**CHAPTER 75**
**(CORRECTED COPY)**

**AN ACT** concerning maternal mortality and morbidity, 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:*

C.26:6C-1 Findings, declarations relative to maternal mortality and morbidity.

1. 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 nearly three times the rate that exists in the United Kingdom, and about six 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 out of the Department of Health (DOH), and which periodically reviews and provides statistics on maternal deaths occurring in the State;

d. A document produced by Every Mother Counts shows that New Jersey is ranked 46th of the 50 states in total maternal mortality, with a rate of 37.3 maternal deaths per every 100,000 live births and African-American women in New Jersey are five times more likely than their white counterparts to die from pregnancy-related complications;

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 aggregation and comparison of data by interested parties more difficult;

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;

i. 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; and

j. In order to ensure that the entity reviewing maternal deaths in the State may operate permanently and sustainably, 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 Committee, situated

in the Department of Health and overseen by the NJMCQC, which committee 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.

C.26:6C-2 Definitions relative to maternal mortality and morbidity.

2. As used in this act:

"Committee" means the Maternal Mortality Review Committee, established pursuant to section 4 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.

"Department" means the Department of Health.

"Maternal death" means a pregnancy-associated death.

"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 committee established pursuant to this act.

"NJMCQC" means the New Jersey Maternal Care Quality Collaborative, established pursuant to section 3 of P.L.2019, c.75 (C.26:6C-3).

"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 a suspected maternal death, which is filed with the department, pursuant to the processes established under subsection a. of section 7 of this act, and which is to be forwarded to the committee 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.

C.26:6C-3 New Jersey Maternal Care Quality Collaborative (NJMCQC)

3. 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.2019, c.75 (C.26:6C-1 et al.); 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.

C.26:6C-4 Maternal Mortality Review Committee.

4. a. There is hereby established, in the Department of Health, the Maternal Mortality Review Committee, 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 severe adverse outcomes related to, or associated with, pregnancy. The committee shall replace and supersede the Maternal Mortality Case Review Team that is currently constituted in the department. The committee shall be composed of 24 members, including 4 ex officio members as provided in subsection b. of this section, and 20 public members, as provided in subsection c. of this section.

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

the State Medical Examiner;

the Director of the Office of Emergency Medical Services in the Department of Health;

the Director of the Maternal Data Center established by section 14 of P.L.2019, c.75 (C.26:6C-13); and

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

c. (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) The additional 13 public members of the committee shall be appointed by the Commissioner of Health, to reflect the diversity in the state's geographic regions and perinatal designations and shall include:

seven 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 critical care medicine, one of whom specializes in perinatal pathology, 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;

one licensed and practicing health care practitioner or mental health care practitioner;

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

one certified nurse midwife;

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

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

one Certified Midwife or Certified Professional Midwife.

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

e. Each public member of the committee 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 committee 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 committee shall be made within 60 days after the effective date of this act. Upon the appointment of a majority of the committee 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.

g. Any member of the committee may be removed by the Commissioner of Health, for cause, after a public hearing.

C.26:6C-5 Committee; organization, meetings, support staff.

5. a. The committee 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 committee.

b. The committee 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 committee meet less than four times a year.

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

d. The members of the committee 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 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. The Department of Health shall also provide such administrative staff support to the committee as shall be necessary for the committee to carry out its duties.

C.26:6C-6 Powers, duties, responsibilities of Maternal Mortality Review Committee.

6. a. The Maternal Mortality Review Committee 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 committee's authorized purposes, or that are made available to assist the committee 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 committee;

(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 committee'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 committee'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 Committee shall have the duty and responsibility to:

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

(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 8 of this act;

(3) review the statistical data on maternal deaths that is forwarded by the Maternal Data Center pursuant to section 14 of this act, and the reports of maternal death that are forwarded by the department, pursuant to subsection b. of section 7 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 9 of this act.

C.26:6C-7 Duties of committee upon organization relative to reporting, recordkeeping of maternal deaths.

7. a. Within 90 days after the committee's organizational meeting, the committee 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. In developing a mandatory maternal death reporting process pursuant to this paragraph, the committee 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; 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 committee 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 committee, so that the committee may properly execute its investigatory functions and other duties and responsibilities under this act.

C.26:6C-8 Actions upon receipt of report of maternal death.

8. a. Upon receipt of a report of maternal death, which has been forwarded to the committee pursuant to subsection b. of section 7 of this act, the committee shall investigate the reported case in accordance with the provisions of this section. In conducting the investigation, the committee 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 and all hospital records including all emergency room and outpatient records from the one-year period following the end of the pregnancy;

(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 committee shall prepare a case summary, which shall include the committee'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 identifying information of the deceased woman and her family members, the health care providers who provided care, and the hospitals where care was provided.

c. The committee 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.

C.26:6C-9 Reports.

9. a. Within one year after its organization, and annually thereafter, the committee 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 committee'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 racial and other 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 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.

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

(1) the case summaries that were prepared by the committee over the preceding year, pursuant to subsection b. of section 8 of this act;

(2) the statistical data that was forwarded to the committee, during the preceding year, by the Maternal Data Center, pursuant to section 14 of this act; and

(3) any other relevant information, including information from the committee's prior annual reports, or 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 committee outreach authorized by subsection c. of section 8 of this act, or by paragraph (9) of subsection a. of section 6, of this act.

c. Upon receipt of the committee'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 committee'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.

C.2C:6C-10 Development of ongoing maternal health educational program and module.

10. a. Upon receipt of the committee's first annual report, issued pursuant to section 9 of this act, the department, working in consultation with the committee, the Perinatal Quality Collaborative, the Maternal Child Health Consortia, and other 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 committee's first report. However, once the educational program is established, the department shall, on at least an annual 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 committee, as reflected in the committee's most recent annual report.

b. 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.

C.26:6C-11 Confidentiality.

11. a. (1) Except as otherwise provided by subsection b. of this section, all proceedings and activities of the Maternal Mortality Review Committee; all opinions of the members of the committee, which are formed as a result of the committee's proceedings and activities; and all records obtained, created, or maintained by the committee, 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 committee 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 8 of this act, or in an annual report that is prepared pursuant to section 9 of this act.

(3) Members of the committee 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 committee; however, nothing in this paragraph shall prohibit a committee 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.

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

C.26:6C-12 Annual compilation of statistics.

12. a. (1) On an annual basis, and using the death records that have been filed during the preceding year, the Maternal Mortality Review Committee shall work collaboratively with the Maternal Data Center in the Healthcare Quality and Informatics Unit, NJMCQC's Maternal Health epidemiologists and other staff to 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; (e) the areas of the State where the rates of maternal death are significantly higher than the Statewide average; and (f) the rate of racial disparities in maternal deaths occurring on a Statewide and regional basis.

(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 Department of Health, and shall also be promptly forwarded to the NJMCQC.

b. In order to accomplish its duties under this section, the Maternal Mortality Review Committee 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 Maternal Mortality Review Committee may also use any other appropriate means or methods to identify maternal deaths. 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 Prevention.

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

Duties, responsibilities of State registrar.

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 or any successor vital reporting system. 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 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;

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 Committee, in accordance with the provisions of section 12 of P.L.2019, c.75 (C.26:6C-12).

C.26:6C-13 Maternal Data Center.

14. 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; collect this information from relevant health care facilities in the State; 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. 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.

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.

C.26:6C-14 Establishment, collection of fees.

15. 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 are licensed to provide maternal care services in the State 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. 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. 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.

C.26:6C-15 “Maternal Data Center Fund.”

16. 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.

C.26:6C-16 Rules, regulations.

17. 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.

18. This act shall take effect immediately.

Approved May 1, 2019.