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.