26:6C-1 to 26:6C-16 and 26:8-24
LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2019 **CHAPTER:** 75

NJSA: 26:6C-1 to 26:6C-16 and 26:8-24 (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.)

BILL NO: A1862 (Substituted for S495)

SPONSOR(S) Pamela L. Lampitt and others

DATE INTRODUCED: 1/9/2018

COMMITTEE: **ASSEMBLY:** Women & Children

SENATE: Budget & Appropriations

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** 3/25/2019

SENATE: 2/21/2019

DATE OF APPROVAL: 5/1/2019

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (Third Reprint enacted) Yes

A1862

SPONSOR'S STATEMENT: (Begins on page 12 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes Women & Children

SENATE: Yes Budget & Appropriations

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: Yes

LEGISLATIVE FISCAL ESTIMATE: Yes 6/12/2018
3/8/2019

S495

SPONSOR'S STATEMENT: (Begins on page 12 of introduced bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes Health, Hum. Serv. & Senior Cit.
Budget & Appropriations

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

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(continued)

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GOVERNOR'S PRESS RELEASE ON SIGNING: Yes

FOLLOWING WERE PRINTED:

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REPORTS: No

HEARINGS: No

NEWSPAPER ARTICLES: Yes

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)***

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

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

[1]1. (New section) The Legislature finds and declares that:

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

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

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

d. [2]**[**According to the DOH Maternal Mortality Case Review Team's latest report, which covers the period from 2009 to 2013, New Jersey ranks 35th of the 50 states in pregnancy-related deaths; however, it is important to note that pregnancy-related deaths make up only a single subset of the total maternal deaths that have occurred in the State, and a**]** A[2] document produced by Every Mother Counts shows that New Jersey is ranked [2]**[**47th**]** 46th[2] of the 50 states in total maternal mortality, with a rate of 37.3 maternal deaths per every 100,000 live births [2]and 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:
[1]Assembly AWC committee amendments adopted March 12, 2018.
[2]Senate SBA committee amendments adopted February 7, 2019.
[3]Senate floor amendments adopted February 21, 2019.

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

e. While the DOH Maternal Mortality Case 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 [2][amalgamation] aggregation[2] and comparison of data by interested parties more difficult;

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

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

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

[f.] i.[2] United States 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; however, 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, as articulated in S.1112; [2]and

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

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

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

[2]["Commission"] "Committee"[2] means the Maternal Mortality Review [2][Commission] Committee[2], established pursuant to section [1][2] [2][3[1]] 4[2] of this act, which is responsible for annually reviewing and reporting on maternal death rates and the causes of maternal death in the State, and which is further responsible for providing recommendations to improve maternal care and reduce adverse maternal outcomes.

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

"Department" means the Department of Health.

"Maternal death" means a pregnancy-associated death [2][, or a pregnancy-related death][2].

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

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

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

"Pregnancy-related death" means the death of a woman, which 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 the pregnancy, and which results from any cause related to, or aggravated by, the pregnancy or its management, but excluding any accidental or incidental cause.

"Report of maternal death" means a report of [2][actual or perceived] a suspected[2] maternal death, which is filed with the department, pursuant to the processes established under subsection a. of section [1][5] [2][6[1]] 7[2] of this act, and which is to be forwarded to the [2][commission] committee[2] for the purposes of investigation, as provided by subsection b. of that section.

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

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

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

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

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

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

the Commissioner of Health;

the Commissioner of Human Services;

the Commissioner of Banking and Insurance;

the Commissioner of Children and Families;

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

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

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

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

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

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

the New Jersey Hospital Association;

the New Jersey Health Care Quality Institute;

the Catholic HealthCare Partnership of New Jersey;

the Hospital Alliance of New Jersey;

the Fair Share Hospitals Collaborative;

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

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

the New Jersey Medical Society;

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

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

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

Planned Parenthood of New Jersey;

the New Jersey Association of Osteopathic Physicians and Surgeons;

the New Jersey Primary Care Association;

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

the Central Jersey Family Health Consortium;

the Southern New Jersey Perinatal Cooperative;

each of the three Accountable Care Organizations established pursuant to P.L.2011, c. 114 or any successor organization to that Accountable Care Organization; and

three additional public members appointed on the recommendation of the Commissioner of Health, one who is engaged in maternal health advocacy; one who is engaged in health equity advocacy; and one who is engaged in healthcare consumer advocacy.

d. The public members of the NJMCQC shall serve without compensation and shall each serve for a term of three years. Each public member shall serve for the term of appointment and shall serve until a successor is appointed and qualified, except that a public member may be reappointed to the NJMCQC upon the expiration of their term. Any vacancy in the membership shall be filled, for the unexpired term, in the same manner as the original appointment.

e. The NJMCQC shall adopt and implement the strategic plan for the State of New Jersey to reduce maternal mortality, morbidity and racial and ethnic disparities. The NJMCQC shall meet quarterly to coordinate activities that forward the strategic plan, strategize on future activities, solicit funding opportunities, focus on translating the data collected by, the Maternal Data Center, the Healthcare Quality and Informatics Unit, the Maternal Mortality Review Committee, the Department of Health, and its partners into action items, and communicate goals and achievement of these goals with stakeholders.

f. The NJMCQC shall:

(1) Employ an Executive Director, a Program Manager, and any other personnel as authorized by the Commissioner of Health. The Department of Health shall provide such administrative staff support to the NJMCQC as shall be necessary for the NJMCQC to carry out its duties. The director shall be appointed by the commissioner and shall serve at the pleasure of the commissioner during the commissioner's term of office and until the appointment and qualification of the director's successor;

(2) Apply for and accept any grant of money from the federal government, private foundations or other sources, which may be

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

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

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

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

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

1[2.**]** **2[**3.**1]** 4.**2** (New section) a. There is hereby established, in the Department of Health, the Maternal Mortality Review **2[**Commission**]** Committee**2**, which shall 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 **2**severe**2** adverse outcomes related to, or associated with, pregnancy. **1**The **2[**commission**]** committee**2** shall replace and supersede the Maternal Mortality Case Review Team that is currently constituted in the department.**1** The **2[**commission**]** committee**2** shall be composed of **1[**31**] 2[**38**1]** 24**2** members, including **1[**18**] 2[**25**1]** 4**2** ex officio members **2[**or their designees,**]2** as provided in subsection b. of this section, and **2[**13**]** 20**2** public members, as provided in subsection c. of this section.

b. The ex officio members of the **2[**commission**]** committee**2** shall include the following persons, or their designees: **2[**(1) the State registrar**]**

(2)**]2** the State Medical Examiner;

2[(3) the Director of the Division of Family Health Services in the Department of Health;

(4)**]2** the Director of the Office of Emergency Medical Services in the Department of Health;

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

[2][(6)][2] the [2]Medical[2] Director of the Division of Medical Assistance and Health Services in the Department of Human Services;

[2][(7) the President of the New Jersey Hospital Association;

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

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

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

(11) the Chair of the New Jersey section of the American [1][Congress] College[1] of Obstetricians and Gynecologists [1](ACOG)[1];

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

(13) [1]the Chair of the New Jersey Section of the Association of Women's Health Obstetric and Neonatal Nurses (AWHONN);

(14) the President of the New Jersey Chapter of the American College of Emergency Physicians;

(15) the President of the New Jersey Association of Osteopathic Physicians and Surgeons;

(16) the President of the New Jersey Academy of Family Physicians;

(17) the President of the New Jersey Chapter of the American Academy of Pediatrics;

(18) the President of the New Jersey Health Officers Association;

(19) the President of the New Jersey Primary Care Association;

(20)[1] the Executive Director of the Partnership for Maternal and Child Health of Northern New Jersey;

[1][(14)] (21)[1] the Chief Executive Officer of the Central Jersey Family Health Consortium;

[1][(15)] (22)[1] the Executive Director of the Southern New Jersey Perinatal Cooperative;

[1][(16)] (23)[1] the Director of the City of Newark Department of Health and Community Wellness;

[1][(17)] (24)[1] the Director of the City of Trenton Health and Human Services Department; and

[1][(18)] (25)[1] the Director of the Camden County Department of Health and Human Services.][2]

c. [2](1) Seven of the public members shall be appointed by the Governor to represent the following groups:

the New Jersey section of the American College of Obstetricians and Gynecologists (ACOG);

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

the New Jersey Section of the Association of Women's Health Obstetric and Neonatal Nurses (AWHONN);

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

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

the Central Jersey Family Health Consortium; and

the Southern New Jersey Perinatal Cooperative.

(2)[2] The [2]additional 13[2] public members of the [2]**[**commission**]** committee[2] shall be appointed by the [2]**[**Governor**]** Commissioner of Health, to reflect the diversity in the state's geographic regions and perinatal designations[2] and shall include:

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

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

one[2] substance use disorder treatment professional who specializes in perinatal addiction;

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

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

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

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

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

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

(9) one private citizen who is engaged in patient advocacy**]** ; and

one Certified Midwife or Certified Professional Midwife[2].

d. Of the [2]13[2] public members appointed to the [2]**[**commission**]** committee by the Commissioner of Health[2], not more than seven shall be of the same political party.

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

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

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

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

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

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

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

d. The members of the ²[commission] committee² shall serve without compensation, but shall 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.

e. ²The Department of Health shall 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 the Commissioner of Health shall deem necessary.² The Department of Health shall ²also² provide such administrative staff support to the ²[Commission] committee² as shall be necessary for the ²[commission] committee² to carry out its duties.

[1][4.] [2][5.[1]] 6.[2] (New section) a. The Maternal Mortality Review [2][Commission] Committee[2] shall have the power to:

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

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

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

(4) apply for, receive, and accept, from any federal, State, or other public or private source, grants, loans, or other moneys that are made available for, or in aid of, the [2][commission's] committee's[2] authorized purposes, or that are made available to assist the [2][commission] committee[2] in carrying out its powers, duties, and responsibilities under this act;

(5) enter into any and all agreements or contracts, execute any and all instruments, and do and perform any and all acts or things necessary, convenient, or desirable to further the purposes of the [2][commission] committee[2];

(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 [2][commission's] committee's[2] 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 [1][, or compel through the issuance of a subpoena,][1] [2], or compel through the issuance of a subpoena,[2] the attendance of relevant witnesses and the production of relevant documents, records, and papers;

(8) solicit and consider public input and comment on the [2][commission's] committee's[2] activities by periodically holding public hearings or conferences, and by providing other opportunities for such input and comment by interested parties; 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.

b. The Maternal Mortality Review [2][Commission] Committee[2] shall have the duty and responsibility to:

(1) develop mandatory and voluntary maternal death reporting processes, in accordance with the provisions of section [2][5] 7[2] of this act [2]and, at a minimum meet or exceed current federal Centers for Disease Control and Prevention reporting methodologies[2];

(2) conduct an investigation of each reported case of maternal death, and prepare a de-identified case summary for each such case,

in accordance with the provisions of section [1]⟦6⟧ [2]⟦7[1]⟧ 8[2] of this act;

(3) review the statistical data on maternal deaths that is forwarded by the [2]⟦State registrar, pursuant to section [1]⟦10⟧ 11[1] of this act⟧ Maternal Data Center pursuant to section 14 of this act[2], and the reports of maternal death that are forwarded by the department, pursuant to subsection b. of section [1]⟦5⟧ [2]⟦6[1]⟧ 7[2] of this act, in order to 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; and

(5) annually report its findings and recommendations on maternal mortality to the department, the Governor, and the Legislature, in accordance with section [1]⟦7⟧ [2]⟦8[1]⟧ 9[2] of this act.

[1]⟦5.⟧ [2]⟦6.[1]⟧ 7.[2] (New section) a. Within 90 days after the [2]⟦commission's⟧ committee's[2] organizational meeting, the [2]⟦commission⟧ committee[2] shall:

(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 Department of Health on individual cases of maternal death [1]. In developing a mandatory maternal death reporting process pursuant to this paragraph, the [2]⟦commission⟧ committee[2] may, as deemed to be appropriate, review and incorporate elements of the maternal death reporting process that is used by the Maternal Mortality Case Review Team as of the effective date of this act[1]; 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 Department of Health on individual cases of perceived maternal death. At a minimum, the process developed pursuant to this paragraph shall require the department to: (a) post on its Internet website a hyperlink, a toll-free telephone number, and an email address, which may each be used for the voluntary submission of public reports of maternal death; and (b) publicize the availability of these resources to professional organizations, community organizations, social service agencies, and members of the public.

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

committee[2], so that the [2]⟦commission⟧ committee[2] may properly execute its investigatory functions and other duties and responsibilities under this act.

[1]⟦6.⟧ [2]⟦7.[1]⟧ 8.[2] (New section) a. Upon receipt of a report of maternal death, which has been forwarded to the [2]⟦commission⟧ committee[2] pursuant to subsection b. of section [1]⟦5.⟧ [2]⟦6.[1]⟧ 7[2] of this act, the [2]⟦commission⟧ committee[2] shall investigate the reported case in accordance with the provisions of this section. In conducting the investigation, the [2]⟦commission⟧ committee[2] shall consider:

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

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

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

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

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

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

b. At the conclusion of an investigation conducted pursuant to this section, the [2]⟦commission⟧ committee[2] shall prepare a case summary, which shall include the [2]⟦commission's⟧ committee's[2] findings with regard to the cause of, or the 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. Any case summary prepared pursuant to this subsection shall omit the

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

c. The [2]**[**commission**]** committee[2] may 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.

[1]**[**7.**]** [2]**[**8.[1]**]** 9.[2] (New section) a. Within one year after its organization, and annually thereafter, the [2]**[**commission**]** committee[2] shall prepare, and submit to the Department of Health, to the Governor, and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature, a report containing the [2]**[**commission's**]** committee's[2] findings on the rates and causes of maternal deaths occurring in the State during the preceding year, and providing recommendations for legislative or other action that can be undertaken to: (a) improve the quality of maternal care and reduce adverse maternal outcomes in the State; (b) increase the availability of, and improve access to, social and health care services for pregnant women; and (c) reduce or eliminate [1]racial and other[1] disparities in maternal care and treatment, both during, and in the year after, pregnancy. Each annual report, with the exception of the first report prepared under this section, shall additionally identify the extent to which the [2]**[**commission's**]** committee's[2] 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.

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

(1) the case summaries that were prepared by the [2]**[**commission**]** committee[2] over the preceding year, pursuant to subsection b. of section [1]**[**6**]** [2]**[**7[1]**]** 8[2] of this act;

(2) the statistical data that was forwarded to the [2]**[**commission**]** committee[2], during the preceding year, by the [2]**[**State registrar**]** Maternal Data Center[2], pursuant to section [1]**[**10**]** [2]**[**11[1]**]** 14[2] of this act; and

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

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 the [2]⟦commission⟧ committee[2] outreach authorized by subsection c. of section [1]⟦6.⟧ [2]⟦7.[1]⟧ 8 of this act[2], or by paragraph (9) of subsection a. of section [1]⟦4.⟧ [2]⟦5[1]⟧ 6[2], of this act.

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

[1]⟦8.⟧ [2]⟦9.[1]⟧ 10.[2] (New section) a. Upon receipt of the [2]⟦commission's⟧ committee's[2] first annual report, issued pursuant to section [1]⟦7.⟧ [2]⟦8.[1]⟧ 9[2] of this act, the department, working in consultation with the [2]⟦commission⟧ committee[2], [1]⟦as well as with⟧ the Perinatal Quality Collaborative, the Maternal Child Health Consortia, and other[1] relevant professional organizations and patient advocacy groups, shall develop an ongoing maternal health educational program for health care practitioners, as may be necessary to improve the quality of maternal care and reduce adverse outcomes related to, or associated with, pregnancy. The educational program established pursuant to this section shall initially be based on, and shall reflect, the findings and recommendations identified in the [2]⟦commission's⟧ committee's[2] first report. However, once the educational program is established, the department shall, on at least [1]⟦a biennial⟧ an annual[1] basis thereafter, review the program and make necessary changes to ensure that the ongoing education provided thereunder accurately reflects, and is consistent with, the latest data, findings, and recommendations of the [2]⟦commission⟧ committee[2], as reflected in the [2]⟦commission's⟧ committee's[2] most recent annual report.

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

educational program as a condition of initial licensure, or, in the case of practitioners who are already licensed as of the effective date of this act, within 180 days after the program is established under this section; and shall additionally require practitioners to complete the program on at least a biennial basis thereafter, as a condition of license renewal.] Each hospital and birthing facility in the State shall 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 subsection a. of this section; however, after the Statewide educational program is finalized under subsection a. of this section, the educational modules implemented pursuant to this subsection shall be modified as necessary to conform to the department's educational program. Any modules implemented before the department's Statewide educational program is finalized shall 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 shall additionally provide this information, both orally and in writing, to any woman who has given birth at the facility, prior to discharge. The educational module implemented under this subsection shall 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.

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

[1][9.] [2][10.[1]] 11.[2] (New section) a. (1) Except as otherwise provided by subsection b. of this section, all proceedings and activities of the Maternal Mortality Review [2][Commission] Committee[2]; all opinions of the members of the [2][commission] committee[2], which are formed as a result of the [2][commission's] committee's[2] proceedings and activities; and all records obtained, created, or maintained by the [2][commission] committee[2], including written reports and records of interviews or oral statements, shall be confidential, and shall not be subject to public inspection, discovery, subpoena, or introduction into evidence in any civil, criminal, legislative, or other proceeding.

(2) In no case shall the [2]⟦commission⟧ committee[2] disclose any personally identifiable information to the public, or include any personally identifiable information in a case summary that is prepared pursuant to subsection b. of section [1]⟦6.⟧ [2]⟦7[1]⟧ 8[2] of this act, or in an annual report that is prepared pursuant to section [1]⟦7.⟧ [2]⟦8[1]⟧ 9[2] of this act.

(3) Members of the [2]⟦commission⟧ committee[2] shall 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 [2]⟦commission⟧ committee[2]; however, nothing in this paragraph shall prohibit a [2]⟦commission⟧ committee[2] 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 [2]⟦commission⟧ committee[2].

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

[1]⟦10.⟧ [2]⟦11[1]⟧ 12.[2] (New section) a. (1) On an annual basis, and using the death records that have been filed during the preceding year, the [2]⟦State registrar⟧ Maternal Mortality Review Committee[2] shall [2]work collaboratively with the Maternal Data Center in the Healthcare Quality and Informatics Unit, NJMCQC's Maternal Health epidemiologists and other staff to[2] identify: (a) the total number of maternal deaths that have occurred in the State during the year, and during each quarter of the year; (b) the average Statewide rate of maternal death occurring during the year; (c) the number and percentage of maternal deaths that occurred during the year in each of the Northern, Central, and Southern regions of the State; (d) 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; [1]⟦and⟧[1] (e) the areas of the State where the rates of maternal death are significantly higher than the Statewide average [1]; and (f) the rate of racial disparities in maternal deaths occurring on a Statewide and regional basis[1] .

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

Registry, in]² the Department of Health, and shall also be promptly forwarded to the ²[commission] NJMCQC².

b. In order to accomplish its duties under this section, the ²[State registrar] Maternal Mortality Review Committee² shall:

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

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

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

¹[11.] ²[12¹] 13.² R.S.26:8-24 is amended to read as follows:

26:8-24. The State registrar shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

j. Facilitate the provision of relevant statistical data on maternal deaths to the Maternal Mortality Review **[**2**]** Commission**]** Committee, in accordance with the provisions of section **[**1**]** 10.**]** **[**2**]** 11**]** 12 of P.L. , c. (C.) (pending before the Legislature as this act).

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

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

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

[2]15. (New section) The Commissioner of Health shall establish and collect maternal data center membership fees from health care facilities, as defined by the Commissioner of Health, that [3]are licensed to[3] provide maternal care services in the State [3]and that enter into a written agreement with the Department of Health to participate in the Maternal Data Center pursuant to section 14 of this act. The membership fee shall be required of each licensed facility participating in the Maternal Data Center, and in no case shall the amount of the fee exceed $10,000 per facility per year. Each participating facility shall pay its annual membership fee on a date as shall be required by the commissioner[3]. The revenue from these fees shall be used to fund the Maternal Data Center to implement the requirements pursuant to section 14 of this act.[2]

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

[3]16. (New section) a. There is established the "Maternal Data Center Fund" as a nonlapsing, revolving fund in the Department of Health. The fund shall be comprised of membership fees collected from facilities licensed to provide maternal care services that enter into a written agreement with the Department of Health to participate in the Maternal Data Center pursuant to section 15 of this act as well as any other funds collected by the department pursuant to section 15 of this act.

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

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

[3][[2]16.] 17.[3] (New section) The Commissioner of Health shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), to effectuate the purposes of this act.[2]

[1][12.] [2][13.[1]] [3][17.[2]] 18.[3] This act shall take effect immediately.

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.

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)

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

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

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

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

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Maternal death" means a pregnancy-associated death, or a pregnancy-related death.

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

"Pregnancy-related death" means the death of a woman, which 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 the pregnancy, and which results from any cause related to, or aggravated by, the pregnancy or its management, but excluding any accidental or incidental cause.

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

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

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

2. (New section) a. There is hereby established, in the Department of Health, the Maternal Mortality Review Commission, which shall be tasked with annually reviewing and reporting on 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 <u>thus</u> is new matter.

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

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

(1) the State registrar;

(2) the State Medical Examiner;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) one licensed and practicing health care practitioner, mental health care practitioner, or substance use disorder treatment professional who specializes in perinatal addiction;

(3) one certified nurse midwife;

(4) one registered professional nurse or advanced practice nurse who specializes in hospital-based obstetric nursing;

(5) one licensed practical nurse, registered professional nurse, or advanced practice nurse who participates in, and represents, the Nurse-Family Partnership operating in New Jersey;

(6) one health care administrator who has experience in overseeing the operations of maternity wards or birthing centers;

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

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

(9) one private citizen who is engaged in patient advocacy.

d. Of the public members appointed to the commission, not more than seven shall be of the same political party.

e. Each public member of the commission shall serve for a term of four years; however, of the public members first appointed, four shall serve an initial term of two years, four shall serve an initial term of three years, and five shall serve an initial term of four years. Each public member shall serve for the term of their appointment, and until a successor is appointed and qualified, except that a public member may be reappointed to the commission upon the expiration of their term. Any vacancy in the membership shall be filled, for the unexpired term, in the same manner as the original appointment.

f. All initial appointments to the commission shall be made within 60 days after the effective date of this act.

g. Any member of the commission may be removed by the Governor, for cause, after a public hearing.

3. (New section) a. The commission shall organize as soon as practicable following the appointment of a majority of its members, and shall annually elect a chairperson and vice-chairperson from among its members. The chairperson may appoint a secretary, who need not be a member of the commission.

b. The commission shall meet pursuant to a schedule to be established at its first meeting, and it shall additionally meet at the call of its chairperson or the Commissioner of Health; however, in no case shall the commission meet less than four times a year.

c. A majority of the total number of members appointed to the commission shall constitute a quorum for the conducting of official commission business. A vacancy in the membership of the commission shall not impair the right of the commission to exercise its powers and duties, provided that a majority of the currently appointed members are available to conduct business. Any

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

d. The members of the commission shall serve without compensation, but shall 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.

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

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

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

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

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

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

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

(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 and comment on the commission's activities by periodically holding public hearings or conferences, and by providing other opportunities for such input and comment by interested parties; 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.

b. The Maternal Mortality Review Commission shall have the duty and responsibility to:

(1) develop mandatory and voluntary maternal death reporting processes, in accordance with the provisions of section 5 of this act;

(2) conduct an investigation of each reported case of maternal death, and prepare a de-identified case summary for each such case, in accordance with the provisions of section 6 of this act;

(3) review the statistical data on maternal deaths that is forwarded by the State registrar, pursuant to section 10 of this act, and the reports of maternal death that are forwarded by the department, pursuant to subsection b. of section 5 of this act, in order to 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; and

(4) annually report its findings and recommendations on maternal mortality to the department, the Governor, and the Legislature, in accordance with section 7 of this act.

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

(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 Department of Health 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 Department of Health on individual cases of perceived maternal death. At a minimum, the process developed pursuant to this paragraph shall require the department to: (a) post on its Internet website a hyperlink, a toll-free telephone number, and an email address, which may each be used for the voluntary submission of public reports of maternal death; and (b) publicize the availability of these resources to professional organizations, community organizations, social service agencies, and members of the public.

b. The department shall keep a record of all reports of maternal death that are submitted thereto through the reporting processes that are established by the commission pursuant to paragraphs (1) and (2) of subsection a. of this section. The department shall also 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 investigatory functions and other duties and responsibilities under this act.

6. (New section) a. Upon receipt of a report of maternal death, which has been forwarded to the commission pursuant to subsection b. of section 5 of this act, the commission shall investigate the reported case in accordance with the provisions of this section. In conducting the investigation, the commission shall consider:

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

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

(3) any relevant information contained in the deceased woman's medical records, including: (a) records related to the health care that was provided to the woman prior to her pregnancy; (b) records related to the woman's prenatal and postnatal care, labor and delivery care, emergency room care, and any other care delivered up until the time of the woman's death; and (c) the woman's hospital discharge records;

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

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

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

b. At the conclusion of an investigation conducted pursuant to this section, the commission shall prepare a case summary, which shall include the commission's findings with regard to the cause of, or the 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. Any case summary prepared pursuant to this subsection shall omit the personally identifying information of the deceased woman and her family members.

c. The commission may 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.

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

7. (New section) a. Within one year after its organization, and annually thereafter, the commission shall prepare, and submit to the Department of Health, to the Governor, and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature, a report containing the commission's findings on the rates and causes of maternal deaths occurring in the State during the preceding year, and providing recommendations for legislative or other action that can be undertaken to: (a) improve the quality of maternal care and reduce adverse maternal outcomes in the State; (b) increase the availability of, and improve access to, social and health care services for pregnant women; and (c) 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 report prepared under this section, shall additionally 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.

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

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

(2) the statistical data that was forwarded to the commission, during the preceding year, by the State registrar, pursuant to section 10 of this act; 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 the commission outreach authorized by subsection c. of section 6, or by paragraph (9) of subsection a. of section 4, of this act.

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

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

8. (New section) a. Upon receipt of the commission's first annual report, issued pursuant to section 7 of this act, the department, working in consultation with the commission, as well as with relevant professional organizations and patient advocacy groups, shall develop an ongoing maternal health educational program for health care practitioners, as may be necessary to improve the quality of maternal care and reduce adverse outcomes related to, or associated with, pregnancy. The educational program established pursuant to this section shall initially be based on, and shall reflect, the findings and recommendations identified in the commission's first report. However, once the educational program is established, the department shall, on at least a biennial basis thereafter, review the program and make 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 annual report.

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

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

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

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

(3) Members of the commission shall 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, nothing in this paragraph shall prohibit a commission 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.

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

10. (New section) a. (1) On an annual basis, and using the death records that have been filed during the preceding year, the State registrar shall identify: (a) the total number of maternal deaths that have occurred in the State during the year, and during each quarter of the year; (b) the average Statewide rate of maternal death occurring during the year; (c) the number and percentage of maternal deaths that occurred during the year in each of the Northern, Central, and Southern regions of the State; (d) 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 (e) the areas of the State where the rates of maternal death are significantly higher than the Statewide average.

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

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

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

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

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

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

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

26:8-24. The State registrar shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

j. Facilitate the provision of relevant statistical data on maternal deaths to the Maternal Mortality Review Commission, in accordance with the provisions of section 10 of P.L. , c. (C.) (pending before the Legislature as this act).

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

12. This act shall take effect immediately.

STATEMENT

This bill would establish a Maternal Mortality Review Commission in the Department of Health (DOH). The commission 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 four 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. 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.

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.

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

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 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 a biennial 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 of the State's professional licensing boards, as appropriate, would be required to adopt rules and regulations applicable to the health care practitioners under each board's respective jurisdiction, in order to require those practitioners who are involved in the provision of care to pregnant women to satisfactorily complete the maternal care educational program. Specifically, each board is to require relevant practitioners under its jurisdiction to complete this educational program as a condition of initial licensure, or, in the case of practitioners who are already licensed as of the bill's effective date, within 180 days after the program is established; and to additionally complete the program on a biennial basis thereafter, as a condition of license renewal.

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 case summaries, statistical compilations, or reports that are based on confidential information, so long as those summaries, compilations, and reports do not 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 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;

– 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	Annual
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	Annual
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.

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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.

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

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

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

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

"Commissioner" means the Commissioner of Health.

"Department" means the Department of Health.

"Maternal death" means a pregnancy-associated death, or a pregnancy-related death.

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

"Pregnancy-related death" means the death of a woman, which 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 the pregnancy, and which results from any cause related to, or aggravated by, the pregnancy or its management, but excluding any accidental or incidental cause.

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

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

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

2. (New section) a. There is hereby established, in the Department of Health, the Maternal Mortality Review Commission, which shall be tasked with annually reviewing and reporting on 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 <u>thus</u> is new matter.

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

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

(1) the State registrar;

(2) the State Medical Examiner;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) one licensed and practicing health care practitioner, mental health care practitioner, or substance use disorder treatment professional who specializes in perinatal addiction;

(3) one certified nurse midwife;

(4) one registered professional nurse or advanced practice nurse who specializes in hospital-based obstetric nursing;

(5) one licensed practical nurse, registered professional nurse, or advanced practice nurse who participates in, and represents, the Nurse-Family Partnership operating in New Jersey;

(6) one health care administrator who has experience in overseeing the operations of maternity wards or birthing centers;

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

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

(9) one private citizen who is engaged in patient advocacy.

d. Of the public members appointed to the commission, not more than seven shall be of the same political party.

e. Each public member of the commission shall serve for a term of four years; however, of the public members first appointed, four shall serve an initial term of two years, four shall serve an initial term of three years, and five shall serve an initial term of four years. Each public member shall serve for the term of their appointment, and until a successor is appointed and qualified, except that a public member may be reappointed to the commission upon the expiration of their term. Any vacancy in the membership shall be filled, for the unexpired term, in the same manner as the original appointment.

f. All initial appointments to the commission shall be made within 60 days after the effective date of this act.

g. Any member of the commission may be removed by the Governor, for cause, after a public hearing.

3. (New section) a. The commission shall organize as soon as practicable following the appointment of a majority of its members, and shall annually elect a chairperson and vice-chairperson from among its members. The chairperson may appoint a secretary, who need not be a member of the commission.

b. The commission shall meet pursuant to a schedule to be established at its first meeting, and it shall additionally meet at the call of its chairperson or the Commissioner of Health; however, in no case shall the commission meet less than four times a year.

c. A majority of the total number of members appointed to the commission shall constitute a quorum for the conducting of official commission business. A vacancy in the membership of the commission shall not impair the right of the commission to exercise its powers and duties, provided that a majority of the currently appointed members are available to conduct business. Any

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

d. The members of the commission shall serve without compensation, but shall 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.

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

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

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

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

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

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

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

(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 and comment on the commission's activities by periodically holding public hearings or conferences, and by providing other opportunities for such input and comment by interested parties; 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.

b. The Maternal Mortality Review Commission shall have the duty and responsibility to:

(1) develop mandatory and voluntary maternal death reporting processes, in accordance with the provisions of section 5 of this act;

(2) conduct an investigation of each reported case of maternal death, and prepare a de-identified case summary for each such case, in accordance with the provisions of section 6 of this act;

(3) review the statistical data on maternal deaths that is forwarded by the State registrar, pursuant to section 10 of this act, and the reports of maternal death that are forwarded by the department, pursuant to subsection b. of section 5 of this act, in order to 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; and

(5) annually report its findings and recommendations on maternal mortality to the department, the Governor, and the Legislature, in accordance with section 7 of this act.

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

(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 Department of Health 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 Department of Health on individual cases of perceived maternal death. At a minimum, the process developed pursuant to this paragraph shall require the department to: (a) post on its Internet website a hyperlink, a toll-free telephone number, and an email address, which may each be used for the voluntary submission of public reports of maternal death; and (b) publicize the availability of these resources to professional organizations, community organizations, social service agencies, and members of the public.

b. The department shall keep a record of all reports of maternal death that are submitted thereto through the reporting processes that are established by the commission pursuant to paragraphs (1) and (2) of subsection a. of this section. The department shall also 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 investigatory functions and other duties and responsibilities under this act.

6. (New section) a. Upon receipt of a report of maternal death, which has been forwarded to the commission pursuant to subsection b. of section 5 of this act, the commission shall investigate the reported case in accordance with the provisions of this section. In conducting the investigation, the commission shall consider:

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

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

(3) any relevant information contained in the deceased woman's medical records, including: (a) records related to the health care that was provided to the woman prior to her pregnancy; (b) records related to the woman's prenatal and postnatal care, labor and delivery care, emergency room care, and any other care delivered up until the time of the woman's death; and (c) the woman's hospital discharge records;

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

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

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

b. At the conclusion of an investigation conducted pursuant to this section, the commission shall prepare a case summary, which shall include the commission's findings with regard to the cause of, or the 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. Any case summary prepared pursuant to this subsection shall omit the personally identifying information of the deceased woman and her family members.

c. The commission may 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.

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

7. (New section) a. Within one year after its organization, and annually thereafter, the commission shall prepare, and submit to the Department of Health, to the Governor, and, pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), to the Legislature, a report containing the commission's findings on the rates and causes of maternal deaths occurring in the State during the preceding year, and providing recommendations for legislative or other action that can be undertaken to: (a) improve the quality of maternal care and reduce adverse maternal outcomes in the State; (b) increase the availability of, and improve access to, social and health care services for pregnant women; and (c) 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 report prepared under this section, shall additionally 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.

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

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

(2) the statistical data that was forwarded to the commission, during the preceding year, by the State registrar, pursuant to section 10 of this act; 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 the commission outreach authorized by subsection c. of section 6, or by paragraph (9) of subsection a. of section 4, of this act.

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

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

8. (New section) a. Upon receipt of the commission's first annual report, issued pursuant to section 7 of this act, the department, working in consultation with the commission, as well as with relevant professional organizations and patient advocacy groups, shall develop an ongoing maternal health educational program for health care practitioners, as may be necessary to improve the quality of maternal care and reduce adverse outcomes related to, or associated with, pregnancy. The educational program established pursuant to this section shall initially be based on, and shall reflect, the findings and recommendations identified in the commission's first report. However, once the educational program is established, the department shall, on at least a biennial basis thereafter, review the program and make 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 annual report.

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

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

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

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

(3) Members of the commission shall 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, nothing in this paragraph shall prohibit a commission 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.

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

10. (New section) a. (1) On an annual basis, and using the death records that have been filed during the preceding year, the State registrar shall identify: (a) the total number of maternal deaths that have occurred in the State during the year, and during each quarter of the year; (b) the average Statewide rate of maternal death occurring during the year; (c) the number and percentage of maternal deaths that occurred during the year in each of the Northern, Central, and Southern regions of the State; (d) 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 (e) the areas of the State where the rates of maternal death are significantly higher than the Statewide average.

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

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

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

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

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

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

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

26:8-24. The State registrar shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

j. Facilitate the provision of relevant statistical data on maternal deaths to the Maternal Mortality Review Commission, in accordance with the provisions of section 10 of P.L. , c. (C.) (pending before the Legislature as this act).

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

12. This act shall take effect immediately.

STATEMENT

This bill would establish a Maternal Mortality Review Commission in the Department of Health (DOH). The commission 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 four 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. 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.

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.

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

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 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 a biennial 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 of the State's professional licensing boards, as appropriate, would be required to adopt rules and regulations applicable to the health care practitioners under each board's respective jurisdiction, in order to require those practitioners who are involved in the provision of care to pregnant women to satisfactorily complete the maternal care educational program. Specifically, each board is to require relevant practitioners under its jurisdiction to complete this educational program as a condition of initial licensure, or, in the case of practitioners who are already licensed as of the bill's effective date, within 180 days after the program is established; and to additionally complete the program on a biennial basis thereafter, as a condition of license renewal.

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 case summaries, statistical compilations, or reports that are based on confidential information, so long as those summaries, compilations, and reports do not 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	Annual
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.

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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.

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 Huttle, 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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