter, review the program and make necessary changes to
20 ensure that the ongoing education provided thereunder accurately
21 reflects, and is consistent with, the latest data, findings, and
22 recommendations of the commission, as reflected in the
23 commission’s most recent annual report.

24 b. Each of the State’s professional licensing boards, as
25 appropriate, shall adopt rules and regulations, pursuant to the
26 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
27 seq.), which are applicable to the health care practitioners under
28 each board’s respective jurisdiction, and which require the
29 practitioners involved in the provision of care to pregnant women to
30 satisfactorily complete the educational program established
31 pursuant to this section. Each licensing board shall require the
32 relevant practitioners under its jurisdiction to complete this
33 educational program as a condition of initial licensure, or, in the
34 case of practitioners who are already licensed as of the effective
35 date of this act, within 180 days after the program is established
36 under this section; and shall additionally require practitioners to
37 complete the program on at least a biennial basis thereafter, as a
38 condition of license renewal.

39
40 9. (New section) a. (1) Except as otherwise provided by
41 subsection b. of this section, all proceedings and activities of the
42 Maternal Mortality Review Commission; all opinions of the
43 members of the commission, which are formed as a result of the
44 commission’s proceedings and activities; and all records obtained,
45 created, or maintained by the commission, including written reports
46 and records of interviews or oral statements, shall be confidential,
47 and shall not be subject to public inspection, discovery, subpoena,

1 or introduction into evidence in any civil, criminal, legislative, or
2 other proceeding.

3 (2) In no case shall the commission disclose any personally
4 identifiable information to the public, or include any personally
5 identifiable information in a case summary that is prepared pursuant
6 to subsection b. of section 6 of this act, or in an annual report that is
7 prepared pursuant to section 7 of this act.

8 (3) Members of the commission shall not be questioned in any
9 civil, criminal, legislative, or other proceeding regarding
10 information that has been presented in, or opinions that have been
11 formed as a result of, a meeting or communication of the
12 commission; however, nothing in this paragraph shall prohibit a
13 commission member from being questioned, or from testifying, in
14 relation to publicly available information or information that was
15 obtained independent of the member's participation on the
16 commission.

17 b. Nothing in this section shall be deemed to prohibit the
18 commission from publishing, or from otherwise making available
19 for public inspection, case summaries, statistical compilations, or
20 reports that are based on confidential information, provided that
21 those summaries, compilations, and reports do not contain
22 personally identifying information or other information that could
23 be used to ultimately identify the individuals concerned.
24

25 10. (New section) a. (1) On an annual basis, and using the
26 death records that have been filed during the preceding year, the
27 State registrar shall identify: (a) the total number of maternal
28 deaths that have occurred in the State during the year, and during
29 each quarter of the year; (b) the average Statewide rate of maternal
30 death occurring during the year; (c) the number and percentage of
31 maternal deaths that occurred during the year in each of the
32 Northern, Central, and Southern regions of the State; (d) the number
33 and percentage of maternal deaths, on a Statewide and regional
34 basis, that constituted pregnancy-associated deaths, and the number
35 and percentage of maternal deaths, on a Statewide and regional
36 basis, that constituted pregnancy-related deaths; and (e) the areas of
37 the State where the rates of maternal death are significantly higher
38 than the Statewide average.

39 (2) The results of the annual analysis that is conducted pursuant
40 to this subsection shall be posted at a publicly accessible location
41 on the Internet website of the Office of Vital Statistics and Registry,
42 in the Department of Health, and shall also be promptly forwarded
43 to the commission.

44 b. In order to accomplish its duties under this section, the State
45 registrar shall:

46 (1) for the purposes of determining the total number of
47 pregnancy-associated deaths, review each woman's death record,
48 and match the death record with a certificate of live birth, or with a

1 fetal or infant death record, for the woman's child, in order to
2 confirm whether the woman died during pregnancy, or within one
3 year after the end of pregnancy; and

4 (2) for the purposes of determining the total number of
5 pregnancy-related deaths, review each woman's death record, and
6 identify each such death record in which the death is reported to
7 have resulted from an underlying or contributing cause related to
8 pregnancy, regardless of the amount of time that has passed
9 between the end of the pregnancy and the death.

10 The State registrar may also use any other appropriate means or
11 methods to identify maternal deaths, including, but not limited to,
12 reviewing a random sample of reported deaths to ascertain cases of
13 pregnancy-related death and pregnancy-associated death that are not
14 discernable from a review of death records alone.

15

16 11. R.S.26:8-24 is amended to read as follows:

17 26:8-24. The State registrar shall:

18 a. Have general supervision throughout the State of the
19 registration of vital records;

20 b. Have supervisory power over local registrars, deputy local
21 registrars, alternate deputy local registrars, and subregistrars, in the
22 enforcement of the law relative to the disposal of dead bodies and
23 the registration of vital records;

24 c. Prepare, print, and supply to all registrars, upon request
25 therefor, all blanks and forms used in registering the records
26 required by said law, and provide for and prescribe the use of the
27 NJ-EDRS. The blanks and forms supplied under this subsection,
28 and any electronic blanks and forms that are used in the NJ-EDRS,
29 shall require the person registering a birth or death record, at a
30 minimum, to provide the same information as is required by the
31 National Center for Vital Health Statistics in its standardized U.S.
32 certificates of live birth, death, and fetal death. No [other] blanks ,
33 forms, or methods of registration shall be used , other than those
34 that satisfy the requirements of this subsection, and which are
35 supplied or approved by the State registrar;

36 d. Carefully examine the certificates or electronic files received
37 periodically from the local registrars or originating from their
38 jurisdiction; and, if any are incomplete or unsatisfactory, require
39 such further information to be supplied as may be necessary to
40 make the record complete and satisfactory;

41 e. Arrange or bind, and permanently preserve the certificates of
42 vital records, or the information comprising those records, in a
43 systematic manner and in a form that is deemed most consistent
44 with contemporary and developing standards of vital statistical
45 archival record keeping;

46 f. Prepare and maintain a comprehensive and continuous index
47 of all vital records registered, the index to be arranged
48 alphabetically;

- 1 1. In the case of deaths, by the name of the decedent;
- 2 2. In the case of births, by the name of child, if given, and if
- 3 not, then by the name of father or mother;
- 4 3. In the case of marriages, by the surname of the husband and
- 5 also by the maiden name of the wife;
- 6 4. In the case of civil unions, by the surname of each of the
- 7 parties to the civil union;
- 8 5. In the case of domestic partnerships, by the surname of each
- 9 of the partners;
- 10 g. Mark the birth certificate of a missing child when notified by
- 11 the Missing Persons Unit in the Department of Law and Public
- 12 Safety pursuant to section 3 of P.L.1995, c.395 (C.52:17B-9.8c);
- 13 h. Develop and provide to local registrars an education and
- 14 training program, which the State registrar may require each local
- 15 registrar to complete as a condition of retaining that position, and
- 16 which may be offered to deputy local registrars, alternate deputy
- 17 local registrars and subregistrars at the discretion of the State
- 18 registrar, that includes material designed to implement the NJ-
- 19 EDRS and to familiarize local registrars with the statutory
- 20 requirements applicable to their duties and any rules and regulations
- 21 adopted pursuant thereto, as deemed appropriate by the State
- 22 registrar; **[and]**
- 23 i. Facilitate the electronic notification, upon completion of the
- 24 death record and issuance of a burial permit, of the decedent's
- 25 name, Social Security number and last known address to the
- 26 Department of Labor and Workforce Development and the
- 27 Department of Human Services to safeguard public benefit
- 28 programs and diminish the criminal use of a decedent's name and
- 29 other identifying information; and
- 30 j. Facilitate the provision of relevant statistical data on
- 31 maternal deaths to the Maternal Mortality Review Commission, in
- 32 accordance with the provisions of section 10 of
- 33 P.L. , c. (C.) (pending before the Legislature as this act).
- 34 (cf: P.L.2013, c.274, s.1)

35
36 12. This act shall take effect immediately.

37

38

39

STATEMENT

40

41 This bill would establish a Maternal Mortality Review
42 Commission in the Department of Health (DOH). The commission
43 would be tasked with annually reviewing and reporting on maternal
44 death rates and the causes of maternal death in the State, and
45 providing recommendations to improve maternal care and reduce
46 adverse maternal outcomes. “Maternal death” includes both
47 pregnancy-associated deaths and pregnancy-related deaths. A
48 “pregnancy-associated death” is one that occurs while the woman is

1 pregnant, or during the one-year period following the date of the
2 end of the pregnancy, irrespective of cause; while a “pregnancy-
3 related death” is one that occurs while the woman is pregnant, or
4 during the one-year period following the date of the end of the
5 pregnancy, regardless of the duration of pregnancy, as a result of a
6 non-accidental or non-incidental cause that is related to, or
7 aggravated by, the pregnancy or its management.

8 The commission would be required to meet pursuant to a
9 schedule to be established at its first meeting, and at the call of its
10 chairperson or the Commissioner of Health, but in no case would
11 the commission be authorized to meet less than four times a year.
12 The members of the commission would serve without
13 compensation, but would be reimbursed for travel and other
14 necessary expenses incurred in the discharge of their official duties,
15 within the limits of funds appropriated or otherwise made available
16 for such purposes. The DOH would be required to provide
17 administrative staff support to the commission, as necessary.

18 The Maternal Mortality Review Commission would have the
19 general power to: 1) carry out any power, duty, or responsibility
20 expressly granted under the bill; 2) adopt, amend, or repeal suitable
21 bylaws; 3) maintain an office; 4) apply for, receive, and accept
22 public or private moneys; 5) enter into agreements or contracts,
23 execute instruments, and do and perform any and all acts or things
24 necessary, convenient, or desirable to further its purposes; 6) call to
25 its assistance, and avail itself of the services of, such employees of
26 any State entity or local government unit as may be required and
27 available for the commission’s purposes; 7) review and investigate
28 reports of maternal death; conduct witness interviews, and hear
29 testimony provided under oath at public or private hearings, on any
30 material matter; and request, or compel through the issuance of a
31 subpoena, the attendance of relevant witnesses and the production
32 of relevant documents, records, and papers; 8) solicit and consider
33 public input on the commission’s activities; and 9) identify, and
34 promote the use of, best practices in maternal care, and encourage
35 and facilitate cooperation and collaboration among health care
36 facilities, health care professionals, administrative agencies, and
37 local government units for the purposes of ensuring the provision of
38 the highest quality maternal care throughout the State.

39 Among its formal duties, the commission would be required,
40 within 90 days after its organizational meeting, to:

41 1) develop a mandatory maternal death reporting process,
42 pursuant to which health care practitioners, medical examiners,
43 hospitals, birthing centers, and other relevant professional actors
44 and health care facilities will be required to confidentially report to
45 the DOH on individual cases of maternal death; and

46 2) develop a voluntary maternal death reporting process,
47 pursuant to which the family members of a deceased woman, and
48 any other interested members of the public, will be permitted, but

1 not required, to confidentially report to the DOH on individual
2 cases of perceived maternal death.

3 The DOH will be required to keep a record of all reports of
4 maternal death that are submitted thereto through these processes,
5 and will also be required to ensure that a copy of each such report
6 of maternal death is promptly forwarded to the commission, so that
7 the commission may properly execute its other duties and
8 responsibilities under the bill.

9 The commission will be required to conduct an investigation in
10 association with each report of maternal death that is forwarded
11 thereto by the DOH. In conducting each case investigation, the
12 commission will be required to consider: 1) the forwarded report of
13 maternal death; 2) the deceased woman's medical records, autopsy
14 report or death record, and other relevant vital records; 3)
15 information obtained through interviews of individuals who were
16 directly involved in the care of the woman either during, or
17 immediately following, her pregnancy, and, as deemed to be
18 appropriate and necessary, through interviews of the woman's
19 family members; 4) background information about the deceased
20 woman; and 5) any other information that may shed light on the
21 death.

22 At the conclusion of an investigation, the commission will be
23 required to prepare a de-identified case summary, which is to
24 include the commission's findings with regard to the cause of, or
25 factors that contributed to, the maternal death, and
26 recommendations for actions that should be undertaken or policies
27 that should be implemented to mitigate or eliminate those factors
28 and causes in the future.

29 The bill would authorize the commission to present its findings
30 and recommendations on each individual case, or on groups of
31 individual cases, as deemed appropriate, to the health care facility
32 or facilities where relevant care was provided in the case or group
33 of cases, and to the individual health care practitioners who
34 provided such care, or to any relevant professional organization, for
35 the purposes of instituting or facilitating policy changes,
36 educational activities, or improvements in the quality of care
37 provided; or for the purposes of exploring, facilitating, or
38 establishing regional projects or other collaborative projects that are
39 designed to reduce instances of maternal death.

40 In addition to the investigation of cases of maternal death, the
41 commission would also be authorized, but not required, to
42 investigate cases of "severe maternal morbidity," which is defined
43 to mean the physical and psychological conditions that result from,
44 or are aggravated by, pregnancy, and which have an adverse effect
45 on the health of a woman.

46 The bill would require the commission to use the maternal death
47 reports that are forwarded by the DOH, as well as statistical data
48 that is forwarded by the State registrar, to identify trends, patterns,

1 and disparities in adverse maternal outcomes, and medical, non-
2 medical, and system-related factors that may have contributed to
3 maternal deaths and treatment disparities. The statistical data that is
4 to be forwarded by the State registrar for these purposes is to
5 include: 1) the total number of maternal deaths that have occurred
6 in the State during the year, and during each quarter of the year; 2)
7 the average Statewide rate of maternal death occurring during the
8 year; 3) the number and percentage of maternal deaths that occurred
9 during the year in each of the Northern, Central, and Southern
10 regions of the State; 4) the number and percentage of maternal
11 deaths, on a Statewide and regional basis, that constituted
12 pregnancy-associated deaths, and the number and percentage of
13 maternal deaths, on a Statewide and regional basis, that constituted
14 pregnancy-related deaths; and 5) the areas of the State where the
15 rates of maternal death are significantly higher than the Statewide
16 average. The State registrar would be required to provide these
17 statistics to the commission on an annual basis, and would further
18 be required to post a copy of this statistical information on the
19 Internet website of the Office of Vital Statistics and Registry, in the
20 DOH. In order to facilitate the State registrar's analysis, in this
21 regard, and ensure that death records contain the information that is
22 necessary to allow the State registrar to make the requisite
23 statistical determinations, the bill would amend the State's existing
24 vital records law, in order to clarify that the blanks and forms used
25 for the registration of a vital record are to include, at a minimum,
26 the same information (including pregnancy-related information) that
27 is to be included in standardized U.S. certificates of live birth,
28 death, and fetal death.

29 Finally, the bill would require the commission to annually report
30 its findings and recommendations on maternal mortality to the
31 DOH, the Governor, and the Legislature. Each annual report is to
32 contain the commission's findings on the rates and causes of
33 maternal deaths occurring in the State during the preceding year,
34 and is to provide recommendations for legislative or other action
35 that can be undertaken to: 1) improve the quality of maternal care
36 and reduce adverse maternal outcomes in the State; 2) increase the
37 availability of, and improve access to, social and health care
38 services for pregnant women; and 3) reduce or eliminate disparities
39 in maternal care and treatment, both during, and in the year after,
40 pregnancy. Each annual report, with the exception of the first,
41 would additionally be required to identify the extent to which the
42 commission's prior recommendations have been successfully
43 implemented in practice, and the apparent impact that the
44 implementation of such recommended changes has had on maternal
45 care in the preceding year.

46 The commission's annual report is to be based on: 1) the case
47 summaries that were prepared by the commission during the
48 preceding year; 2) the statistical data that was forwarded thereto by

1 the State registrar during the preceding year; and 3) any other
2 relevant information, including information on any collaborative
3 maternal health arrangements that have been established by health
4 care providers, professional organizations, local government units,
5 or other relevant actors or entities in the preceding year, in response
6 to commission outreach.

7 The DOH would be required to post a copy of each commission
8 report on its Internet website, and take appropriate steps to
9 otherwise broadly publicize the commission's findings and
10 recommendations. The Commissioner of Health would also be
11 required to adopt rules and regulations to implement the
12 recommendations contained in each such report, to the extent that
13 those recommendations can be implemented through administrative
14 rule-making action.

15 The DOH, working in consultation with the commission, as well
16 as with relevant professional organizations and patient advocacy
17 groups, will also be required to develop an ongoing maternal health
18 educational program for health care practitioners. Although the
19 program would initially be designed to reflect the findings and
20 recommendations contained in the commission's first report, the
21 DOH would be required to review the program, on at least a
22 biennial basis, and make any necessary changes to ensure that the
23 ongoing education provided thereunder accurately reflects, and is
24 consistent with, the latest data, findings, and recommendations of
25 the commission, as reflected in the commission's most recent
26 report. Each of the State's professional licensing boards, as
27 appropriate, would be required to adopt rules and regulations
28 applicable to the health care practitioners under each board's
29 respective jurisdiction, in order to require those practitioners who
30 are involved in the provision of care to pregnant women to
31 satisfactorily complete the maternal care educational program.
32 Specifically, each board is to require relevant practitioners under its
33 jurisdiction to complete this educational program as a condition of
34 initial licensure, or, in the case of practitioners who are already
35 licensed as of the bill's effective date, within 180 days after the
36 program is established; and to additionally complete the program on
37 a biennial basis thereafter, as a condition of license renewal.

38 The bill would specify that, except as otherwise provided
39 thereby, all proceedings and activities of the commission; all
40 opinions of the commission members, which are formed as a result
41 of the commission's proceedings and activities; and all records
42 obtained, created, or maintained by the commission, are to remain
43 confidential, and will not be subject to public inspection, discovery,
44 subpoena, or introduction into evidence in any civil, criminal,
45 legislative, or other proceeding. The commission will be prohibited
46 from disclosing any personally identifiable information to the
47 public, or including any personally identifiable information in a
48 case summary or annual report prepared pursuant to the bill's

1 provisions. Members of the commission may also not be
2 questioned in any civil, criminal, legislative, or other proceeding
3 regarding information that has been presented in, or opinions that
4 have been formed as a result of, a meeting or communication of the
5 commission; however, this would not prevent a member from being
6 questioned, or from testifying, in relation to publicly available
7 information or information that was obtained independent of the
8 member's participation on the commission. Furthermore, the
9 commission will be authorized to publish case summaries, statistical
10 compilations, or reports that are based on confidential information,
11 so long as those summaries, compilations, and reports do not
12 contain any personally identifying information.

ASSEMBLY WOMEN AND CHILDREN COMMITTEE

STATEMENT TO

ASSEMBLY, No. 1862

with committee amendments

STATE OF NEW JERSEY

DATED: MARCH 12, 2018

The Assembly Women and Children Committee reports favorably and with committee amendments Assembly Bill No. 1862.

As amended by the committee, this bill would establish a Maternal Mortality Review Commission in the Department of Health (DOH), which would take the place of the State's existing Maternal Mortality Case Review Team. While the existing review team produces important statistical data, the team is not permanently established by statute, does not meet regularly, produces only periodic reports on maternal mortality, and uses varying datasets in those periodic reports, making the amalgamation and comparison of data by interested parties more difficult. U.S. Senate Bill No. 1112, introduced in the 115th Congress, would establish a federal grant program to assist states in establishing and sustaining state-level maternal mortality review committees, but a state will only be eligible to obtain a grant under this bill if the state's maternal mortality review committee satisfies certain specific requirements. This bill would ensure that the newly established Maternal Mortality Review Commission complies with the provisions of S.1112, so that the State may obtain a grant under its provisions, if and when the bill is enacted.

The Maternal Mortality Review Commission established by the bill would be tasked with annually reviewing and reporting on maternal death rates and the causes of maternal death in the State, and providing recommendations to improve maternal care and reduce adverse maternal outcomes. "Maternal death" includes both pregnancy-associated deaths and pregnancy-related deaths. A "pregnancy-associated death" is one that occurs while the woman is pregnant, or during the one-year period following the date of the end of the pregnancy, irrespective of cause; while a "pregnancy-related death" is one that occurs while the woman is pregnant, or during the one-year period following the date of the end of the pregnancy, regardless of the duration of pregnancy, as a result of a non-accidental or non-incidental cause that is related to, or aggravated by, the pregnancy or its management.

The commission would be required to meet pursuant to a schedule to be established at its first meeting, and at the call of its chairperson or the Commissioner of Health, but in no case would the commission

be authorized to meet less than two times a year. The members of the commission would serve without compensation, but would be reimbursed for travel and other necessary expenses incurred in the discharge of their official duties, within the limits of funds appropriated or otherwise made available for such purposes. Upon the appointment of a majority of the commission's members, the existing Maternal Mortality Case Review Team would be disbanded. The DOH would be required to provide administrative staff support to the commission, as necessary.

The Maternal Mortality Review Commission would have the general power to: 1) carry out any power, duty, or responsibility expressly granted under the bill; 2) adopt, amend, or repeal suitable bylaws; 3) maintain an office; 4) apply for, receive, and accept public or private moneys; 5) enter into agreements or contracts, execute instruments, and do and perform any and all acts or things necessary, convenient, or desirable to further its purposes; 6) call to its assistance, and avail itself of the services of, such employees of any State entity or local government unit as may be required and available for the commission's purposes; 7) review and investigate reports of maternal death; conduct witness interviews, and hear testimony provided under oath at public or private hearings, on any material matter; and request the attendance of relevant witnesses and the production of relevant documents, records, and papers; 8) solicit and consider public input on the commission's activities; and 9) identify, and promote the use of, best practices in maternal care, and encourage and facilitate cooperation and collaboration among health care facilities, health care professionals, administrative agencies, and local government units for the purposes of ensuring the provision of the highest quality maternal care throughout the State.

Among its formal duties, the commission would be required, within 90 days after its organizational meeting, to: 1) develop a mandatory maternal death reporting process, pursuant to which health care practitioners, medical examiners, hospitals, birthing centers, and other relevant professional actors and health care facilities will be required to confidentially report to the DOH on individual cases of maternal death; and 2) develop a voluntary maternal death reporting process, pursuant to which the family members of a deceased woman, and any other interested members of the public, will be permitted, but not required, to confidentially report to the DOH on individual cases of perceived maternal death. In developing the mandatory reporting process required by the bill, the commission would be authorized to review and incorporate elements of the maternal death reporting process that is used by the Maternal Mortality Case Review Team as of the bill's effective date.

The DOH will be required to keep a record of all reports of maternal death that are submitted thereto through these processes, and will also be required to ensure that a copy of each such report of

maternal death is promptly forwarded to the commission, so that the commission may properly execute its other duties and responsibilities under the bill.

The commission will be required to conduct an investigation in association with each report of maternal death that is forwarded thereto by the DOH. In conducting each case investigation, the commission will be required to consider: 1) the forwarded report of maternal death; 2) the deceased woman's medical records, autopsy report or death record, and other relevant vital records; 3) information obtained through interviews of individuals who were directly involved in the care of the woman either during, or immediately following, her pregnancy, and, as deemed to be appropriate and necessary, through interviews of the woman's family members; 4) background information about the deceased woman; and 5) any other information that may shed light on the death.

At the conclusion of an investigation, the commission will be required to prepare a de-identified case summary, which is to include the commission's findings with regard to the cause of, or factors that contributed to, the maternal death, and recommendations for actions that should be undertaken or policies that should be implemented to mitigate or eliminate those factors and causes in the future.

The bill would authorize the commission to present its findings and recommendations on each individual case, or on groups of individual cases, as deemed appropriate, to the health care facility or facilities where relevant care was provided in the case or group of cases, and to the individual health care practitioners who provided such care, or to any relevant professional organization, for the purposes of instituting or facilitating policy changes, educational activities, or improvements in the quality of care provided; or for the purposes of exploring, facilitating, or establishing regional projects or other collaborative projects that are designed to reduce instances of maternal death.

The bill would require the commission to use the maternal death reports that are forwarded by the DOH, as well as statistical data that is forwarded by the State registrar, to identify trends, patterns, and disparities in adverse maternal outcomes, and medical, non-medical, and system-related factors that may have contributed to maternal deaths and treatment disparities. The statistical data that is to be forwarded by the State registrar for these purposes is to include: 1) the total number of maternal deaths that have occurred in the State during the year, and during each quarter of the year; 2) the average Statewide rate of maternal death occurring during the year; 3) the number and percentage of maternal deaths that occurred during the year in each of the Northern, Central, and Southern regions of the State; 4) the number and percentage of maternal deaths, on a Statewide and regional basis, that constituted pregnancy-associated deaths, and the number and percentage of maternal deaths, on a Statewide and regional basis, that constituted pregnancy-related deaths; and 5) the areas of the State

where the rates of maternal death are significantly higher than the Statewide average. The State registrar would be required to provide these statistics to the commission on an annual basis, and would further be required to post a copy of this statistical information on the Internet website of the Office of Vital Statistics and Registry, in the DOH. In order to facilitate the State registrar's analysis, in this regard, and ensure that death records contain the information that is necessary to allow the State registrar to make the requisite statistical determinations, the bill would amend the State's existing vital records law, in order to clarify that the blanks and forms used for the registration of a vital record are to include, at a minimum, the same information (including pregnancy-related information) that is to be included in standardized U.S. certificates of live birth, death, and fetal death.

Finally, the bill would require the commission to annually report its findings and recommendations on maternal mortality to the DOH, the Governor, and the Legislature. Each annual report is to contain the commission's findings on the rates and causes of maternal deaths occurring in the State during the preceding year, and is to provide recommendations for legislative or other action that can be undertaken to: 1) improve the quality of maternal care and reduce adverse maternal outcomes in the State; 2) increase the availability of, and improve access to, social and health care services for pregnant women; and 3) reduce or eliminate disparities in maternal care and treatment, both during, and in the year after, pregnancy. Each annual report, with the exception of the first, would additionally be required to identify the extent to which the commission's prior recommendations have been successfully implemented in practice, and the apparent impact that the implementation of such recommended changes has had on maternal care in the preceding year.

The commission's annual report is to be based on: 1) the case summaries that were prepared by the commission during the preceding year; 2) the statistical data that was forwarded thereto by the State registrar during the preceding year; and 3) any other relevant information, including information on any collaborative maternal health arrangements that have been established by health care providers, professional organizations, local government units, or other relevant actors or entities in the preceding year, in response to commission outreach.

The DOH would be required to post a copy of each commission report on its Internet website, and take appropriate steps to otherwise broadly publicize the commission's findings and recommendations. The Commissioner of Health would also be required to adopt rules and regulations to implement the recommendations contained in each such report, to the extent that those recommendations can be implemented through administrative rule-making action.

The DOH, working in consultation with the commission, as well as with the Perinatal Quality Collaborative, the Maternal Child Health Consortia, and other relevant professional organizations and patient advocacy groups, will also be required to develop an ongoing maternal health educational program for health care practitioners. Although the program would initially be designed to reflect the findings and recommendations contained in the commission's first report, the DOH would be required to review the program, on at least an annual basis, and make any necessary changes to ensure that the ongoing education provided thereunder accurately reflects, and is consistent with, the latest data, findings, and recommendations of the commission, as reflected in the commission's most recent report.

Each hospital and birthing facility in the State is to additionally require its health care practitioners involved in labor, delivery, and postpartum care to complete a standardized maternal patient discharge education module, pursuant to which such health care practitioners will be educated in the complications of childbirth, and the warning signs of complications in women who have just given birth. This educational module may be implemented in each facility before the department finalizes the Statewide educational program that is to be established under the bill; however, after the Statewide educational program is finalized, the educational modules implemented by facilities are to be modified as necessary to conform to the department's educational program. Any modules implemented before the department's Statewide educational program is finalized are to address the most frequent causes of maternal mortality, including but not limited to, hemorrhage, hypertension, preeclampsia, heart failure and chest pain, infection, embolism, and postpartum depression. Each facility is to additionally provide this information, both orally and in writing, to any woman who has given birth at the facility, prior to discharge. An educational module is to be completed by all relevant health care practitioners at the facility, as a condition of their practice or employment in the facility, and may be used to satisfy relevant continuing education requirements applicable to each such health care practitioner.

The bill would specify that, except as otherwise provided thereby, all proceedings and activities of the commission; all opinions of the commission members, which are formed as a result of the commission's proceedings and activities; and all records obtained, created, or maintained by the commission, are to remain confidential, and will not be subject to public inspection, discovery, subpoena, or introduction into evidence in any civil, criminal, legislative, or other proceeding. The commission will be prohibited from disclosing any personally identifiable information to the public, or including any personally identifiable information in a case summary or annual report prepared pursuant to the bill's provisions. Members of the commission may also not be questioned in any civil, criminal,

legislative, or other proceeding regarding information that has been presented in, or opinions that have been formed as a result of, a meeting or communication of the commission; however, this would not prevent a member from being questioned, or from testifying, in relation to publicly available information or information that was obtained independent of the member's participation on the commission. Furthermore, the commission will be authorized to publish statistical compilations, or reports that are based on confidential information, so long as those compilations and reports do not contain any personally identifying information.

COMMITTEE AMENDMENTS:

The committee amended the bill to:

- add a legislative findings and declarations section clarifying that the bill's intent is to establish a permanent commission that will replace the existing informal Maternal Mortality Case Review Team operating out of the Department of Health;
- add a definition of "Maternal Mortality Case Review Team," which indicates that the team is being replaced by the commission being established under the bill, and add another provision specifying that the review team will be disbanded upon the appointment of a majority of the commission members;
- add seven new members to the commission membership;
- require the commission to meet at least twice a year (as opposed to four times per year);
- authorize the commission, in establishing a mandatory maternal death reporting process, to review and incorporate elements of the maternal death reporting process that is used by the Maternal Mortality Case Review team as of the bill's effective date;
- require the commission to consider all relevant hospital records in association with its investigation of a maternal death (as opposed to requiring the commission to consider only the woman's hospital discharge records);
- specify that a case summary prepared by the commission is to omit identifying information of the deceased woman and her family members, as well as the health care providers who provided care, and the hospitals where care was provided;
- authorize the commission to review any relevant information, including its prior annual reports, when preparing an annual report as required under the bill;
- require the Department of Health to work in consultation with the Perinatal Quality Collaborative, the Maternal Child Health Consortia, and other relevant professional organizations and patient advocacy groups in developing an ongoing maternal health educational program, and require the department to review the educational program on an annual (rather than a biennial) basis;

- remove language requiring each of the State’s professional licensing boards to adopt rules and regulations to require practitioners who are involved in the provision of care to pregnant women to satisfactorily complete the maternal care educational program established by the department as a condition of licensure or license renewal, and replace with new language calling for hospitals and birthing facilities to implement a maternal health education module, which may be used to satisfy professional continuing education requirements;
- remove language that would have authorized the commission to publish de-identified case summaries;
- remove language that would have granted the commission subpoena power to compel the attendance of relevant witnesses and the production of relevant documents, records, and papers; require the State Registrar, in providing statistics related to maternal deaths, to identify the rate of racial disparities in maternal deaths occurring on a Statewide and regional basis;
- authorize the State Registrar to use the case ascertainment system devised by the federal Centers for Disease Control and Prevention when identifying maternal deaths; and
- make technical changes.

As amended, this bill is identical to Senate Bill No.495 (1R) (Vitale/Ruiz) which was released from the Senate Health, Human Services, and Senior Services Committee on February 15, 2017.

This bill was pre-filed for introduction in the 2018-2019 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

ASSEMBLY, No. 1862

with committee amendments

STATE OF NEW JERSEY

DATED: FEBRUARY 7, 2019

The Senate Budget and Appropriations Committee reports favorably Assembly Bill No. 1862 (1R), with committee amendments.

As amended, this bill would establish a Maternal Mortality Review Committee in the Department of Health (DOH), which would take the place of the State's existing Maternal Mortality Case Review Team. While the existing review team produces important statistical data, the team is not permanently established by statute, does not meet regularly, produces only periodic reports on maternal mortality, and uses varying datasets in those periodic reports, making the amalgamation and comparison of data by interested parties more difficult. U.S. Senate Bill No. 1112, introduced in the 115th Congress, would establish a federal grant program to assist states in establishing and sustaining state-level maternal mortality review committees, but a state will only be eligible to obtain a grant under this bill if the state's maternal mortality review committee satisfies certain specific requirements. This bill would ensure that the newly established Maternal Mortality Review Committee complies with the provisions of S.1112, so that the State may obtain a grant under its provisions, if an identical bill is enacted by Congress in the future.

The Maternal Mortality Review Committee established by the bill would be tasked with annually reviewing and reporting on maternal death rates and the causes of maternal death in the State, and providing recommendations to improve maternal care and reduce adverse maternal outcomes.

The committee would be required to meet pursuant to a schedule to be established at its first meeting, and at the call of its chairperson or the Commissioner of Health, but in no case would the committee be authorized to meet less than four times a year. The members of the committee would serve without compensation, but would be reimbursed for travel and other necessary expenses incurred in the discharge of their official duties, within the limits of funds appropriated or otherwise made available for such purposes. Upon the appointment of a majority of the committee's members, the existing Maternal Mortality Case Review Team would be disbanded. The

DOH would be required to provide administrative staff support to the committee.

The Maternal Mortality Review Committee would have the general responsibility and power to review and investigate reports of maternal death; conduct witness interviews, and hear testimony provided under oath at public or private hearings, on any material matter; and request the attendance of relevant witnesses and the production of relevant documents, records, and papers; solicit and consider public input on the committee's activities; and identify, and promote the use of, best practices in maternal care, and encourage and facilitate cooperation and collaboration among health care facilities, health care professionals, administrative agencies, and local government units for the purposes of ensuring the provision of the highest quality maternal care throughout the State.

Among its formal duties, the committee would be required, within 90 days after its organizational meeting, to: 1) develop a mandatory maternal death reporting process for health care facilities and professionals; and 2) develop a voluntary maternal death reporting process for family members of a deceased woman, and any other interested members of the public to confidentially report to the DOH on individual cases of perceived maternal death. In developing the mandatory reporting process required by the bill, the committee would be authorized to review and incorporate elements of the maternal death reporting process that is used by the Maternal Mortality Case Review Team as of the bill's effective date.

The DOH will be required to keep a record of all reports of maternal death that are submitted thereto through these processes, and will also be required to ensure that a copy of each such report of maternal death is promptly forwarded to the committee, so that the committee may properly execute its other duties and responsibilities under the bill. The committee will be required to conduct an investigation in association with each report of maternal death that is forwarded thereto by the DOH. At the conclusion of an investigation, the committee will be required to prepare a de-identified case summary, which is to include the committee's findings with regard to the cause of, or factors that contributed to, the maternal death, and recommendations for actions that should be undertaken or policies that should be implemented to mitigate or eliminate those factors and causes in the future.

The bill would authorize the committee to present its findings and recommendations on each individual case, or on groups of individual cases, as deemed appropriate, to the health care facility or facilities where relevant care was provided in the case or group of cases, and to the individual health care practitioners who provided such care, or to any relevant professional organization, for the purposes of instituting or facilitating policy changes, educational activities, or improvements in the quality of care provided; or for the purposes of exploring,

facilitating, or establishing regional projects or other collaborative projects that are designed to reduce instances of maternal death.

The bill would require the committee to use the maternal death reports that are forwarded by the DOH and statistical data forwarded by the State registrar to identify trends, patterns, and disparities in adverse maternal outcomes, and medical, non-medical, and system-related factors that may have contributed to maternal deaths and treatment disparities. In order to facilitate the State registrar's collection of relevant data and ensure that death records contain the information that is necessary to allow the committee to make the requisite statistical determinations, the bill would amend the State's existing vital records law to clarify that the blanks and forms used for the registration of a vital record are to include, at a minimum, the same information (including pregnancy-related information) that is to be included in standardized U.S. certificates of live birth, death, and fetal death.

Finally, the bill would require the committee to annually report its findings and recommendations on maternal mortality to the DOH, the Governor, and the Legislature. Each annual report is to contain the committee's findings on the rates and causes of maternal deaths occurring in the State during the preceding year, and is to provide recommendations for legislative or other action that can be undertaken. Each annual report, with the exception of the first, would additionally be required to identify the extent to which the committee's prior recommendations have been successfully implemented in practice, and the apparent impact that the implementation of such recommended changes has had on maternal care in the preceding year. The DOH would be required to post a copy of each committee report on its Internet website, and take appropriate steps to otherwise broadly publicize the committee's findings and recommendations. The Commissioner of Health would also be required to adopt rules and regulations to implement the recommendations contained in each such report, to the extent that those recommendations can be implemented through administrative rule-making action.

The DOH, working in consultation with the committee, as well as with the Perinatal Quality Collaborative, the Maternal Child Health Consortia, and other relevant professional organizations and patient advocacy groups, will also be required to develop an ongoing maternal health educational program for health care practitioners. Although the program would initially be designed to reflect the findings and recommendations contained in the committee's first report, the DOH would be required to review the program, on at least an annual basis, and make any necessary changes to ensure that the ongoing education provided thereunder accurately reflects, and is consistent with, the latest data, findings, and recommendations of the committee, as reflected in the committee's most recent report.

Each hospital and birthing facility in the State is to additionally require its health care practitioners involved in labor, delivery, and postpartum care to complete a standardized maternal patient discharge education module, pursuant to which such health care practitioners will be educated in the complications of childbirth, and the warning signs of complications in women who have just given birth. This educational module may be implemented in each facility before the department finalizes the Statewide educational program that is to be established under the bill; however, after the Statewide educational program is finalized, the educational modules implemented by facilities are to be modified as necessary to conform to the department's educational program. Any modules implemented before the department's Statewide educational program is finalized are to address the most frequent causes of maternal mortality, including but not limited to, hemorrhage, hypertension, preeclampsia, heart failure and chest pain, infection, embolism, and postpartum depression. Each facility is to additionally provide this information, both orally and in writing, to any woman who has given birth at the facility, prior to discharge. An educational module is to be completed by all relevant health care practitioners at the facility, as a condition of their practice or employment in the facility, and may be used to satisfy relevant continuing education requirements applicable to each such health care practitioner.

The bill would specify that, except as otherwise provided thereby, all proceedings and activities of the committee; all opinions of the committee members, which are formed as a result of the committee's proceedings and activities; and all records obtained, created, or maintained by the committee, are to remain confidential, and will not be subject to public inspection, discovery, subpoena, or introduction into evidence in any civil, criminal, legislative, or other proceeding. The committee will be prohibited from disclosing any personally identifiable information to the public, or including any personally identifiable information in a case summary or annual report prepared pursuant to the bill's provisions. Members of the committee may also not be questioned in any civil, criminal, legislative, or other proceeding regarding information that has been presented in, or opinions that have been formed as a result of, a meeting or communication of the committee; however, this would not prevent a member from being questioned, or from testifying, in relation to publicly available information or information that was obtained independent of the member's participation on the committee. Furthermore, the committee will be authorized to publish statistical compilations, or reports that are based on confidential information, so long as those compilations and reports do not contain any personally identifying information.

As amended and reported, this bill is identical to Assembly Bill No.1862 (1R), as also amended and reported by the committee.

COMMITTEE AMENDMENTS:

The committee amendments to the bill:

- Establish in the Department of Health a 34-member New Jersey Maternal Care Quality Collaborative, which will work to coordinate efforts and strategies to reduce maternal mortality, morbidity, and racial and ethnic disparities in the State;
- Change the designation of the Maternal Mortality Review Commission to the Maternal Mortality Review Committee.
- Change the membership of the Maternal Mortality Review Committee to a total of 24 members, including four ex officio members and 20 public members;
- Specify that the Department of Health must employ a program manager, a clinical nurse care abstractor, two maternal child health epidemiologists, a case abstraction manager, and any other staff the Commissioner of Health shall deem necessary to support the committee;
- Grant the Maternal Mortality Review Committee power to subpoena the attendance of relevant witnesses and the production of relevant documents, records, and papers, to make the bill identical to its Senate counterpart;
- Shift responsibilities of the State Registrar under the bill to the Maternal Mortality Review Committee;
- Make certain changes to required maternal death reporting processes;
- Establish in the Healthcare Quality and Informatics Unit of the Department of Health a Maternal Data Center, which will develop protocols concerning, collect, and analyze maternal mortality, morbidity and racial and ethnic disparity data, and disseminate this information;
- Require the Commissioner of Health to establish and collect Maternal Data Center membership fees from health care facilities that provide maternal care services in the State, which will fund the Maternal Data Center; and
- Make a variety of technical and stylistic changes.

FISCAL IMPACT:

The Office of Legislative Services (OLS) concludes that the bill, by establishing a Maternal Mortality Review Committee, New Jersey Maternal Care Quality Collaborative, and Maternal Data Center in the Department of Health (DOH) and requiring the department to support the work of all three entities, will increase expenditures by the DOH. The department will also incur expenses under the bill due to the requirements imposed upon the State registrar regarding the collection of certain statistical information. The bill specifies minimum staff positions to support each newly created entity, and permits the hiring of additional staff beyond those required. The new entities will also

incur costs for facilities, equipment, travel, and other expenses. Without information from the Executive, the OLS cannot quantify these costs.

The OLS notes that the collection of certain fees, as established by the Commissioner of Health under the bill, will offset the expenses associated with the Maternal Data Center. The OLS further notes that certain expenses of the committee may be minimized or absorbed by the DOH's existing operational budget as a function of the committee replacing the existing Maternal Mortality Case Review Team within the department. In addition, any State costs may be offset by federal or private funds pursued by and awarded to the committee.

STATEMENT TO
[Second Reprint]
ASSEMBLY, No. 1862

with Senate Floor Amendments
(Proposed by Senator VITALE)

ADOPTED: FEBRUARY 21, 2019

These Senate floor amendments clarify that the membership fees established under the bill are to be collected from licensed facilities that enter into a written agreement with the Department of Health to participate in the Maternal Data Center under the bill. The membership fees will be paid by each participating facility on a date as required by the commissioner. The amount of the membership fee will be established by the commissioner, but in no case will the amount of the fee exceed \$10,000 per facility per year. The commissioner will also be authorized to seek out and accept other appropriate sources of funding as are necessary for the purposes of the Maternal Data Center.

The Senate floor amendments also establish a nonlapsing, revolving “Maternal Data Center Fund,” into which membership fees and other Maternal Data Center funds are to be deposited and annually appropriated for the sole purpose of operating and maintaining the Maternal Data Center.

The Senate floor amendments provide that participating facilities will have access to all data reported to the Maternal Data Center, provided that the accessible data is de-identified and does not include any personal identifying or confidential information concerning any patient.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

ASSEMBLY, No. 1862

STATE OF NEW JERSEY 218th LEGISLATURE

DATED: JUNE 12, 2018

SUMMARY

- Synopsis:** Establishes Maternal Mortality Review Commission to annually review and report on rates and causes of maternal death in New Jersey, and to recommend improvements in maternal care.
- Type of Impact:** Expenditure Increase; General Fund.
- Agencies Affected:** Department of Health.

Office of Legislative Services Estimate

Fiscal Impact	<u>Annual</u>
State Cost	Indeterminate Increase

- The Office of Legislative Services (OLS) concludes that the bill, by establishing a Maternal Mortality Review Commission in the Department of Health (DOH) and requiring the department to support the work of the commission, will increase expenditures by the DOH. The department will also incur expenses under the bill due to the requirements imposed upon the State registrar regarding the collection of certain statistical information. Without information from the Executive, the OLS cannot quantify these costs.
- The OLS notes that certain expenses of the commission may be minimized or absorbed by the DOH's existing operational budget as a function of the commission replacing the existing Maternal Mortality Case Review Team within the department. In addition, any State costs may be offset by federal or private funds pursued by and awarded to the commission.

BILL DESCRIPTION

This bill establishes a Maternal Mortality Review Commission in the DOH, which replaces the State's existing Maternal Mortality Case Review Team. The Maternal Mortality Review Commission is tasked with annually reviewing and reporting on maternal death rates and the

causes of maternal death, as defined by the bill, in the State, and providing recommendations to improve maternal care and reduce adverse maternal outcomes.

Under the bill, the members of the commission serve without compensation, but may be reimbursed for travel and other necessary expenses incurred in the discharge of their official duties, within the limits of funds appropriated or otherwise made available for such purposes. The DOH is required to provide administrative staff support to the commission, as necessary.

The Maternal Mortality Review Commission has the general power to: 1) adopt, amend, or repeal suitable bylaws; 2) maintain an office; 3) apply for, receive, and accept public or private moneys; 4) enter into agreements or contracts; 5) call to its assistance employees of any State entity or local government unit as may be required and available for the commission's purposes; 6) review and investigate reports of maternal death; 7) solicit and consider public input on the commission's activities; and 8) identify and promote the use of best practices in maternal care.

Among its formal duties, the commission is required to develop: 1) a mandatory maternal death reporting process for use by the medical provider community; and 2) a voluntary maternal death reporting process for use by the public. The DOH is required to keep a record of all reports of maternal death that are submitted through these processes and to promptly forward a copy of each report to the commission.

At the conclusion of all maternal death investigations, the commission is required to prepare a de-identified case summary with recommendations for preventative actions. The bill authorizes the commission to present its findings and recommendations to the health care providers where relevant care was provided in the case under investigation.

The bill requires the commission to use the maternal death reports that are forwarded by the DOH, as well as statistical data that is forwarded by the State registrar, to identify trends, patterns, and disparities in adverse maternal outcomes, and medical, non-medical, and system-related factors that may have contributed to maternal deaths and treatment disparities. The State registrar is required to provide the statistics outlined in the bill to the commission on an annual basis and to post a copy of this statistical information on the Internet website of the Office of Vital Statistics and Registry within the DOH.

Finally, the bill requires the commission to annually report its findings and recommendations on maternal mortality to the DOH, the Governor, and the Legislature. The DOH is required to post a copy of each commission report on its Internet website, and take appropriate steps to otherwise broadly publicize the commission's findings and recommendations. The Commissioner of Health is also required to adopt rules and regulations to implement the recommendations contained in each such report, to the extent that those recommendations can be implemented through administrative rule-making action.

The DOH, working in consultation with the commission, as well as with the Perinatal Quality Collaborative, the Maternal Child Health Consortia, and other relevant professional organizations and patient advocacy groups, is also required to develop, and annually review, an ongoing maternal health educational program for health care practitioners.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS concludes that the bill, by establishing a Maternal Mortality Review Commission in the DOH and requiring the department to support the work of the commission, will increase expenditures by the DOH. The department will also incur expenses under the bill due to the requirements imposed upon the State registrar regarding the collection of certain statistical information. However, without information from the Executive, the OLS cannot quantify these costs.

The bill provides for a variety of one-time costs to establish the infrastructure for the work of the commission, such as: the development of mandatory and voluntary maternal death reporting processes by the commission, the development of a maternal health education program by the department, and the reformatting of certain vital records forms by the State registrar.

Annual expenses associated with this bill will largely be due to the investigation and reporting of maternal deaths by the commission. The existing New Jersey Maternal Mortality Case Review Team (CRT) identified a total of 225 maternal deaths between 2009 and 2013. Of the 225 pregnancy associated deaths, CRT determined 78 (34.7 percent) were pregnancy-related, 129 (57.3 percent) were not pregnancy-related, and 18 (8 percent) were undetermined.

The OLS is unable to determine the effect of this bill on the overall number of investigations performed by the commission. It is possible that the establishment of voluntary reporting procedures for the public, as well as increased outreach by the commission regarding information about maternal death, may result in initial growth in the number of deaths reported and, therefore, investigated. However, over time, the establishment of a maternal health education program for health care practitioners, along with implementation of the commission's annual report recommendations, may result in a general decrease in maternal deaths and, consequently, investigations.

Other more minor annual expenses may be incurred by the DOH in collecting maternal death reports and by the State registrar in providing annual analysis of maternal death statistics to the commission.

The OLS notes that certain expenses of the commission may be minimized or absorbed by the DOH's existing operational budget as a function of the commission replacing the existing Maternal Mortality Case Review Team within the department. In addition, any State costs may be offset by federal or private funds pursued by and awarded to the commission.

Section: Human Services
Analyst: Sarah Schmidt
Associate Research Analyst
Approved: Frank W. Haines III
Legislative Budget and Finance Officer

his fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

LEGISLATIVE FISCAL ESTIMATE

[Third Reprint]

ASSEMBLY, No. 1862

STATE OF NEW JERSEY 218th LEGISLATURE

DATED: MARCH 8, 2019

SUMMARY

- Synopsis:** Establishes Maternal Mortality Review Committee to annually review and report on rates and causes of maternal mortality and morbidity in New Jersey, and to recommend improvements in maternal care.
- Type of Impact:** Expenditure and Revenue Increase; General Fund.
- Agencies Affected:** Department of Health.

Office of Legislative Services Estimate

Fiscal Impact	<u>Annual</u>
State Expenditure	Indeterminate Potential Increase
State Revenue	Indeterminate Increase

- The Office of Legislative Services (OLS) concludes that the bill, by establishing in the Department of Health (DOH) the Maternal Mortality Review Committee, the New Jersey Maternal Care Quality Collaborative (NJMCQC), and the Maternal Data Center, would likely increase certain one-time and annual expenditures of the department. However, there is no information available to the OLS on the current cost of the Maternal Mortality Case Review Team which is disbanded by the bill. Accordingly the marginal cost of the bill is indeterminate.
- The OLS also concludes that the bill will result in an increase in revenues. Any annual expenditures associated with the Maternal Data Center will be funded by the annual collection of a maternal data center membership fee, as established by the Commissioner of Health within the parameters of the bill's provisions, from health care facilities. Without information on the cost base of the Maternal Data Center and other factors within Executive discretion, the OLS lacks a basis for estimating these revenues.

BILL DESCRIPTION

This bill would establish, in the DOH, the Maternal Mortality Review Committee, the NJMCQC, and the Maternal Data Center.

The Maternal Mortality Review Committee, which would replace the State's existing Maternal Mortality Case Review Team, would be tasked with annually reviewing and reporting on maternal death rates and the causes of maternal death in the State, and providing recommendations to improve maternal care and reduce adverse maternal outcomes. The review team would be disbanded upon the Committee's formation.

Under the bill, the members of the committee would serve without compensation, but may be reimbursed for certain expenses incurred in the discharge of their official duties, within the limits of funds available for such purposes. The DOH would be required to provide administrative staff support to the committee, as necessary, and to employ, at a minimum, the following support staff for the committee: a program manager, a clinical nurse case abstractor, two maternal child health epidemiologists, a case abstraction manager, and any other staff that the commissioner deems necessary.

The committee would have the general power to: 1) adopt, amend, or repeal suitable bylaws; 2) maintain an office; 3) apply for, receive, and accept public or private moneys; 4) enter into agreements or contracts; 5) call to its assistance employees of any State entity or local government unit as may be required and available for the committee's purposes; 6) review and investigate reports of maternal death; 7) solicit and consider public input on the committee's activities; and 8) identify and promote the use of best practices in maternal care.

Among its formal duties, the committee would be required to develop: 1) a mandatory maternal death reporting process for use by the medical provider community; and 2) a voluntary maternal death reporting process for use by the public. In developing the mandatory reporting process required by the bill, the committee would be authorized to review and incorporate elements of the maternal death reporting process that is used by the Maternal Mortality Case Review Team as of the bill's effective date. The DOH would be required to keep a record of all reports of maternal death that are submitted through these processes and to promptly forward a copy of each report to the committee.

At the conclusion of all maternal death investigations, the committee would be required to prepare a de-identified case summary with recommendations for preventative actions. The bill authorizes the committee to present its findings and recommendations to the health care providers where relevant care was provided in the case under investigation.

The bill would require the committee, in collaboration with the Maternal Data Center, the NJMCQC, and other staff, to use the maternal death reports that are forwarded by the DOH, as well as data that is forwarded by the Maternal Data Center, to annually identify: Statewide and regional maternal death rates; trends, patterns, and disparities in adverse maternal outcomes; and medical, non-medical, and system-related factors that may have contributed to maternal deaths and treatment disparities. The committee would further be required to post a copy of this statistical information on the Internet website of the DOH.

In order to facilitate the collection of relevant data and ensure that death records contain the information that is necessary to allow the committee to make the requisite statistical determinations, the bill would amend the State's existing vital records law to clarify that the blanks and forms used for the registration of a vital record are to include, at a minimum, the same information (including pregnancy-related information) that is to be included in standardized U.S. certificates of live birth, death, and fetal death.

Finally, the bill would require the committee to annually report its findings and recommendations on maternal mortality to the DOH, the Governor, and the Legislature. The

DOH would be required to post a copy of each committee report on its Internet website, and take appropriate steps to otherwise broadly publicize the committee's findings and recommendations. The Commissioner of Health would also be required to adopt rules and regulations to implement the recommendations contained in each such report, to the extent that those recommendations can be implemented through administrative rule-making action.

The DOH, working in consultation with the committee, the Perinatal Quality Collaborative, the Maternal Child Health Consortia, and other relevant professional organizations and patient advocacy groups, would also be required to develop, and annually review, an ongoing maternal health educational program for health care practitioners. Prior to the implementation of the Statewide educational program, each hospital and birthing facility in the State is to require its health care practitioners involved in labor, delivery, and postpartum care to complete a standardized maternal patient discharge education module. After the Statewide program is finalized, facilities are to modify existing modules as necessary to conform to the department's program.

The bill would also establish in the DOH the 34-member NJMCQC, which will work to coordinate efforts to adopt and implement a strategic plan to reduce maternal mortality, morbidity, and racial and ethnic disparities in the State by performing such tasks as: supervision and oversight of the committee; applying for and accepting grant money; serving as the State designated entity for the receipt of federal funds; enter into contracts; and develop and publicize statistical information. The public members of the NJMCQC would serve without compensation, and the collaborative would employ an Executive Director, a Program Manager, and any other personnel as authorized by the Commissioner of Health. The DOH would be required to provide administrative staff support to the NJMCQC, as necessary, and other departments and agencies are directed to cooperate with the collaborative.

Finally, the bill would establish a Maternal Data Center in the Healthcare Quality and Informatics Unit in the DOH, which would develop protocols and requirements for the submission of data indicators; collect such data from health care facilities in the State; conduct data analytics; develop reports and a public facing dashboard; and disseminate the collected information to the NJMCQC, the committee, participating healthcare facilities, and other stakeholders. The Maternal Data Center would be required to employ a director, three research scientists, a technical assistant, and any other necessary staff.

Under the bill, the Commissioner of Health would be required to establish and collect maternal data center membership fees from health care facilities that are licensed to provide maternal services in the State and that enter into a written agreement with the department to participate in the Maternal Data Center. The fee cannot exceed \$10,000 per facility per year. The revenue from these fees, as well as well as additional sources of public and private funding that the commissioner pursues and accepts for the purposes of the Maternal Data Center, are to be deposited into the Maternal Data Center Fund, a nonlapsing revolving fund in the DOH established under the bill, and used to fund the Maternal Data Center.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS concludes that the bill, by establishing in the DOH the Maternal Mortality Review Committee, the NJMCQC, and the Maternal Data Center, would likely increase certain one-time and annual expenditures by the DOH. However, because the OLS has no information on the current cost of the existing Maternal Mortality Case Review Team, which is disbanded by the bill, the marginal cost of new required positions and related costs is indeterminate.

A significant portion of the annual expenses of supporting two new organizations would be due to salary and benefit costs associated with employing additional staff within the department and as specified by the bill.

The OLS also concludes the bill will result in an increase in State revenue. Any annual expenditures associated with the Maternal Data Center would be funded by the annual collection of a maternal data center membership fee from health care facilities, as established by the Commissioner of Health within the parameters of the bill's provisions. Without information on the cost base of the Maternal Data Center and other factors within Executive discretion, the OLS lacks a basis for estimating these revenues.

Expenditures: In total, the bill requires the committee, the NJMCQC, and the Maternal Data Center to employ a minimum of 12 staff members to support the functions of these entities. Furthermore, the DOH would be required to provide administrative support staff for the committee and the NJMCQC, which may require increasing staff or the use of employees' time that might otherwise be spent on other duties. The OLS estimates that the DOH could annually incur \$1.68 million in costs to fulfill these provisions of the bill.

This estimate assumes: 1) the department will hire 12 full-time staff members with benefits, at a cost of \$120,000 each, to fill the positions required under the bill, instead of relying on existing resources; and 2) staff hours used to support the committee and the collaborative would be, at a maximum, equivalent to two full-time-equivalent employees (FTE) and that the salary, equipment, and fringe benefits of a single FTE would total up to \$120,000 annually. Actual costs could differ based on the department's decisions, such as the salary of and hours worked by the positions required under the bill; additional staff deemed necessary by the department to help support these entities; and the job title and salary of the existing staff who provide administrative support to the committee and NJMCQC.

The OLS is unable to determine if, and to what extent, additional staff may be needed beyond the 12 positions enumerated in the bill. Regarding the Maternal Mortality Review Committee, the work of the committee would largely be driven by the number of investigations performed by the committee; however, the OLS cannot predict the effect of this bill on the overall number of investigations. It is possible that the establishment of voluntary reporting procedures for the public, as well as increased outreach by the committee regarding information about maternal death, may result in initial growth in the number of deaths reported and, therefore, investigated. However, over time, the establishment of a maternal health education program for health care practitioners, along with implementation of the committee's annual report recommendations, may result in a general decrease in maternal deaths and, consequentially, investigations.

For reference, the existing New Jersey Maternal Mortality Case Review Team identified a total of 225 maternal deaths between 2009 and 2013. Of the 225 pregnancy associated deaths, CRT determined 78 (34.7 percent) were pregnancy-related, 129 (57.3 percent) were not pregnancy-related, and 18 (8 percent) were undetermined.

In addition to staff costs, other annual expenses may be incurred by the DOH under the bill in collecting maternal death reports; developing publications to publicize and distribute the findings and recommendations issued by the committee, statistical information via the NJMCQC, and

data collected by the Maternal Data Center; and maintaining certain information reported on the department's Internet website, as required under the bill.

The bill also requires for a variety of one-time costs to establish the infrastructure for the work of the established entities, such as: the development of mandatory and voluntary maternal death reporting processes by the committee, the development of a maternal health education program by the department, the reformatting of certain vital records forms by the State registrar, and the development of a public facing dashboard by the Maternal Data Center to display the Center's collected data. The OLS notes that certain costs associated with the development of the mandatory reporting process may be minimized by incorporating existing elements of the maternal death reporting process that is currently used by the Maternal Mortality Case Review Team, as authorized under the bill.

Revenue: Certain costs of the bill will be offset by an indeterminate increase in State revenue. Any annual expenditures associated with the Maternal Data Center would be funded by the annual collection of maternal data center membership fees established by the Commissioner of Health and imposed on health care facilities, as defined by the Commissioner, that are licensed to provide maternal care services in the State and that enter into an agreement with the department to participate in the Maternal Data Center. Under the bill, the membership fee is not to exceed \$10,000 per facility per year.

The OLS is unable to quantify the amount of revenue that would be collected under this provision without information on the amount of the fee, as determined by the commissioner within the parameters of the bill's provisions; the specific health care facilities on which the fee will be imposed; and the cost base of the Maternal Data Center which the fees are to approximate in total. Furthermore, the OLS cannot predict how many healthcare facilities may choose to participate in the Maternal Data Center.

Section: Human Services

*Analyst: Sarah Schmidt
Senior Research Analyst*

*Approved: Frank W. Haines III
Legislative Budget and Finance Officer*

This legislative fiscal estimate has been produced by the Office of Legislative Services due to the failure of the Executive Branch to respond to our request for a fiscal note.

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

SENATE, No. 495

STATE OF NEW JERSEY 218th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2018 SESSION

Sponsored by:

Senator JOSEPH F. VITALE

District 19 (Middlesex)

Senator M. TERESA RUIZ

District 29 (Essex)

SYNOPSIS

Establishes Maternal Mortality Review Commission to annually review and report on rates and causes of maternal death in New Jersey, and to recommend improvements in maternal care.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 AN ACT concerning maternal deaths, supplementing Title 26 of the
2 Revised Statutes, and amending R.S.26:8-24.

3

4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

6

7 1. (New section) As used in this act:

8 “Commission” means the Maternal Mortality Review
9 Commission, established pursuant to section 2 of this act, which is
10 responsible for annually reviewing and reporting on maternal death
11 rates and the causes of maternal death in the State, and which is
12 further responsible for providing recommendations to improve
13 maternal care and reduce adverse maternal outcomes.

14 “Commissioner” means the Commissioner of Health.

15 “Department” means the Department of Health.

16 “Maternal death” means a pregnancy-associated death, or a
17 pregnancy-related death.

18 “Pregnancy-associated death” means the death of a woman,
19 which occurs while the woman is pregnant, or during the one-year
20 period following the date of the end of the pregnancy, irrespective
21 of the cause of death.

22 “Pregnancy-related death” means the death of a woman, which
23 occurs while the woman is pregnant, or during the one-year period
24 following the date of the end of the pregnancy, regardless of the
25 duration of the pregnancy, and which results from any cause related
26 to, or aggravated by, the pregnancy or its management, but
27 excluding any accidental or incidental cause.

28 “Report of maternal death” means a report of actual or perceived
29 maternal death, which is filed with the department, pursuant to the
30 processes established under subsection a. of section 5 of this act,
31 and which is to be forwarded to the commission for the purposes of
32 investigation, as provided by subsection b. of that section.

33 “Severe maternal morbidity” means the physical and
34 psychological conditions that result from, or are aggravated by,
35 pregnancy, and which have an adverse effect on the health of a
36 woman.

37 “State registrar” means the State registrar of vital statistics, who
38 is responsible for supervising the registration of, and maintaining,
39 death records in the State, in accordance with the provisions of
40 R.S.26:8-1 et seq.

41

42 2. (New section) a. There is hereby established, in the
43 Department of Health, the Maternal Mortality Review Commission,
44 which shall be tasked with annually reviewing and reporting on
45 maternal death rates and the causes of maternal death in the State,

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

1 and providing recommendations to improve maternal care and
2 reduce adverse outcomes related to, or associated with, pregnancy.
3 The commission shall be composed of 31 members, including 18 ex
4 officio members or their designees, as provided in subsection b. of
5 this section, and 13 public members, as provided in subsection c. of
6 this section.

7 b. The ex officio members of the commission shall include the
8 following persons, or their designees:

9 (1) the State registrar;

10 (2) the State Medical Examiner;

11 (3) the Director of the Division of Family Health Services in the
12 Department of Health;

13 (4) the Director of the Office of Emergency Medical Services in
14 the Department of Health;

15 (5) the Director of the Office of Minority and Multicultural
16 Health in the Department of Health;

17 (6) the Director of the Division of Medical Assistance and
18 Health Services in the Department of Human Services;

19 (7) the President of the New Jersey Hospital Association;

20 (8) the President of the New Jersey Health Care Quality
21 Institute;

22 (9) the Chief Executive Officer of the Medical Society of New
23 Jersey;

24 (10) the Executive Director of the New Jersey Chapter of the
25 National Association of Social Workers;

26 (11) the Chair of the New Jersey section of the American
27 Congress of Obstetricians and Gynecologists;

28 (12) the President of the New Jersey Affiliate of the American
29 College of Nurse Midwives;

30 (13) the Executive Director of the Partnership for Maternal and
31 Child Health of Northern New Jersey;

32 (14) the Chief Executive Officer of the Central Jersey Family
33 Health Consortium;

34 (15) the Executive Director of the Southern New Jersey Perinatal
35 Cooperative;

36 (16) the Director of the City of Newark Department of Health
37 and Community Wellness;

38 (17) the Director of the City of Trenton Health and Human
39 Services Department; and

40 (18) the Director of the Camden County Department of Health
41 and Human Services.

42 c. The public members of the commission shall be appointed
43 by the Governor, and shall include:

44 (1) five licensed and practicing health care practitioners, one of
45 whom specializes in obstetrics or gynecology, one of whom
46 specializes in maternal and fetal medicine, one of whom specializes
47 in family planning, one of whom specializes in critical care
48 medicine, and one of whom specializes in perinatal pathology;

- 1 (2) one licensed and practicing health care practitioner, mental
2 health care practitioner, or substance use disorder treatment
3 professional who specializes in perinatal addiction;
4 (3) one certified nurse midwife;
5 (4) one registered professional nurse or advanced practice nurse
6 who specializes in hospital-based obstetric nursing;
7 (5) one licensed practical nurse, registered professional nurse, or
8 advanced practice nurse who participates in, and represents, the
9 Nurse-Family Partnership operating in New Jersey;
10 (6) one health care administrator who has experience in
11 overseeing the operations of maternity wards or birthing centers;
12 (7) one private citizen who is engaged in maternal health
13 advocacy;
14 (8) one private citizen who is engaged in minority health
15 advocacy; and
16 (9) one private citizen who is engaged in patient advocacy.
17 d. Of the public members appointed to the commission, not
18 more than seven shall be of the same political party.
19 e. Each public member of the commission shall serve for a
20 term of four years; however, of the public members first appointed,
21 four shall serve an initial term of two years, four shall serve an
22 initial term of three years, and five shall serve an initial term of four
23 years. Each public member shall serve for the term of their
24 appointment, and until a successor is appointed and qualified,
25 except that a public member may be reappointed to the commission
26 upon the expiration of their term. Any vacancy in the membership
27 shall be filled, for the unexpired term, in the same manner as the
28 original appointment.
29 f. All initial appointments to the commission shall be made
30 within 60 days after the effective date of this act.
31 g. Any member of the commission may be removed by the
32 Governor, for cause, after a public hearing.
33
34 3. (New section) a. The commission shall organize as soon as
35 practicable following the appointment of a majority of its members,
36 and shall annually elect a chairperson and vice-chairperson from
37 among its members. The chairperson may appoint a secretary, who
38 need not be a member of the commission.
39 b. The commission shall meet pursuant to a schedule to be
40 established at its first meeting, and it shall additionally meet at the
41 call of its chairperson or the Commissioner of Health; however, in
42 no case shall the commission meet less than four times a year.
43 c. A majority of the total number of members appointed to the
44 commission shall constitute a quorum for the conducting of official
45 commission business. A vacancy in the membership of the
46 commission shall not impair the right of the commission to exercise
47 its powers and duties, provided that a majority of the currently
48 appointed members are available to conduct business. Any

1 recommendations of the commission shall be approved by a
2 majority of the members present.

3 d. The members of the commission shall serve without
4 compensation, but shall be reimbursed for travel and other
5 necessary expenses incurred in the discharge of their official duties,
6 within the limits of funds appropriated or otherwise made available
7 for such purposes.

8 e. The Department of Health shall provide such administrative
9 staff support to the commission as shall be necessary for the
10 commission to carry out its duties.

11

12 4. (New section) a. The Maternal Mortality Review
13 Commission shall have the power to:

14 (1) carry out any power, duty, or responsibility expressly
15 granted by this act;

16 (2) adopt, amend, or repeal suitable bylaws for the management
17 of its affairs;

18 (3) maintain an office at such place or places as it may
19 designate;

20 (4) apply for, receive, and accept, from any federal, State, or
21 other public or private source, grants, loans, or other moneys that
22 are made available for, or in aid of, the commission's authorized
23 purposes, or that are made available to assist the commission in
24 carrying out its powers, duties, and responsibilities under this act;

25 (5) enter into any and all agreements or contracts, execute any
26 and all instruments, and do and perform any and all acts or things
27 necessary, convenient, or desirable to further the purposes of the
28 commission;

29 (6) call to its assistance, and avail itself of the services of, such
30 employees of any State entity or local government unit as may be
31 required and available for the commission's purposes;

32 (7) review and investigate reports of maternal death; conduct
33 witness interviews, and hear testimony provided under oath at
34 public or private hearings, on any material matter; and request, or
35 compel through the issuance of a subpoena, the attendance of
36 relevant witnesses and the production of relevant documents,
37 records, and papers;

38 (8) solicit and consider public input and comment on the
39 commission's activities by periodically holding public hearings or
40 conferences, and by providing other opportunities for such input
41 and comment by interested parties; and

42 (9) identify, and promote the use of, best practices in maternal
43 care, and encourage and facilitate cooperation and collaboration
44 among health care facilities, health care professionals,
45 administrative agencies, and local government units for the
46 purposes of ensuring the provision of the highest quality maternal
47 care throughout the State.

1 b. The Maternal Mortality Review Commission shall have the
2 duty and responsibility to:
3 (1) develop mandatory and voluntary maternal death reporting
4 processes, in accordance with the provisions of section 5 of this act;
5 (2) conduct an investigation of each reported case of maternal
6 death, and prepare a de-identified case summary for each such case,
7 in accordance with the provisions of section 6 of this act;
8 (3) review the statistical data on maternal deaths that is
9 forwarded by the State registrar, pursuant to section 10 of this act,
10 and the reports of maternal death that are forwarded by the
11 department, pursuant to subsection b. of section 5 of this act, in
12 order to identify Statewide and regional maternal death rates;
13 trends, patterns, and disparities in adverse maternal outcomes; and
14 medical, non-medical, and system-related factors that may have
15 contributed to maternal deaths and treatment disparities; and
16 (5) annually report its findings and recommendations on
17 maternal mortality to the department, the Governor, and the
18 Legislature, in accordance with section 7 of this act.

19
20 5. (New section) a. Within 90 days after the commission's
21 organizational meeting, the commission shall:

22 (1) develop a mandatory maternal death reporting process,
23 pursuant to which health care practitioners, medical examiners,
24 hospitals, birthing centers, and other relevant professional actors
25 and health care facilities will be required to confidentially report to
26 the Department of Health on individual cases of maternal death; and
27 (2) develop a voluntary maternal death reporting process,
28 pursuant to which the family members of a deceased woman, and
29 any other interested members of the public, will be permitted, but
30 not required, to confidentially report to the Department of Health on
31 individual cases of perceived maternal death. At a minimum, the
32 process developed pursuant to this paragraph shall require the
33 department to: (a) post on its Internet website a hyperlink, a toll-
34 free telephone number, and an email address, which may each be
35 used for the voluntary submission of public reports of maternal
36 death; and (b) publicize the availability of these resources to
37 professional organizations, community organizations, social service
38 agencies, and members of the public.

39 b. The department shall keep a record of all reports of maternal
40 death that are submitted thereto through the reporting processes that
41 are established by the commission pursuant to paragraphs (1) and
42 (2) of subsection a. of this section. The department shall also
43 ensure that a copy of each such report of maternal death is promptly
44 forwarded to the commission, so that the commission may properly
45 execute its investigatory functions and other duties and
46 responsibilities under this act.

1 6. (New section) a. Upon receipt of a report of maternal death,
2 which has been forwarded to the commission pursuant to subsection
3 b. of section 5 of this act, the commission shall investigate the
4 reported case in accordance with the provisions of this section. In
5 conducting the investigation, the commission shall consider:
6 (1) the information contained in the forwarded report of
7 maternal death;
8 (2) any relevant information contained in the deceased woman's
9 autopsy report or death record, or in a certificate of live birth or
10 fetal death for the woman's child, or in any other vital records
11 pertaining to the woman;
12 (3) any relevant information contained in the deceased woman's
13 medical records, including: (a) records related to the health care
14 that was provided to the woman prior to her pregnancy; (b) records
15 related to the woman's prenatal and postnatal care, labor and
16 delivery care, emergency room care, and any other care delivered
17 up until the time of the woman's death; and (c) the woman's
18 hospital discharge records;
19 (4) information obtained through the oral and written interviews
20 of individuals who were directly involved in the care of the woman
21 either during, or immediately following, her pregnancy, including
22 interviews with relevant health care practitioners, mental health
23 care practitioners, and social service providers, and, as deemed to
24 be appropriate and necessary, interviews with the woman's family
25 members;
26 (5) background information about the deceased woman,
27 including, but not limited to, information regarding the woman's
28 age, race, and socioeconomic status; and
29 (6) any other information that may shed light on the maternal
30 death, including, but not limited to, reports from social service or
31 child welfare agencies.

32 b. At the conclusion of an investigation conducted pursuant to
33 this section, the commission shall prepare a case summary, which
34 shall include the commission's findings with regard to the cause of,
35 or the factors that contributed to, the maternal death, and
36 recommendations for actions that should be undertaken, or policies
37 that should be implemented, to mitigate or eliminate those factors
38 and causes in the future. Any case summary prepared pursuant to
39 this subsection shall omit the personally identifying information of
40 the deceased woman and her family members.

41 c. The commission may present its findings and
42 recommendations on each individual case, or on groups of
43 individual cases, as deemed appropriate, to the health care facility
44 or facilities where relevant care was provided in the case or group
45 of cases, and to the individual health care practitioners who
46 provided such care, or to any relevant professional organization, for
47 the purposes of instituting or facilitating policy changes,
48 educational activities, or improvements in the quality of care

1 provided; or for the purposes of exploring, facilitating, or
2 establishing regional projects or other collaborative projects that are
3 designed to reduce instances of maternal death.

4 d. In addition to investigating reports of maternal death, as
5 provided by this section, the Maternal Mortality Review
6 Commission may additionally elect to investigate alleged cases of
7 severe maternal morbidity, using data and information obtained
8 through patient registries, or the oral or written interviews of
9 pregnant women and their families.

10

11 7. (New section) a. Within one year after its organization, and
12 annually thereafter, the commission shall prepare, and submit to the
13 Department of Health, to the Governor, and, pursuant to section 2
14 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature, a report
15 containing the commission's findings on the rates and causes of
16 maternal deaths occurring in the State during the preceding year,
17 and providing recommendations for legislative or other action that
18 can be undertaken to: (a) improve the quality of maternal care and
19 reduce adverse maternal outcomes in the State; (b) increase the
20 availability of, and improve access to, social and health care
21 services for pregnant women; and (c) reduce or eliminate disparities
22 in maternal care and treatment, both during, and in the year after,
23 pregnancy. Each annual report, with the exception of the first
24 report prepared under this section, shall additionally identify the
25 extent to which the commission's prior recommendations have been
26 successfully implemented in practice, and the apparent impact that
27 the implementation of such recommended changes has had on
28 maternal care in the preceding year.

29 b. The report that is annually prepared pursuant to this section
30 shall be based on:

31 (1) the case summaries that were prepared by the commission
32 over the preceding year, pursuant to subsection b. of section 6 of
33 this act;

34 (2) the statistical data that was forwarded to the commission,
35 during the preceding year, by the State registrar, pursuant to section
36 10 of this act; and

37 (3) any other relevant information, including information on any
38 collaborative maternal health arrangements that have been
39 established by health care providers, professional organizations,
40 local government units, or other relevant actors or entities in the
41 preceding year, in response to the commission outreach authorized
42 by subsection c. of section 6, or by paragraph (9) of subsection a. of
43 section 4, of this act.

44 c. Upon receipt of the commission's annual report pursuant to
45 this section, the department shall post a copy of the report at a
46 publicly accessible location on its Internet website, and shall take
47 appropriate steps to otherwise broadly publicize the commission's
48 findings and recommendations. The Commissioner of Health shall

1 also adopt rules and regulations, pursuant to the “Administrative
2 Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et seq.), to implement
3 the recommendations contained in the report, to the extent that such
4 recommendations can be implemented through administrative rule-
5 making action.

6
7 8. (New section) a. Upon receipt of the commission’s first
8 annual report, issued pursuant to section 7 of this act, the
9 department, working in consultation with the commission, as well
10 as with relevant professional organizations and patient advocacy
11 groups, shall develop an ongoing maternal health educational
12 program for health care practitioners, as may be necessary to
13 improve the quality of maternal care and reduce adverse outcomes
14 related to, or associated with, pregnancy. The educational program
15 established pursuant to this section shall initially be based on, and
16 shall reflect, the findings and recommendations identified in the
17 commission’s first report. However, once the educational program
18 is established, the department shall, on at least a biennial basis
19 thereafter, review the program and make necessary changes to
20 ensure that the ongoing education provided thereunder accurately
21 reflects, and is consistent with, the latest data, findings, and
22 recommendations of the commission, as reflected in the
23 commission’s most recent annual report.

24 b. Each of the State’s professional licensing boards, as
25 appropriate, shall adopt rules and regulations, pursuant to the
26 “Administrative Procedure Act,” P.L.1968, c.410 (C.52:14B-1 et
27 seq.), which are applicable to the health care practitioners under
28 each board’s respective jurisdiction, and which require the
29 practitioners involved in the provision of care to pregnant women to
30 satisfactorily complete the educational program established
31 pursuant to this section. Each licensing board shall require the
32 relevant practitioners under its jurisdiction to complete this
33 educational program as a condition of initial licensure, or, in the
34 case of practitioners who are already licensed as of the effective
35 date of this act, within 180 days after the program is established
36 under this section; and shall additionally require practitioners to
37 complete the program on at least a biennial basis thereafter, as a
38 condition of license renewal.

39
40 9. (New section) a. (1) Except as otherwise provided by
41 subsection b. of this section, all proceedings and activities of the
42 Maternal Mortality Review Commission; all opinions of the
43 members of the commission, which are formed as a result of the
44 commission’s proceedings and activities; and all records obtained,
45 created, or maintained by the commission, including written reports
46 and records of interviews or oral statements, shall be confidential,
47 and shall not be subject to public inspection, discovery, subpoena,

1 or introduction into evidence in any civil, criminal, legislative, or
2 other proceeding.

3 (2) In no case shall the commission disclose any personally
4 identifiable information to the public, or include any personally
5 identifiable information in a case summary that is prepared pursuant
6 to subsection b. of section 6 of this act, or in an annual report that is
7 prepared pursuant to section 7 of this act.

8 (3) Members of the commission shall not be questioned in any
9 civil, criminal, legislative, or other proceeding regarding
10 information that has been presented in, or opinions that have been
11 formed as a result of, a meeting or communication of the
12 commission; however, nothing in this paragraph shall prohibit a
13 commission member from being questioned, or from testifying, in
14 relation to publicly available information or information that was
15 obtained independent of the member's participation on the
16 commission.

17 b. Nothing in this section shall be deemed to prohibit the
18 commission from publishing, or from otherwise making available
19 for public inspection, case summaries, statistical compilations, or
20 reports that are based on confidential information, provided that
21 those summaries, compilations, and reports do not contain
22 personally identifying information or other information that could
23 be used to ultimately identify the individuals concerned.
24

25 10. (New section) a. (1) On an annual basis, and using the
26 death records that have been filed during the preceding year, the
27 State registrar shall identify: (a) the total number of maternal
28 deaths that have occurred in the State during the year, and during
29 each quarter of the year; (b) the average Statewide rate of maternal
30 death occurring during the year; (c) the number and percentage of
31 maternal deaths that occurred during the year in each of the
32 Northern, Central, and Southern regions of the State; (d) the number
33 and percentage of maternal deaths, on a Statewide and regional
34 basis, that constituted pregnancy-associated deaths, and the number
35 and percentage of maternal deaths, on a Statewide and regional
36 basis, that constituted pregnancy-related deaths; and (e) the areas of
37 the State where the rates of maternal death are significantly higher
38 than the Statewide average.

39 (2) The results of the annual analysis that is conducted pursuant
40 to this subsection shall be posted at a publicly accessible location
41 on the Internet website of the Office of Vital Statistics and Registry,
42 in the Department of Health, and shall also be promptly forwarded
43 to the commission.

44 b. In order to accomplish its duties under this section, the State
45 registrar shall:

46 (1) for the purposes of determining the total number of
47 pregnancy-associated deaths, review each woman's death record,
48 and match the death record with a certificate of live birth, or with a

1 fetal or infant death record, for the woman's child, in order to
2 confirm whether the woman died during pregnancy, or within one
3 year after the end of pregnancy; and

4 (2) for the purposes of determining the total number of
5 pregnancy-related deaths, review each woman's death record, and
6 identify each such death record in which the death is reported to
7 have resulted from an underlying or contributing cause related to
8 pregnancy, regardless of the amount of time that has passed
9 between the end of the pregnancy and the death.

10 The State registrar may also use any other appropriate means or
11 methods to identify maternal deaths, including, but not limited to,
12 reviewing a random sample of reported deaths to ascertain cases of
13 pregnancy-related death and pregnancy-associated death that are not
14 discernable from a review of death records alone.

15

16 11. R.S.26:8-24 is amended to read as follows:

17 26:8-24. The State registrar shall:

18 a. Have general supervision throughout the State of the
19 registration of vital records;

20 b. Have supervisory power over local registrars, deputy local
21 registrars, alternate deputy local registrars, and subregistrars, in the
22 enforcement of the law relative to the disposal of dead bodies and
23 the registration of vital records;

24 c. Prepare, print, and supply to all registrars, upon request
25 therefor, all blanks and forms used in registering the records
26 required by said law, and provide for and prescribe the use of the
27 NJ-EDRS. The blanks and forms supplied under this subsection,
28 and any electronic blanks and forms that are used in the NJ-EDRS,
29 shall require the person registering a birth or death record, at a
30 minimum, to provide the same information as is required by the
31 National Center for Vital Health Statistics in its standardized U.S.
32 certificates of live birth, death, and fetal death. No [other] blanks ,
33 forms, or methods of registration shall be used , other than those
34 that satisfy the requirements of this subsection, and which are
35 supplied or approved by the State registrar;

36 d. Carefully examine the certificates or electronic files received
37 periodically from the local registrars or originating from their
38 jurisdiction; and, if any are incomplete or unsatisfactory, require
39 such further information to be supplied as may be necessary to
40 make the record complete and satisfactory;

41 e. Arrange or bind, and permanently preserve the certificates of
42 vital records, or the information comprising those records, in a
43 systematic manner and in a form that is deemed most consistent
44 with contemporary and developing standards of vital statistical
45 archival record keeping;

46 f. Prepare and maintain a comprehensive and continuous index
47 of all vital records registered, the index to be arranged
48 alphabetically;

1 pregnant, or during the one-year period following the date of the
2 end of the pregnancy, irrespective of cause; while a “pregnancy-
3 related death” is one that occurs while the woman is pregnant, or
4 during the one-year period following the date of the end of the
5 pregnancy, regardless of the duration of pregnancy, as a result of a
6 non-accidental or non-incidental cause that is related to, or
7 aggravated by, the pregnancy or its management.

8 The commission would be required to meet pursuant to a
9 schedule to be established at its first meeting, and at the call of its
10 chairperson or the Commissioner of Health, but in no case would
11 the commission be authorized to meet less than four times a year.
12 The members of the commission would serve without
13 compensation, but would be reimbursed for travel and other
14 necessary expenses incurred in the discharge of their official duties,
15 within the limits of funds appropriated or otherwise made available
16 for such purposes. The DOH would be required to provide
17 administrative staff support to the commission, as necessary.

18 The Maternal Mortality Review Commission would have the
19 general power to: 1) carry out any power, duty, or responsibility
20 expressly granted under the bill; 2) adopt, amend, or repeal suitable
21 bylaws; 3) maintain an office; 4) apply for, receive, and accept
22 public or private moneys; 5) enter into agreements or contracts,
23 execute instruments, and do and perform any and all acts or things
24 necessary, convenient, or desirable to further its purposes; 6) call to
25 its assistance, and avail itself of the services of, such employees of
26 any State entity or local government unit as may be required and
27 available for the commission’s purposes; 7) review and investigate
28 reports of maternal death; conduct witness interviews, and hear
29 testimony provided under oath at public or private hearings, on any
30 material matter; and request, or compel through the issuance of a
31 subpoena, the attendance of relevant witnesses and the production
32 of relevant documents, records, and papers; 8) solicit and consider
33 public input on the commission’s activities; and 9) identify, and
34 promote the use of, best practices in maternal care, and encourage
35 and facilitate cooperation and collaboration among health care
36 facilities, health care professionals, administrative agencies, and
37 local government units for the purposes of ensuring the provision of
38 the highest quality maternal care throughout the State.

39 Among its formal duties, the commission would be required,
40 within 90 days after its organizational meeting, to:

41 1) develop a mandatory maternal death reporting process,
42 pursuant to which health care practitioners, medical examiners,
43 hospitals, birthing centers, and other relevant professional actors
44 and health care facilities will be required to confidentially report to
45 the DOH on individual cases of maternal death; and

46 2) develop a voluntary maternal death reporting process,
47 pursuant to which the family members of a deceased woman, and
48 any other interested members of the public, will be permitted, but

1 not required, to confidentially report to the DOH on individual
2 cases of perceived maternal death.

3 The DOH will be required to keep a record of all reports of
4 maternal death that are submitted thereto through these processes,
5 and will also be required to ensure that a copy of each such report
6 of maternal death is promptly forwarded to the commission, so that
7 the commission may properly execute its other duties and
8 responsibilities under the bill.

9 The commission will be required to conduct an investigation in
10 association with each report of maternal death that is forwarded
11 thereto by the DOH. In conducting each case investigation, the
12 commission will be required to consider: 1) the forwarded report of
13 maternal death; 2) the deceased woman's medical records, autopsy
14 report or death record, and other relevant vital records; 3)
15 information obtained through interviews of individuals who were
16 directly involved in the care of the woman either during, or
17 immediately following, her pregnancy, and, as deemed to be
18 appropriate and necessary, through interviews of the woman's
19 family members; 4) background information about the deceased
20 woman; and 5) any other information that may shed light on the
21 death.

22 At the conclusion of an investigation, the commission will be
23 required to prepare a de-identified case summary, which is to
24 include the commission's findings with regard to the cause of, or
25 factors that contributed to, the maternal death, and
26 recommendations for actions that should be undertaken or policies
27 that should be implemented to mitigate or eliminate those factors
28 and causes in the future.

29 The bill would authorize the commission to present its findings
30 and recommendations on each individual case, or on groups of
31 individual cases, as deemed appropriate, to the health care facility
32 or facilities where relevant care was provided in the case or group
33 of cases, and to the individual health care practitioners who
34 provided such care, or to any relevant professional organization, for
35 the purposes of instituting or facilitating policy changes,
36 educational activities, or improvements in the quality of care
37 provided; or for the purposes of exploring, facilitating, or
38 establishing regional projects or other collaborative projects that are
39 designed to reduce instances of maternal death.

40 In addition to the investigation of cases of maternal death, the
41 commission would also be authorized, but not required, to
42 investigate cases of "severe maternal morbidity," which is defined
43 to mean the physical and psychological conditions that result from,
44 or are aggravated by, pregnancy, and which have an adverse effect
45 on the health of a woman.

46 The bill would require the commission to use the maternal death
47 reports that are forwarded by the DOH, as well as statistical data
48 that is forwarded by the State registrar, to identify trends, patterns,

1 and disparities in adverse maternal outcomes, and medical, non-
2 medical, and system-related factors that may have contributed to
3 maternal deaths and treatment disparities. The statistical data that is
4 to be forwarded by the State registrar for these purposes is to
5 include: 1) the total number of maternal deaths that have occurred
6 in the State during the year, and during each quarter of the year; 2)
7 the average Statewide rate of maternal death occurring during the
8 year; 3) the number and percentage of maternal deaths that occurred
9 during the year in each of the Northern, Central, and Southern
10 regions of the State; 4) the number and percentage of maternal
11 deaths, on a Statewide and regional basis, that constituted
12 pregnancy-associated deaths, and the number and percentage of
13 maternal deaths, on a Statewide and regional basis, that constituted
14 pregnancy-related deaths; and 5) the areas of the State where the
15 rates of maternal death are significantly higher than the Statewide
16 average. The State registrar would be required to provide these
17 statistics to the commission on an annual basis, and would further
18 be required to post a copy of this statistical information on the
19 Internet website of the Office of Vital Statistics and Registry, in the
20 DOH. In order to facilitate the State registrar's analysis, in this
21 regard, and ensure that death records contain the information that is
22 necessary to allow the State registrar to make the requisite
23 statistical determinations, the bill would amend the State's existing
24 vital records law, in order to clarify that the blanks and forms used
25 for the registration of a vital record are to include, at a minimum,
26 the same information (including pregnancy-related information) that
27 is to be included in standardized U.S. certificates of live birth,
28 death, and fetal death.

29 Finally, the bill would require the commission to annually report
30 its findings and recommendations on maternal mortality to the
31 DOH, the Governor, and the Legislature. Each annual report is to
32 contain the commission's findings on the rates and causes of
33 maternal deaths occurring in the State during the preceding year,
34 and is to provide recommendations for legislative or other action
35 that can be undertaken to: 1) improve the quality of maternal care
36 and reduce adverse maternal outcomes in the State; 2) increase the
37 availability of, and improve access to, social and health care
38 services for pregnant women; and 3) reduce or eliminate disparities
39 in maternal care and treatment, both during, and in the year after,
40 pregnancy. Each annual report, with the exception of the first,
41 would additionally be required to identify the extent to which the
42 commission's prior recommendations have been successfully
43 implemented in practice, and the apparent impact that the
44 implementation of such recommended changes has had on maternal
45 care in the preceding year.

46 The commission's annual report is to be based on: 1) the case
47 summaries that were prepared by the commission during the
48 preceding year; 2) the statistical data that was forwarded thereto by

1 the State registrar during the preceding year; and 3) any other
2 relevant information, including information on any collaborative
3 maternal health arrangements that have been established by health
4 care providers, professional organizations, local government units,
5 or other relevant actors or entities in the preceding year, in response
6 to commission outreach.

7 The DOH would be required to post a copy of each commission
8 report on its Internet website, and take appropriate steps to
9 otherwise broadly publicize the commission's findings and
10 recommendations. The Commissioner of Health would also be
11 required to adopt rules and regulations to implement the
12 recommendations contained in each such report, to the extent that
13 those recommendations can be implemented through administrative
14 rule-making action.

15 The DOH, working in consultation with the commission, as well
16 as with relevant professional organizations and patient advocacy
17 groups, will also be required to develop an ongoing maternal health
18 educational program for health care practitioners. Although the
19 program would initially be designed to reflect the findings and
20 recommendations contained in the commission's first report, the
21 DOH would be required to review the program, on at least a
22 biennial basis, and make any necessary changes to ensure that the
23 ongoing education provided thereunder accurately reflects, and is
24 consistent with, the latest data, findings, and recommendations of
25 the commission, as reflected in the commission's most recent
26 report. Each of the State's professional licensing boards, as
27 appropriate, would be required to adopt rules and regulations
28 applicable to the health care practitioners under each board's
29 respective jurisdiction, in order to require those practitioners who
30 are involved in the provision of care to pregnant women to
31 satisfactorily complete the maternal care educational program.
32 Specifically, each board is to require relevant practitioners under its
33 jurisdiction to complete this educational program as a condition of
34 initial licensure, or, in the case of practitioners who are already
35 licensed as of the bill's effective date, within 180 days after the
36 program is established; and to additionally complete the program on
37 a biennial basis thereafter, as a condition of license renewal.

38 The bill would specify that, except as otherwise provided
39 thereby, all proceedings and activities of the commission; all
40 opinions of the commission members, which are formed as a result
41 of the commission's proceedings and activities; and all records
42 obtained, created, or maintained by the commission, are to remain
43 confidential, and will not be subject to public inspection, discovery,
44 subpoena, or introduction into evidence in any civil, criminal,
45 legislative, or other proceeding. The commission will be prohibited
46 from disclosing any personally identifiable information to the
47 public, or including any personally identifiable information in a
48 case summary or annual report prepared pursuant to the bill's

1 provisions. Members of the commission may also not be
2 questioned in any civil, criminal, legislative, or other proceeding
3 regarding information that has been presented in, or opinions that
4 have been formed as a result of, a meeting or communication of the
5 commission; however, this would not prevent a member from being
6 questioned, or from testifying, in relation to publicly available
7 information or information that was obtained independent of the
8 member's participation on the commission. Furthermore, the
9 commission will be authorized to publish case summaries, statistical
10 compilations, or reports that are based on confidential information,
11 so long as those summaries, compilations, and reports do not
12 contain any personally identifying information.

LEGISLATIVE FISCAL ESTIMATE

[Second Reprint]

SENATE, No. 495

STATE OF NEW JERSEY 218th LEGISLATURE

DATED: FEBRUARY 27, 2019

SUMMARY

- Synopsis:** Establishes Maternal Mortality Review Committee to annually review and report on rates and causes of maternal mortality and morbidity in New Jersey, and to recommend improvements in maternal care.
- Type of Impact:** Expenditure and Revenue Increase; General Fund.
- Agencies Affected:** Department of Health.

Office of Legislative Services Estimate

Fiscal Impact	<u>Annual</u>
State Expenditure	Indeterminate Potential Increase
State Revenue	Indeterminate Increase

- The Office of Legislative Services (OLS) concludes that the bill, by establishing in the Department of Health (DOH) the Maternal Mortality Review Committee, the New Jersey Maternal Care Quality Collaborative (NJMCQC), and the Maternal Data Center, would likely increase certain one-time and annual expenditures of the department. However, there is no information available to the OLS on the current cost of the Maternal Mortality Case Review Team which is disbanded by the bill. Accordingly the marginal cost of the bill is indeterminate.
- The OLS also concludes that the bill will result in an increase in revenues. Any annual expenditures associated with the Maternal Data Center will be funded by the collection of maternal data center membership fees, as established by the Commissioner of Health, from health care facilities. Without information on the cost base of the Maternal Data Center and other factors within Executive discretion, the OLS lacks a basis for estimating these revenues.

BILL DESCRIPTION

This bill would establish, in the DOH, the Maternal Mortality Review Committee, the NJMCQC, and the Maternal Data Center.

The Maternal Mortality Review Committee, which would replace the State's existing Maternal Mortality Case Review Team, would be tasked with annually reviewing and reporting on maternal death rates and the causes of maternal death in the State, and providing recommendations to improve maternal care and reduce adverse maternal outcomes. The review team would be disbanded upon the Committee's formation.

Under the bill, the members of the committee would serve without compensation, but may be reimbursed for certain expenses incurred in the discharge of their official duties, within the limits of funds available for such purposes. The DOH would be required to provide administrative staff support to the committee, as necessary, and to employ, at a minimum, the following support staff for the committee: a program manager, a clinical nurse case abstractor, two maternal child health epidemiologists, a case abstraction manager, and any other staff that the commissioner deems necessary.

The committee would have the general power to: 1) adopt, amend, or repeal suitable bylaws; 2) maintain an office; 3) apply for, receive, and accept public or private moneys; 4) enter into agreements or contracts; 5) call to its assistance employees of any State entity or local government unit as may be required and available for the committee's purposes; 6) review and investigate reports of maternal death; 7) solicit and consider public input on the committee's activities; and 8) identify and promote the use of best practices in maternal care.

Among its formal duties, the committee would be required to develop: 1) a mandatory maternal death reporting process for use by the medical provider community; and 2) a voluntary maternal death reporting process for use by the public. In developing the mandatory reporting process required by the bill, the committee would be authorized to review and incorporate elements of the maternal death reporting process that is used by the Maternal Mortality Case Review Team as of the bill's effective date. The DOH would be required to keep a record of all reports of maternal death that are submitted through these processes and to promptly forward a copy of each report to the committee.

At the conclusion of all maternal death investigations, the committee would be required to prepare a de-identified case summary with recommendations for preventative actions. The bill authorizes the committee to present its findings and recommendations to the health care providers where relevant care was provided in the case under investigation.

The bill would require the committee, in collaboration with the Maternal Data Center, the NJMCQC, and other staff, to use the maternal death reports that are forwarded by the DOH, as well as data that is forwarded by the Maternal Data Center, to annually identify: Statewide and regional maternal death rates; trends, patterns, and disparities in adverse maternal outcomes; and medical, non-medical, and system-related factors that may have contributed to maternal deaths and treatment disparities. The committee would further be required to post a copy of this statistical information on the Internet website of the DOH.

In order to facilitate the collection of relevant data and ensure that death records contain the information that is necessary to allow the committee to make the requisite statistical determinations, the bill would amend the State's existing vital records law to clarify that the blanks and forms used for the registration of a vital record are to include, at a minimum, the same information (including pregnancy-related information) that is to be included in standardized U.S. certificates of live birth, death, and fetal death.

Finally, the bill would require the committee to annually report its findings and recommendations on maternal mortality to the DOH, the Governor, and the Legislature. The

DOH would be required to post a copy of each committee report on its Internet website, and take appropriate steps to otherwise broadly publicize the committee's findings and recommendations. The Commissioner of Health would also be required to adopt rules and regulations to implement the recommendations contained in each such report, to the extent that those recommendations can be implemented through administrative rule-making action.

The DOH, working in consultation with the committee, the Perinatal Quality Collaborative, the Maternal Child Health Consortia, and other relevant professional organizations and patient advocacy groups, would also be required to develop, and annually review, an ongoing maternal health educational program for health care practitioners. Prior to the implementation of the Statewide educational program, each hospital and birthing facility in the State is to require its health care practitioners involved in labor, delivery, and postpartum care to complete a standardized maternal patient discharge education module. After the Statewide program is finalized, facilities are to modify existing modules as necessary to conform to the department's program.

The bill would also establish in the DOH the 34-member NJMCQC, which will work to coordinate efforts to adopt and implement a strategic plan to reduce maternal mortality, morbidity, and racial and ethnic disparities in the State by performing such tasks as: supervision and oversight of the committee; applying for and accepting grant money; serving as the State designated entity for the receipt of federal funds; enter into contracts; and develop and publicize statistical information. The public members of the NJMCQC would serve without compensation, and the collaborative would employ an Executive Director, a Program Manager, and any other personnel as authorized by the Commissioner of Health. The DOH would be required to provide administrative staff support to the NJMCQC, as necessary, and other departments and agencies are directed to cooperate with the collaborative.

Finally, the bill would establish a Maternal Data Center in the Healthcare Quality and Informatics Unit in the DOH, which would develop protocols and requirements for the submission of data indicators, collect such data from health care facilities in the State, conduct data analytics, develop reports and a public facing dashboard, and disseminate the collected information to the NJMCQC, the committee, participating healthcare facilities, and other stakeholders. The Maternal Data Center would be required to employ a director, three research scientists, a technical assistant, and any other necessary staff. Under the bill, the Commissioner of Health would be required to establish and collect maternal data center membership fees from health care facilities that provide maternal services in the State, which are to be used to fund the Maternal Data Center.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS concludes that the bill, by establishing in the DOH the Maternal Mortality Review Committee, the NJMCQC, and the Maternal Data Center, would likely increase certain one-time and annual expenditures by the DOH. However, because the OLS has no information on the

current cost of the existing Maternal Mortality Case Review Team, which is disbanded by the bill, the marginal cost of new required positions and related costs is indeterminate.

A significant portion of the annual expenses of supporting two new organizations would be due to salary and benefit costs associated with employing additional staff within the department and as specified by the bill.

The OLS also concludes the bill will result in an increase in State revenue. Any annual expenditures associated with the Maternal Data Center would be funded by the collection of maternal data center membership fees from health care facilities, as established by the Commissioner of Health. Without information on the cost base of the Maternal Data Center and other factors within Executive discretion, the OLS lacks a basis for estimating these revenues.

Expenditures: In total, the bill requires the committee, the NJMCQC, and the Maternal Data Center to employ a minimum of 12 staff members to support the functions of these entities. Furthermore, the DOH would be required to provide administrative support staff for the committee and the NJMCQC, which may require increasing staff or the use of employees' time that might otherwise be spent on other duties. The OLS estimates that the DOH could annually incur \$1.68 million in costs to fulfill these provisions of the bill.

This estimate assumes: 1) the department will hire 12 full-time staff members with benefits, at a cost of \$120,000 each, to fill the positions required under the bill, instead of relying on existing resources; and 2) staff hours used to support the committee and the collaborative would be, at a maximum, equivalent to two full-time-equivalent employees (FTE) and that the salary, equipment, and fringe benefits of a single FTE would total up to \$120,000 annually. Actual costs could differ based on the department's decisions, such as the salary of and hours worked by the positions required under the bill; additional staff deemed necessary by the department to help support these entities; and the job title and salary of the existing staff who provide administrative support to the committee and NJMCQC.

The OLS is unable to determine if, and to what extent, additional staff may be needed beyond the 12 positions enumerated in the bill. Regarding the Maternal Mortality Review Committee, the work of the committee would largely be driven by the number of investigations performed by the committee; however, the OLS cannot predict the effect of this bill on the overall number of investigations. It is possible that the establishment of voluntary reporting procedures for the public, as well as increased outreach by the committee regarding information about maternal death, may result in initial growth in the number of deaths reported and, therefore, investigated. However, over time, the establishment of a maternal health education program for health care practitioners, along with implementation of the committee's annual report recommendations, may result in a general decrease in maternal deaths and, consequentially, investigations.

For reference, the existing New Jersey Maternal Mortality Case Review Team identified a total of 225 maternal deaths between 2009 and 2013. Of the 225 pregnancy associated deaths, CRT determined 78 (34.7 percent) were pregnancy-related, 129 (57.3 percent) were not pregnancy-related, and 18 (8 percent) were undetermined.

In addition to staff costs, other annual expenses may be incurred by the DOH under the bill in collecting maternal death reports; developing publications to publicize and distribute the findings and recommendations issued by the committee, statistical information via the NJMCQC, and data collected by the Maternal Data Center; and maintaining certain information reported on the department's Internet website, as required under the bill.

The bill also requires a variety of one-time costs to establish the infrastructure for the work of the established entities, such as: the development of mandatory and voluntary maternal death reporting processes by the committee, the development of a maternal health education program by the department, the reformatting of certain vital records forms by the State registrar, and the development of a public facing dashboard by the Maternal Data Center to display the Center's

collected data. The OLS notes that certain costs associated with the development of the mandatory reporting process may be minimized by incorporating existing elements of the maternal death reporting process that is currently used by the Maternal Mortality Case Review Team, as authorized under the bill.

Revenue: Certain costs of the bill will be offset by an indeterminate increase in State revenue. Any annual expenditures associated with the Maternal Data Center would be funded by the collection of maternal data center membership fees established by the Commissioner of Health and imposed on health care facilities that provide maternal care services, as defined by the Commissioner. The OLS is unable to quantify the amount of revenue that would be collected under this provision without information on the amount of the fee, the frequency of fee collection, the specific health care facilities on which the fee will be imposed, and the cost base of the Maternal Data Center which the fees are to approximate in total.

Section: Human Services

*Analyst: Sarah Schmidt
Senior Research Analyst*

*Approved: Frank W. Haines III
Legislative Budget and Finance Officer*

This fiscal estimate has been prepared pursuant to P.L.1980, c.67 (C.52:13B-6 et seq.).

SENATE HEALTH, HUMAN SERVICES AND SENIOR
CITIZENS COMMITTEE

STATEMENT TO

SENATE, No. 495

with committee amendments

STATE OF NEW JERSEY

DATED: FEBRUARY 15, 2018

The Senate Health, Human Services and Senior Citizens Committee reports favorably and with committee amendments Senate Bill No. 495.

As amended by the committee, this bill would establish a Maternal Mortality Review Commission in the Department of Health (DOH), which would take the place of the State's existing Maternal Mortality Case Review Team. While the existing review team produces important statistical data, the team is not permanently established by statute, does not meet regularly, produces only periodic reports on maternal mortality, and uses varying datasets in those periodic reports, making the amalgamation and comparison of data by interested parties more difficult. U.S. Senate Bill No. 1112, introduced in the 115th Congress, would establish a federal grant program to assist states in establishing and sustaining state-level maternal mortality review committees, but a state will only be eligible to obtain a grant under this bill if the state's maternal mortality review committee satisfies certain specific requirements. This bill would ensure that the newly established Maternal Mortality Review Commission complies with the provisions of S.1112, so that the State may obtain a grant under its provisions, if and when the bill is enacted.

The Maternal Mortality Review Commission established by the bill would be tasked with annually reviewing and reporting on maternal death rates and the causes of maternal death in the State, and providing recommendations to improve maternal care and reduce adverse maternal outcomes. "Maternal death" includes both pregnancy-associated deaths and pregnancy-related deaths. A "pregnancy-associated death" is one that occurs while the woman is pregnant, or during the one-year period following the date of the end of the pregnancy, irrespective of cause; while a "pregnancy-related death" is one that occurs while the woman is pregnant, or during the one-year period following the date of the end of the pregnancy, regardless of the duration of pregnancy, as a result of a non-accidental or non-incidental cause that is related to, or aggravated by, the pregnancy or its management.

The commission would be required to meet pursuant to a schedule to be established at its first meeting, and at the call of its chairperson or the Commissioner of Health, but in no case would the commission be authorized to meet less than two times a year. The members of the commission would serve without compensation, but would be reimbursed for travel and other necessary expenses incurred in the discharge of their official duties, within the limits of funds appropriated or otherwise made available for such purposes. Upon the appointment of a majority of the commission's members, the existing Maternal Mortality Case Review Team would be disbanded. The DOH would be required to provide administrative staff support to the commission, as necessary.

The Maternal Mortality Review Commission would have the general power to: 1) carry out any power, duty, or responsibility expressly granted under the bill; 2) adopt, amend, or repeal suitable bylaws; 3) maintain an office; 4) apply for, receive, and accept public or private moneys; 5) enter into agreements or contracts, execute instruments, and do and perform any and all acts or things necessary, convenient, or desirable to further its purposes; 6) call to its assistance, and avail itself of the services of, such employees of any State entity or local government unit as may be required and available for the commission's purposes; 7) review and investigate reports of maternal death; conduct witness interviews, and hear testimony provided under oath at public or private hearings, on any material matter; and request, or compel through the issuance of a subpoena, the attendance of relevant witnesses and the production of relevant documents, records, and papers; 8) solicit and consider public input on the commission's activities; and 9) identify, and promote the use of, best practices in maternal care, and encourage and facilitate cooperation and collaboration among health care facilities, health care professionals, administrative agencies, and local government units for the purposes of ensuring the provision of the highest quality maternal care throughout the State.

Among its formal duties, the commission would be required, within 90 days after its organizational meeting, to: 1) develop a mandatory maternal death reporting process, pursuant to which health care practitioners, medical examiners, hospitals, birthing centers, and other relevant professional actors and health care facilities will be required to confidentially report to the DOH on individual cases of maternal death; and 2) develop a voluntary maternal death reporting process, pursuant to which the family members of a deceased woman, and any other interested members of the public, will be permitted, but not required, to confidentially report to the DOH on individual cases of perceived maternal death. In developing the mandatory reporting process required by the bill, the commission would be authorized to review and incorporate elements of the maternal death reporting

process that is used by the Maternal Mortality Case Review Team as of the bill's effective date.

The DOH will be required to keep a record of all reports of maternal death that are submitted thereto through these processes, and will also be required to ensure that a copy of each such report of maternal death is promptly forwarded to the commission, so that the commission may properly execute its other duties and responsibilities under the bill.

The commission will be required to conduct an investigation in association with each report of maternal death that is forwarded thereto by the DOH. In conducting each case investigation, the commission will be required to consider: 1) the forwarded report of maternal death; 2) the deceased woman's medical records, autopsy report or death record, and other relevant vital records; 3) information obtained through interviews of individuals who were directly involved in the care of the woman either during, or immediately following, her pregnancy, and, as deemed to be appropriate and necessary, through interviews of the woman's family members; 4) background information about the deceased woman; and 5) any other information that may shed light on the death.

At the conclusion of an investigation, the commission will be required to prepare a de-identified case summary, which is to include the commission's findings with regard to the cause of, or factors that contributed to, the maternal death, and recommendations for actions that should be undertaken or policies that should be implemented to mitigate or eliminate those factors and causes in the future.

The bill would authorize the commission to present its findings and recommendations on each individual case, or on groups of individual cases, as deemed appropriate, to the health care facility or facilities where relevant care was provided in the case or group of cases, and to the individual health care practitioners who provided such care, or to any relevant professional organization, for the purposes of instituting or facilitating policy changes, educational activities, or improvements in the quality of care provided; or for the purposes of exploring, facilitating, or establishing regional projects or other collaborative projects that are designed to reduce instances of maternal death.

The bill would require the commission to use the maternal death reports that are forwarded by the DOH, as well as statistical data that is forwarded by the State registrar, to identify trends, patterns, and disparities in adverse maternal outcomes, and medical, non-medical, and system-related factors that may have contributed to maternal deaths and treatment disparities. The statistical data that is to be forwarded by the State registrar for these purposes is to include: 1) the total number of maternal deaths that have occurred in the State during the year, and during each quarter of the year; 2) the average Statewide rate of maternal death occurring during the year; 3) the number and percentage of maternal deaths that occurred during the year in each of

the Northern, Central, and Southern regions of the State; 4) the number and percentage of maternal deaths, on a Statewide and regional basis, that constituted pregnancy-associated deaths, and the number and percentage of maternal deaths, on a Statewide and regional basis, that constituted pregnancy-related deaths; and 5) the areas of the State where the rates of maternal death are significantly higher than the Statewide average. The State registrar would be required to provide these statistics to the commission on an annual basis, and would further be required to post a copy of this statistical information on the Internet website of the Office of Vital Statistics and Registry, in the DOH. In order to facilitate the State registrar's analysis, in this regard, and ensure that death records contain the information that is necessary to allow the State registrar to make the requisite statistical determinations, the bill would amend the State's existing vital records law, in order to clarify that the blanks and forms used for the registration of a vital record are to include, at a minimum, the same information (including pregnancy-related information) that is to be included in standardized U.S. certificates of live birth, death, and fetal death.

Finally, the bill would require the commission to annually report its findings and recommendations on maternal mortality to the DOH, the Governor, and the Legislature. Each annual report is to contain the commission's findings on the rates and causes of maternal deaths occurring in the State during the preceding year, and is to provide recommendations for legislative or other action that can be undertaken to: 1) improve the quality of maternal care and reduce adverse maternal outcomes in the State; 2) increase the availability of, and improve access to, social and health care services for pregnant women; and 3) reduce or eliminate disparities in maternal care and treatment, both during, and in the year after, pregnancy. Each annual report, with the exception of the first, would additionally be required to identify the extent to which the commission's prior recommendations have been successfully implemented in practice, and the apparent impact that the implementation of such recommended changes has had on maternal care in the preceding year.

The commission's annual report is to be based on: 1) the case summaries that were prepared by the commission during the preceding year; 2) the statistical data that was forwarded thereto by the State registrar during the preceding year; and 3) any other relevant information, including information on any collaborative maternal health arrangements that have been established by health care providers, professional organizations, local government units, or other relevant actors or entities in the preceding year, in response to commission outreach.

The DOH would be required to post a copy of each commission report on its Internet website, and take appropriate steps to otherwise broadly publicize the commission's findings and recommendations.

The Commissioner of Health would also be required to adopt rules and regulations to implement the recommendations contained in each such report, to the extent that those recommendations can be implemented through administrative rule-making action.

The DOH, working in consultation with the commission, as well as with the Perinatal Quality Collaborative, the Maternal Child Health Consortia, and other relevant professional organizations and patient advocacy groups, will also be required to develop an ongoing maternal health educational program for health care practitioners. Although the program would initially be designed to reflect the findings and recommendations contained in the commission's first report, the DOH would be required to review the program, on at least an annual basis, and make any necessary changes to ensure that the ongoing education provided thereunder accurately reflects, and is consistent with, the latest data, findings, and recommendations of the commission, as reflected in the commission's most recent report.

Each hospital and birthing facility in the State is to additionally require its health care practitioners involved in labor, delivery, and postpartum care to complete a standardized maternal patient discharge education module, pursuant to which such health care practitioners will be educated in the complications of childbirth, and the warning signs of complications in women who have just given birth. This educational module may be implemented in each facility before the department finalizes the Statewide educational program that is to be established under the bill; however, after the Statewide educational program is finalized, the educational modules implemented by facilities are to be modified as necessary to conform to the department's educational program. Any modules implemented before the department's Statewide educational program is finalized are to address the most frequent causes of maternal mortality, including but not limited to, hemorrhage, hypertension, preeclampsia, heart failure and chest pain, infection, embolism, and postpartum depression. Each facility is to additionally provide this information, both orally and in writing, to any woman who has given birth at the facility, prior to discharge. An educational module is to be completed by all relevant health care practitioners at the facility, as a condition of their practice or employment in the facility, and may be used to satisfy relevant continuing education requirements applicable to each such health care practitioner.

The bill would specify that, except as otherwise provided thereby, all proceedings and activities of the commission; all opinions of the commission members, which are formed as a result of the commission's proceedings and activities; and all records obtained, created, or maintained by the commission, are to remain confidential, and will not be subject to public inspection, discovery, subpoena, or introduction into evidence in any civil, criminal, legislative, or other proceeding. The commission will be prohibited from disclosing any

personally identifiable information to the public, or including any personally identifiable information in a case summary or annual report prepared pursuant to the bill's provisions. Members of the commission may also not be questioned in any civil, criminal, legislative, or other proceeding regarding information that has been presented in, or opinions that have been formed as a result of, a meeting or communication of the commission; however, this would not prevent a member from being questioned, or from testifying, in relation to publicly available information or information that was obtained independent of the member's participation on the commission. Furthermore, the commission will be authorized to publish statistical compilations, or reports that are based on confidential information, so long as those compilations and reports do not contain any personally identifying information.

The committee amended the bill to:

- add a legislative findings and declarations section clarifying that the bill's intent is to establish a permanent commission that will replace the existing informal Maternal Mortality Case Review Team operating out of the Department of Health;
- add a definition of "Maternal Mortality Case Review Team," which indicates that the team is being replaced by the commission being established under the bill, and add another provision specifying that the review team will be disbanded upon the appointment of a majority of the commission members;
- add seven new members to the commission membership;
- require the commission to meet at least twice a year (as opposed to four times per year);
- authorize the commission, in establishing a mandatory maternal death reporting process, to review and incorporate elements of the maternal death reporting process that is used by the Maternal Morality Case Review team as of the bill's effective date;
- require the commission to consider all relevant hospital records in association with its investigation of a maternal death (as opposed to requiring the commission to consider only the woman's hospital discharge records);
- specify that a case summary prepared by the commission is to omit identifying information of the deceased woman and her family members, as well as the health care providers who provided care, and the hospitals where care was provided;
- authorize the commission to review any relevant information, including its prior annual reports, when preparing an annual report as required under the bill;
- require the Department of Health to work in consultation with the Perinatal Quality Collaborative, the Maternal Child Health Consortia, and other relevant professional organizations and patient advocacy groups in developing an ongoing maternal health educational

program, and require the department to review the educational program on an annual (rather than a biennial) basis;

- remove language requiring each of the State’s professional licensing boards to adopt rules and regulations to require practitioners who are involved in the provision of care to pregnant women to satisfactorily complete the maternal care educational program established by the department as a condition of licensure or license renewal, and replace with new language calling for hospitals and birthing facilities to implement a maternal health education module, which may be used to satisfy professional continuing education requirements;

- remove language that would have authorized the commission to publish de-identified case summaries;

- require the State Registrar, in providing statistics related to maternal deaths, to identify the rate of racial disparities in maternal deaths occurring on a Statewide and regional basis;

- authorize the State Registrar to use the case ascertainment system devised by the federal Centers for Disease Control and Prevention when identifying maternal deaths; and

- make technical changes.

This bill was pre-filed for introduction in the 2018-2019 session pending technical review. As reported, the bill includes the changes required by technical review, which has been performed.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

[First Reprint]

SENATE, No. 495

with committee amendments

STATE OF NEW JERSEY

DATED: FEBRUARY 7, 2019

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 495 (1R), with committee amendments.

As amended, this bill would establish a Maternal Mortality Review Committee in the Department of Health (DOH), which would take the place of the State's existing Maternal Mortality Case Review Team. While the existing review team produces important statistical data, the team is not permanently established by statute, does not meet regularly, produces only periodic reports on maternal mortality, and uses varying datasets in those periodic reports, making the amalgamation and comparison of data by interested parties more difficult. U.S. Senate Bill No. 1112, introduced in the 115th Congress, would establish a federal grant program to assist states in establishing and sustaining state-level maternal mortality review committees, but a state will only be eligible to obtain a grant under this bill if the state's maternal mortality review committee satisfies certain specific requirements. This bill would ensure that the newly established Maternal Mortality Review Committee complies with the provisions of S.1112, so that the State may obtain a grant under its provisions, if an identical bill is enacted by Congress in the future.

The Maternal Mortality Review Committee established by the bill would be tasked with annually reviewing and reporting on maternal death rates and the causes of maternal death in the State, and providing recommendations to improve maternal care and reduce adverse maternal outcomes.

The committee would be required to meet pursuant to a schedule to be established at its first meeting, and at the call of its chairperson or the Commissioner of Health, but in no case would the committee be authorized to meet less than four times a year. The members of the committee would serve without compensation, but would be reimbursed for travel and other necessary expenses incurred in the discharge of their official duties, within the limits of funds appropriated or otherwise made available for such purposes. Upon the appointment of a majority of the committee's members, the existing Maternal Mortality Case Review Team would be disbanded. The

DOH would be required to provide administrative staff support to the committee.

The Maternal Mortality Review Committee would have the general responsibility and power to review and investigate reports of maternal death; conduct witness interviews, and hear testimony provided under oath at public or private hearings, on any material matter; and request the attendance of relevant witnesses and the production of relevant documents, records, and papers; solicit and consider public input on the committee's activities; and identify, and promote the use of, best practices in maternal care, and encourage and facilitate cooperation and collaboration among health care facilities, health care professionals, administrative agencies, and local government units for the purposes of ensuring the provision of the highest quality maternal care throughout the State.

Among its formal duties, the committee would be required, within 90 days after its organizational meeting, to: 1) develop a mandatory maternal death reporting process for health care facilities and professionals; and 2) develop a voluntary maternal death reporting process for family members of a deceased woman, and any other interested members of the public to confidentially report to the DOH on individual cases of perceived maternal death. In developing the mandatory reporting process required by the bill, the committee would be authorized to review and incorporate elements of the maternal death reporting process that is used by the Maternal Mortality Case Review Team as of the bill's effective date.

The DOH will be required to keep a record of all reports of maternal death that are submitted thereto through these processes, and will also be required to ensure that a copy of each such report of maternal death is promptly forwarded to the committee, so that the committee may properly execute its other duties and responsibilities under the bill. The committee will be required to conduct an investigation in association with each report of maternal death that is forwarded thereto by the DOH. At the conclusion of an investigation, the committee will be required to prepare a de-identified case summary, which is to include the committee's findings with regard to the cause of, or factors that contributed to, the maternal death, and recommendations for actions that should be undertaken or policies that should be implemented to mitigate or eliminate those factors and causes in the future.

The bill would authorize the committee to present its findings and recommendations on each individual case, or on groups of individual cases, as deemed appropriate, to the health care facility or facilities where relevant care was provided in the case or group of cases, and to the individual health care practitioners who provided such care, or to any relevant professional organization, for the purposes of instituting or facilitating policy changes, educational activities, or improvements in the quality of care provided; or for the purposes of exploring,

facilitating, or establishing regional projects or other collaborative projects that are designed to reduce instances of maternal death.

The bill would require the committee to use the maternal death reports that are forwarded by the DOH and statistical data forwarded by the State registrar to identify trends, patterns, and disparities in adverse maternal outcomes, and medical, non-medical, and system-related factors that may have contributed to maternal deaths and treatment disparities. In order to facilitate the State registrar's collection of relevant data and ensure that death records contain the information that is necessary to allow the committee to make the requisite statistical determinations, the bill would amend the State's existing vital records law to clarify that the blanks and forms used for the registration of a vital record are to include, at a minimum, the same information (including pregnancy-related information) that is to be included in standardized U.S. certificates of live birth, death, and fetal death.

Finally, the bill would require the committee to annually report its findings and recommendations on maternal mortality to the DOH, the Governor, and the Legislature. Each annual report is to contain the committee's findings on the rates and causes of maternal deaths occurring in the State during the preceding year, and is to provide recommendations for legislative or other action that can be undertaken. Each annual report, with the exception of the first, would additionally be required to identify the extent to which the committee's prior recommendations have been successfully implemented in practice, and the apparent impact that the implementation of such recommended changes has had on maternal care in the preceding year. The DOH would be required to post a copy of each committee report on its Internet website, and take appropriate steps to otherwise broadly publicize the committee's findings and recommendations. The Commissioner of Health would also be required to adopt rules and regulations to implement the recommendations contained in each such report, to the extent that those recommendations can be implemented through administrative rule-making action.

The DOH, working in consultation with the committee, as well as with the Perinatal Quality Collaborative, the Maternal Child Health Consortia, and other relevant professional organizations and patient advocacy groups, will also be required to develop an ongoing maternal health educational program for health care practitioners. Although the program would initially be designed to reflect the findings and recommendations contained in the committee's first report, the DOH would be required to review the program, on at least an annual basis, and make any necessary changes to ensure that the ongoing education provided thereunder accurately reflects, and is consistent with, the latest data, findings, and recommendations of the committee, as reflected in the committee's most recent report.

Each hospital and birthing facility in the State is to additionally require its health care practitioners involved in labor, delivery, and postpartum care to complete a standardized maternal patient discharge education module, pursuant to which such health care practitioners will be educated in the complications of childbirth, and the warning signs of complications in women who have just given birth. This educational module may be implemented in each facility before the department finalizes the Statewide educational program that is to be established under the bill; however, after the Statewide educational program is finalized, the educational modules implemented by facilities are to be modified as necessary to conform to the department's educational program. Any modules implemented before the department's Statewide educational program is finalized are to address the most frequent causes of maternal mortality, including but not limited to, hemorrhage, hypertension, preeclampsia, heart failure and chest pain, infection, embolism, and postpartum depression. Each facility is to additionally provide this information, both orally and in writing, to any woman who has given birth at the facility, prior to discharge. An educational module is to be completed by all relevant health care practitioners at the facility, as a condition of their practice or employment in the facility, and may be used to satisfy relevant continuing education requirements applicable to each such health care practitioner.

The bill would specify that, except as otherwise provided thereby, all proceedings and activities of the committee; all opinions of the committee members, which are formed as a result of the committee's proceedings and activities; and all records obtained, created, or maintained by the committee, are to remain confidential, and will not be subject to public inspection, discovery, subpoena, or introduction into evidence in any civil, criminal, legislative, or other proceeding. The committee will be prohibited from disclosing any personally identifiable information to the public, or including any personally identifiable information in a case summary or annual report prepared pursuant to the bill's provisions. Members of the committee may also not be questioned in any civil, criminal, legislative, or other proceeding regarding information that has been presented in, or opinions that have been formed as a result of, a meeting or communication of the committee; however, this would not prevent a member from being questioned, or from testifying, in relation to publicly available information or information that was obtained independent of the member's participation on the committee. Furthermore, the committee will be authorized to publish statistical compilations, or reports that are based on confidential information, so long as those compilations and reports do not contain any personally identifying information.

As amended and reported, this bill is identical to Assembly Bill No.1862 (1R), as also amended and reported by the committee.

COMMITTEE AMENDMENTS:

The committee amendments to the bill:

- Establish in the Department of Health a 34-member New Jersey Maternal Care Quality Collaborative, which will work to coordinate efforts and strategies to reduce maternal mortality, morbidity, and racial and ethnic disparities in the State;
- Change the designation of the Maternal Mortality Review Commission to the Maternal Mortality Review Committee;
- Change the membership of the Maternal Mortality Review Committee to a total of 24 members, including four ex officio members and 20 public members;
- Specify that the Department of Health must employ a program manager, a clinical nurse care abstractor, two maternal child health epidemiologists, a case abstraction manager, and any other staff the Commissioner of Health shall deem necessary to support the committee;
- Shift responsibilities of the State Registrar under the bill to the Maternal Mortality Review Committee;
- Make certain changes to required maternal death reporting processes;
- Establish in the Healthcare Quality and Informatics Unit of the Department of Health a Maternal Data Center, which will develop protocols concerning, collect, and analyze maternal mortality, morbidity and racial and ethnic disparity data, and disseminate this information;
- Require the Commissioner of Health to establish and collect Maternal Data Center membership fees from health care facilities that provide maternal care services in the State, which will fund the Maternal Data Center; and
- Make a variety of technical and stylistic changes.

FISCAL IMPACT:

The Office of Legislative Services (OLS) concludes that the bill, by establishing a Maternal Mortality Review Committee, New Jersey Maternal Care Quality Collaborative, and Maternal Data Center in the Department of Health (DOH) and requiring the department to support the work of all three entities, will increase expenditures by the DOH. The department will also incur expenses under the bill due to the requirements imposed upon the State registrar regarding the collection of certain statistical information. The bill specifies minimum staff positions to support each newly created entity, and permits the hiring of additional staff beyond those required. The new entities will also incur costs for facilities, equipment, travel, and other expenses. Without information from the Executive, the OLS cannot quantify these costs.

The OLS notes that the collection of certain fees, as established by the Commissioner of Health under the bill, will offset the expenses associated with the Maternal Data Center. The OLS further notes that certain expenses of the committee may be minimized or absorbed by the DOH's existing operational budget as a function of the committee replacing the existing Maternal Mortality Case Review Team within the department. In addition, any State costs may be offset by federal or private funds pursued by and awarded to the committee.



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Newark, N.J.

Governor Murphy Signs Legislation to Establish Maternal Mortality Review Committee

05/01/2019

TRENTON – Governor Phil Murphy today signed legislation (A1862) to establish a Maternal Mortality Review Committee to annually review and report on rates and causes of maternal mortality and morbidity in New Jersey, and to recommend improvements in maternal care.

“Improving health outcomes for New Jersey’s mothers is a vital component of tackling the maternal and infant health crisis,” **said Governor Phil Murphy**. “This legislation will allow us to take a comprehensive approach to analyzing data and finding solutions to address maternal mortality and morbidity in our state. I commend my partners in Legislature for working with me to build a stronger, fairer and healthier New Jersey.”

“New Jersey’s maternal mortality rates are alarming, and for women and infants of color the statistics are even more distressing,” **said First Lady Tammy Murphy**. “Today’s bill signing is a critical step forward in combatting the maternal and infant health crisis. From examining data to determining economic and social factors that contribute to maternal mortality, we are working every angle to better serve New Jersey’s mothers, babies and families.”

“This bill formally enshrines a critical group that helps us learn from tragic maternal deaths across NJ,” **said New Jersey Department of Health Commissioner Shereef Elnahal**. “Importantly, it also empowers us to convene stakeholders across government and the health care system to respond by improving the quality and safety of maternity care—with a particular focus on eliminating the shameful disparities in outcomes for Black women. I applaud the Governor and the Legislature for bringing us one step closer to breaking the back of institutional racism and its legacy on maternal-child health.”

Primary sponsors of the bill include Senators Joseph Vitale, Teresa Ruiz, and Nellie Pou; and Assemblymembers Pamela Lampitt, Raj Mukherji, Valerie Vainieri Huttler, and Shavonda Sumter.

“Race, ethnicity and socioeconomic standings should never influence the quality of maternal care a woman receives,” **said Senate President Pro Tempore Teresa Ruiz**. “Far too often we see the concerns of women of color fall on deaf ears, at times leading to catastrophic birth and post-partum complications. Tracking maternal care outcomes and continuously searching for ways to improve best practices will ensure that improving maternal mortality is an ongoing effort.”

“Our maternal mortality rates are unacceptable by any standard, and action must be taken,” **said Senator Joe Vitale**. “But if we want to be sure we are taking the right action, we need to know we have the right information. Formalizing the review committee will not only help centralize the data, it will open avenues for greater federal funding. These two together will ensure that once we know the most effective way to help the mothers of New Jersey, we will also be able to afford to take the appropriate steps.”

“How can we expect to fully understand the problem of maternal mortality in the State of New Jersey if we don’t have the information we need in a centralized database,” **said Senator Nellie Pou.** “I am proud to have sponsored this effort, and I look forward to seeing the benefits of knowing the exact scope of the problem. It is then, that we can truly determine the best course of action to take to help our mothers and their babies in this state.”

“It’s heartbreaking to think that the United States has the highest maternal mortality rate in the industrialized world, and it’s also unacceptable,” **said Assemblywoman Pamela Lampitt.** “The Commission created under this new law will help us further understand why our mothers are dying at such a high rate, and how we can change that. We owe it not only to our mothers, but to their partners and children to make New Jersey a leader in women’s health.”

“New Jersey’s maternal mortality rate is almost double the national average, with 37.3 pregnancy-associated or pregnancy-related deaths for every 100,000 live births,” **said Assemblyman Raj Mukherji.** “It is imperative that we figure out why New Jersey mothers are dying at an unprecedented rate in a state with high-quality healthcare. Collecting and investigating the data will enable us to develop solutions to prevent further tragedy.”

“Information and knowledge are the only way to combat this overlooked tragedy,” **said Assemblywoman Valerie Vainieri Huttle.** “In order to tackle this problem head-on, we must first understand why and how this is a problem. Then we can determine how to promote best practices in maternal care for all New Jersey mothers.”

“These maternal mortality rates are extremely unsettling,” **said Assemblywoman Shavonda Sumter.** “This Commission will allow us to look closely as to what could be causing them. I’m interested in hearing directly from the community as part of the public hearings - all of this will help us gain better insight on how we can reverse this disturbing trend.”

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