SB 182 - AS INTRODUCED

2025 SESSION

25-1108
05/09

SENATE BILL ***182***

AN ACT relative to the maternal mortality review committee.

SPONSORS: Sen. Prentiss, Dist 5; Sen. Fenton, Dist 10; Sen. Rosenwald, Dist 13; Sen. Perkins Kwoka, Dist 21; Sen. Altschiller, Dist 24; Rep. Hakken-Phillips, Graf. 12; Rep. Kuttab, Rock. 17

COMMITTEE: Executive Departments and Administration

ANALYSIS

This bill renames the maternal mortality review panel as the maternal mortality review committee, revises its membership, and provides for the committee to be administered by the department of health and human services and facilitated by the New Hampshire perinatal quality collaborative (NHPQC) affiliated with Dartmouth Health. The bill also revises the definition of "pregnancy-related death" by removing the exclusion of accidental or incidental causes.

The bill is a request of the department of health and human services.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

25-1108
05/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Five

AN ACT relative to the maternal mortality review committee.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 Public Health; Maternal Mortality Review Committee. Amend the subdivision heading preceding RSA 132:29 to read as follows:

Maternal Mortality Review [~~Panel~~] ***Committee***

2 Public Health; Maternal Mortality Review Committee; Definitions. Amend RSA 132:29, I to read as follows:

I. "Pregnancy-related" means the death of a woman while pregnant or within one year of the end of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management[~~, but not from accidental or incidental causes~~].

3 Public Health; Maternal Mortality Review Committee Established. Amend RSA 132:30 to read as follows:

132:30 Maternal Mortality Review [~~Panel~~] ***Committee*** Established.

I. There is established a maternal mortality review [~~panel~~] ***committee*** to conduct comprehensive, multidisciplinary reviews of maternal deaths in New Hampshire for the purpose of identifying factors associated with the deaths and to make recommendations for system changes to improve services for women in the state. ***The committee shall be administered by the department of health and human services and facilitated jointly with the New Hampshire perinatal quality collaborative (NHPQC) affiliated with Dartmouth Health.*** The [~~panel~~] ***committee*** shall consist of:

(a) Two members from the New Hampshire chapter of the American College of Obstetricians and Gynecologists, one of whom shall be a generalist obstetrician, and one of whom shall be a maternal fetal medicine specialist.

(b) One member from the New Hampshire chapter of the American Academy of Pediatrics, specializing in neonatology.

(c) One member from the New Hampshire chapter of the American College of Nurse-Midwives.

(d) One member from the New Hampshire section of the Association for Women's Health, Obstetric and Neonatal Nurses.

(e) The administrator of maternal and child health who also is the Title V director, division of public health services, department of health and human services.

(f) An epidemiologist from the department of health and human services with experience analyzing perinatal data, or designee.

(g) A representative of the community mental health centers.

(h) A public member.

(i) The chief medical examiner, or designee.

(j) A representative of the division for children, youth and families, appointed by the commissioner of the department of health and human services.

(k) A representative of the department of corrections, appointed by the commissioner of the department of corrections.

II. Each member in subparagraphs I(a)-(h) shall be appointed by the commissioner of health and human services, or designee, in collaboration with the organizations listed in paragraph I.

III. [~~The term of each member shall be 3 years and the terms shall be staggered.~~] The ***committee*** chair shall be appointed by the commissioner ***or designee***. [~~The initially appointed chair shall call the meeting and panel together and shall serve as chair for 6 months, after which time, the panel shall elect its chair. Members of the panel shall receive no compensation.~~]

IV. The commissioner may delegate to [~~the Northern New England Perinatal Quality Improvement Network (NNEPQIN)~~] ***NHPQC*** the functions of collecting, analyzing, and disseminating maternal mortality information, organizing and convening meetings of the [~~panel~~] ***committee***, and other substantive and administrative tasks as may be incident to these activities. The activities of [~~NNEPQIN~~] ***NHPQC*** and its employees or agents shall be subject to the same confidentiality provisions as those that apply to the [~~panel~~] ***committee***.

V. The commissioner shall submit an annual report [~~beginning on June 1, 2011~~] to the oversight committee on health and human services describing adverse events reviewed by the [~~panel~~] ***committee***, including statistics and causes, and outlining, in aggregate, corrective action plans, and making recommendations for system change and legislation relative to state health care operations.

VI.(a) The [~~panel, in collaboration with the commissioner of the department of health and human services, or designee,~~] ***committee*** shall conduct comprehensive multidisciplinary reviews of the maternal mortality deaths, as defined in RSA 132:29, I-III[~~, in New Hampshire~~].

(b) Each [~~member of the panel~~] ***committee meeting*** shall [~~be responsible for the dissemination of panel recommendations to his or her respective institutions and professional organizations~~] ***conclude with the development of committee recommendations with members responsible for the dissemination of recommendations to his or her respective institutions or professional organizations***. All such information shall be disseminated through each participant's quality assurance program in order to protect the confidentiality of all participants and patients involved in any incident.

(c) The [~~panel~~] ***committee*** shall not:

(1) Call witnesses or take testimony from individuals involved in the investigation of a maternal death.

(2) Enforce any public health standard or criminal law or otherwise participate in any legal proceeding, except if a member of the team is involved in the investigation of the death or resulting prosecution and must participate in a legal proceeding in the course of performing in his or her duties outside the team.

(d) Proceedings, records, and opinions of the maternal mortality review [~~panel~~] ***committee*** are confidential, not subject to RSA 91-A, and not subject to discovery, subpoena, or introduction into evidence in any civil or criminal proceeding. Nothing in this subparagraph shall be construed to limit or restrict the right to discover or use in any civil or criminal proceeding anything that is available from another source and entirely independent of the proceedings of the [~~panel~~] ***committee***.

(e) Members of the [~~panel~~] ***committee*** shall not be questioned in any civil or criminal proceeding regarding information presented in or opinions formed as a result of a meeting of the team. Nothing in this subparagraph shall be construed to prevent a member of the [~~panel~~] ***committee*** from testifying to information obtained independently of the team or which is public information.

VII. The commissioner of the department of health and human services, with the advice and recommendation of a majority of members of the [~~panel~~] ***committee***, shall adopt rules, pursuant to RSA 541-A, relative to the following:

(a) The system for identifying and reporting maternal [~~deaths~~] ***mortalities*** to the commissioner, or designee.

(b) The form and manner through which the program may acquire information under RSA 132:31.

(c) The protocol to be used in carefully and sensitively contacting [~~a~~] family [~~member~~] ***members and close contacts*** of the deceased [~~woman~~] ***individual*** for a discussion of the events surrounding the death, allowing grieving family members to refuse such an interview.

(d) Assuring de-identification of all individuals and facilities involved in the [~~panel~~] ***committee*** review of cases.

4 Public Health; Maternal Mortality Review Committee; Acquisition of Information Related to Maternal Mortality. Amend RSA 132:31 to read as follows:

132:31 Acquisition of Information Related to Maternal Mortality.

I. [~~If a root cause analysis of a maternal mortality event has been completed, such findings shall be included in the records supplied to the review panel~~] ***All case findings shall be included in the case narrative supplied to the committee***.

II. Health care providers, health care facilities, clinics, laboratories, medical records departments, and state offices, agencies and departments shall report all maternal mortality deaths as defined in RSA 132:29, I-III to [~~the chair of the panel and~~] the commissioner, or designee. The commissioner ***or desginee*** shall have access to individually identifiable information relating to the

occurrence of maternal [~~deaths only on a case-by-case basis where public health is at risk~~] ***mortality***. This information includes, but is not limited to: vital records, hospital discharge data, prenatal, fetal, pediatric, or infant medical records, hospital or clinic records, laboratory reports, records of fetal deaths or induced terminations of pregnancies, and autopsy reports. The same case information may be acquired from health care facilities, maternal mortality review programs, and other sources in other states to ensure that its records of New Hampshire maternal mortality cases are accurate and complete. [~~The chair shall not acquire and retain any individually identifiable information.~~]

III. The commissioner, or designee, may retain identifiable information regarding facilities where maternal deaths occur and geographical information on each case solely for the purposes of trending and analysis over time. Pursuant to RSA 132:30, VII(d), ***personally*** identifiable information on all individuals and facilities shall be removed prior to any case review by the [~~panel~~] ***committee***.

5 Effective Date. This act shall take effect upon its passage.