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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2021

S **D**

SENATE BILL DRS45358-MMa-79

Short Title:	North Carolina Momnibus Act.	(Public)
Sponsors:	Senators Murdock, Batch, and Salvador (Primary Sponsors).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO ENACT THE NORTH CAROLINA MOMNIBUS ACT.

Whereas, every person should be entitled to dignity and respect during and after pregnancy and childbirth, and patients should receive the best care possible regardless of age, race, ethnicity, color, religion, ancestry, disability, medical condition, genetic information, marital status, sex, gender identity, gender expression, sexual orientation, socioeconomic status, citizenship, nationality, immigration status, primary language, or language proficiency; and

Whereas, the United States has the highest maternal mortality rate in the developed world, where about 700 women die each year from childbirth and another 50,000 suffer from severe complications; and

Whereas, according to the North Carolina Maternal Mortality Review and Prevention Committee, sixty-three percent (63%) of all maternal deaths in 2014-2015 were determined to be preventable; and black women are at increased risk to die from pregnancy complications compared to white women; and

Whereas, the federal Centers for Disease Control and Prevention finds that the majority of pregnancy-related deaths are preventable; and

Whereas, pregnancy-related deaths among black birthing people are also more likely to be miscoded; and

Whereas, access to prenatal care, socioeconomic status, and general physical health do not fully explain the disparity seen in maternal mortality and morbidity rates among black individuals, and there is a growing body of evidence that black people are often treated unfairly and unequally in the health care system; and

Whereas, implicit bias is a key driver of health disparities in communities of color; and

Whereas, health care providers in North Carolina are not required to undergo any implicit bias testing or training; and

Whereas, currently there does not exist any system to track the number of incidents where implicit prejudice and implicit stereotypes led to negative birth and maternal health outcomes; and

Whereas, it is in the interest of this State to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care so that all people are treated with dignity and respect by their health care providers; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. ADDRESSING SOCIAL DETERMINANTS OF HEALTH AND COMMUNITY-BASED ORGANIZATIONS

ESTABLISHMENT OF SOCIAL DETERMINANTS OF MATERNAL HEALTH TASK FORCE

SECTION 1.1. Part 5 of Article 1B of Chapter 130A of the General Statutes reads as rewritten:

"Part 5. Maternal ~~Mortality Review Committee.~~Health.

…

"**§ 130A-33.61. Social Determinants of Maternal Health Task Force.**

(a) Definitions. – The following definitions apply in this section:

(1) Maternity care provider. – A health care provider who meets the following criteria:

a. Is a licensed or certified (i) physician; (ii) physician assistant; (iii) midwife who, at minimum, meets the international definition of a midwife and meets the global standards for midwifery education, as established by the International Confederation of Midwives; (iv) nurse practitioner; or (v) clinical nurse specialist.

b. Is focused in practice on maternal or perinatal health.

(2) Perinatal health worker. – A doula, community health worker, peer supporter, breastfeeding and lactation educator or counselor, nutritionist or dietitian, childbirth educator, social worker, home visitor, language interpreter, or navigator.

(3) Postpartum or postpartum period. – The one-year period beginning on the last day of the pregnancy of an individual.

(4) Pregnancy-related death. – A death of a pregnant or postpartum individual that occurs during, or within one year following, the individual's pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

(5) Severe maternal morbidity. – A health condition, including a mental health condition or substance use disorder, or both, attributed to or aggravated by pregnancy or childbirth that results in significant short-term or long-term consequences to the health of the individual who was pregnant.

(6) Social determinants of maternal health. – Nonclinical factors that impact maternal health outcomes, including the following:

a. Economic factors, which may include poverty, employment, food security, support for and access to lactation and other infant feeding options, housing stability, and related factors.

b. Neighborhood factors, which may include quality of housing, access to transportation, access to child care, availability of healthy foods and nutrition counseling, availability of clean water, air and water quality, ambient temperatures, neighborhood crime and violence, access to broadband, and related factors.

c. Social and community factors, which may include systemic racism, gender discrimination or discrimination based on other protected classes, workplace conditions, incarceration, and related factors.

d. Household factors, which may include an individual's ability to conduct lead testing and abatement, car seat installation, indoor air temperatures, and related factors.

e. Education access and quality factors, which may include educational attainment, language and literacy, and related factors.

f. Health care access factors, including health insurance coverage, access to culturally respectful health care services, providers, and nonclinical

support, access to home visiting services, access to wellness and stress management programs, health literacy, access to telehealth and equipment and other items required to receive telehealth services, and related factors.

(b) Task Force Creation and Membership. – There is created the Social Determinants of Maternal Health Task Force (Task Force) within the Department of Health and Human Services. The purpose of the Task Force is to develop a strategy to coordinate efforts between State agencies to address social determinants of maternal health with respect to pregnant and postpartum individuals. The Task Force shall be composed of the following members:

(1) Eight members appointed by the Governor that are representatives of State or local agencies whose decisions may have an impact on the social determinants of maternal health, including, but not limited to, agencies responsible for health, housing, food, environment, labor, and education.

(2) Two members appointed by the Speaker of the House of Representatives, representing each of the following:

a. Patients who have suffered from severe maternal morbidity.

b. Patients whose family member suffered a pregnancy-related death.

(3) Two members appointed by the President Pro Tempore of the Senate who shall be leaders of community-based organizations that address maternal mortality and severe maternal morbidity with a specific focus on racial and ethnic disparities. In appointing these members, priority shall be given to individuals who are leaders of organizations led by individuals from racial and ethnic minority groups.

(4) Two members appointed by the House Majority Leader who are perinatal health workers.

(5) Two members appointed by the Senate Majority Leader who are maternity care providers.

(6) The Secretary of the Department of Health and Human Services or a designee of the Secretary.

(c) Task Force Chair and Meetings. – The Governor shall select the chair of the Task Force from among the members of the Task Force. The Task Force shall meet at least quarterly at the call of the chair.

(d) Task Force Report. – Not later than two years after this act becomes effective, the Task Force shall submit to the Governor and the General Assembly a report containing all of the following:

(1) A State plan for coordinating efforts among State agencies to address social determinants of maternal health with respect to pregnant and postpartum individuals.

(2) Recommendations on the amount of State funding necessary to implement the State plan developed under subdivision (1) of this subsection.

(3) Recommendations on how to leverage services available under the State's Medicaid program to address social determinants of maternal health."

ESTABLISHMENT OF MATERNAL MORTALITY PREVENTION GRANT PROGRAM

SECTION 1.2.(a) Definitions. – The following definitions apply in this section:

(1) Culturally respectful congruent. – Sensitive to and respectful of the preferred cultural values, beliefs, world view, and practices of the patient, and aware that cultural differences between patients and health care providers or other service providers must be proactively addressed to ensure that patients receive equitable, high-quality services that meet their needs.

(2) Department. – The North Carolina Department of Health and Human Services.

(3) Postpartum. – The one-year period beginning on the last day of a woman's pregnancy.

SECTION 1.2.(b) Establishment of Grant Program. – The Department shall establish and operate a Maternal Mortality Prevention Grant Program to award competitive grants to eligible entities to establish or expand programs for the prevention of maternal mortality and severe maternal morbidity among black women. The Department shall establish eligibility requirements for program participation which shall, at a minimum, require that applicants be community-based organizations offering programs and resources aligned with evidence-based practices for improving maternal health outcomes for black women.

SECTION 1.2.(c) Outreach and Application Assistance. – Beginning July 1, 2021, the Department shall (i) conduct outreach to encourage eligible applicants to apply for grants under this program and (ii) provide application assistance to eligible applicants on best practices for applying for grants under this program. In conducting the outreach required by this section, the Department shall give special consideration to eligible applicants that meet the following criteria:

(1) Are based in, and provide support for, communities with high rates of adverse maternal health outcomes and significant racial and ethnic disparities in maternal health outcomes.

(2) Are led by black women.

(3) Offer programs and resources that are aligned with evidence-based practices for improving maternal health outcomes for black women.

SECTION 1.2.(d) Grant Awards. – In awarding grants under this section, the Department shall award a maximum of five grants, and, to the extent possible, the grant recipients shall reflect different areas of the State. The Department shall not award a single grant for less than ten thousand dollars ($10,000) or more than fifty thousand dollars ($50,000) per grant recipient. In selecting grant recipients, the Department shall give special consideration to eligible applicants that meet all of the following criteria:

(1) Meet all the criteria specified in subdivisions (1) through (3) of subsection (c) of this section.

(2) Offer programs and resources designed in consultation with and intended for black women.

(3) Offer programs and resources in the communities in which they are located that include any of the following activities:

a. Promoting maternal mental health and maternal substance use disorder treatments that are aligned with evidence-based practices for improving maternal mental health outcomes for black women.

b. Addressing social determinants of health for women in the prenatal and postpartum periods, including, but not limited to, any of the following:

1. Inadequate housing.
2. Transportation barriers.
3. Poor nutrition and a lack of access to healthy foods.
4. Need for lactation support.
5. Need for lead abatement and other efforts to improve air and water quality.
6. Lack of access to child care.
7. Need for baby supplies such as diapers, formula, clothing, baby and child equipment, and safe car seat installation.
8. Need for wellness and stress management programs.

9. Education about maternal health and well-being.
10. Need for coordination across safety net and social support services and programs.

c. Promoting evidence-based health literacy and pregnancy, childbirth, and parenting education for women in the prenatal and postpartum periods, including group-based programs and peer support groups.

d. Providing individually tailored support from doulas and other perinatal health workers to women from pregnancy through the postpartum period.

e. Providing culturally respectful congruent training to perinatal health workers such as doulas, community health workers, peer supporters, certified lactation consultants, nutritionists and dietitians, social workers, home visitors, and navigators.

f. Conducting or supporting research on issues affecting black maternal health.

g. Developing other programs and resources that address community-specific needs for women in the prenatal and postpartum periods and are aligned with evidence-based practices for improving maternal health outcomes for black women.

SECTION 1.2.(e) Technical Assistance to Grant Recipients. – The Department shall provide technical assistance to grant recipients regarding all of the following:

(1) Capacity building to establish or expand programs to prevent adverse maternal health outcomes among black women.

(2) Best practices in data collection, measurement, evaluation, and reporting.

(3) Planning centered around sustaining programs implemented with grant funds to prevent maternal mortality and severe maternal morbidity among black women when the grant funds have been expended.

SECTION 1.2.(f) Reports. – The Department shall submit the following reports on the grant program authorized by this section to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division:

(1) A report by October 1, 2023, that includes at least all of the following components:

a. A detailed report on funds expended for the program for the 2021-2022 fiscal year.

b. An assessment of the effectiveness of outreach efforts by the Department during the application process in diversifying the pool of grant recipients.

c. Recommendations for future outreach efforts to diversify the pool of grant recipients for this program and other related grant programs, as well as for funding opportunities related to the social determinants of maternal health.

(2) A report by October 1, 2024, that includes at least all of the following components:

a. A detailed report on funds expended for the program for the 2022-2023 fiscal year.

b. An assessment of the effectiveness of programs funded by grants awarded under this section in improving maternal health outcomes for black women.

c. Recommendations for future grant programs to be administered by the Department and for future funding opportunities for community-based organizations to improve maternal health outcomes for black women

through programs and resources that are aligned with evidence-based practices for improving maternal health outcomes for black women.

SECTION 1.2.(g) The Maternal Mortality Prevention Grant Program authorized by this section expires on June 30, 2023.

APPROPRIATIONS TO IMPLEMENT PART I

SECTION 1.3.(a) The following sums are appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, for the 2021-2022 fiscal year:

(1) $23,000 in recurring funds to be allocated to the Social Determinants of Maternal Health Task Force established in G.S. 130A-33.61.

(2) $82,000 in recurring funds to establish a full-time, permanent Public Health Program Coordinator IV position with the following responsibilities:

a. Assisting the Social Determinants of Maternal Health Task Force.

b. Providing application assistance to Maternal Mortality Prevention Grant Program applicants.

c. Providing technical assistance to Maternal Mortality Prevention Grant Program recipients.

d. Preparing the reports due under Section 1.2(f) of this Part.

(3) $395,500 in nonrecurring funds to be allocated to the Maternal Mortality Prevention Grant Program authorized by Section 1.2 of this Part. Up to ten percent (10%) of these funds may be used for administrative purposes. The balance of these funds shall be used to operate the program.

SECTION 1.3.(b) The following sums are appropriated from the General Fund to the Department of Health and Human Services, Division of Public Health, for the 2022-2023 fiscal year:

(1) $23,000 in recurring funds to be allocated to the Social Determinants of Maternal Health Task Force established in G.S. 130A-33.61.

(2) $82,000 in recurring funds to cover the cost of the full-time, permanent Public Health Program Coordinator IV position established in subdivision (a)(2) of this section.

(3) $395,500 in nonrecurring funds to be allocated to the Maternal Mortality Prevention Grant Program authorized by Section 1.2 of this Part. Up to ten percent (10%) of these funds may be used for administrative purposes. The balance of these funds shall be used to operate the program.

SECTION 1.3.(c) The Department is authorized to hire one full-time, permanent Public Health Program Coordinator IV to perform the responsibilities described in subdivision (a)(2) of this section.

SECTION 1.3.(d) This section becomes effective July 1, 2021.

EFFECTIVE DATE FOR PART I

SECTION 1.4. Except as otherwise provided, this Part becomes effective October 1, 2021.

PART II. IMPLICIT BIAS IN HEALTH CARE

SECTION 2.1. Part 5 of Article 1B of Chapter 130A of the General Statutes, as amended by Section 1.1 of this act, is amended by adding two new sections to read:

"**§ 130A-33.62. Department to establish implicit bias training program for health care professionals engaged in perinatal care.**

(a) The following definitions apply in this section:

(1) Health care professional. – A licensed physician or other health care provider licensed, registered, accredited, or certified to perform perinatal care and regulated under the authority of a health care professional licensing authority.

(2) Health care professional licensing authority. – The Department of Health and Human Services or an agency, board, council, or committee with the authority to impose training or education requirements or licensure fees as a condition of practicing in this State as a health care professional.

(3) Implicit bias. – A bias in judgment or behavior that results from subtle cognitive processes, including implicit prejudice and implicit stereotypes, that often operate at a level below conscious awareness and without intentional control.

(4) Implicit prejudice. – Prejudicial negative feelings or beliefs about a group that a person holds without being aware of them.

(5) Implicit stereotypes. – The unconscious attributions of particular qualities to a member of a certain social group that are influenced by experience and based on learned associations between various qualities and social categories, including race and gender.

(6) Perinatal care. – The provision of care during pregnancy, labor, delivery, and postpartum and neonatal periods.

(7) Perinatal facility. – A hospital, clinic, or birthing center that provides perinatal care in this State.

(b) The Department, in collaboration with (i) community-based organizations led by Black women that serve primarily Black birthing people and (ii) a historically Black college or university or other institution that primarily serves minority populations, shall create or identify an evidence-based implicit bias training program for health care professionals involved in perinatal care. The implicit bias training program shall include, at a minimum, all of the following components:

(1) Identification of previous or current unconscious biases and misinformation.

(2) Identification of personal, interpersonal, institutional, structural, and cultural barriers to inclusion.

(3) Corrective measures to decrease implicit bias at the interpersonal and institutional levels, including ongoing policies and practices for that purpose.

(4) Information about the effects of implicit bias, including, but not limited to, ongoing personal effects of racism and the historical and contemporary exclusion and oppression of minority communities.

(5) Information about cultural identity across racial or ethnic groups.

(6) Information about how to communicate more effectively across identities, including racial, ethnic, religious, and gender identities.

(7) Information about power dynamics and organizational decision-making.

(8) Trauma-informed care best practices and an emphasis on shared decision making between providers and patients.

(9) Information about health inequities within the perinatal care field, including information on how implicit bias impacts maternal and infant health outcomes.

(10) Perspectives of diverse, local constituency groups and experts on particular racial, identity, cultural, and provider-community relations issues in the community; and

(11) Information about socioeconomic bias.

(12) Information about reproductive justice.

(c) Notwithstanding any provision of Chapter 90 or Chapter 93B of the General Statutes, or any other provision of law to the contrary, all health care professionals are required to complete the implicit bias training program established under this section as follows:

(1) Health care professionals who hold a current license, registration, accreditation, or certification on December 31, 2021, shall complete the training program no later than December 31, 2022.

(2) Health care professionals issued an initial license, registration, accreditation, or certification on or after January 1, 2022, shall complete the training program no later than one year after the date of issuance.

A health care professional licensing authority shall not renew the license, registration, accreditation, or certification of a health care professional unless the health care professional provides proof of completion of the training program established under this section within the 24-month period leading up to the date of the renewal application.

(d) The Department is encouraged to seek opportunities to make the implicit bias training program established under this section available to all health care professionals and to promote its use among the following groups:

(1) All maternity care providers and any employees who interact with pregnant and postpartum individuals in the provider setting, including front desk employees, sonographers, schedulers, health system–employed lactation consultants, hospital or health system administrators, security staff, and other employees.

(2) Undergraduate programs that funnel into health professions schools.

(3) Providers of the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966.

(4) Obstetric emergency simulation trainings or related trainings.

(5) Emergency department employees, emergency medical technicians, and other specialized health care providers who interact with pregnant and postpartum individuals.

(e) The Department shall collect the following information for the purpose of informing ongoing improvements to the implicit bias training program:

(1) Data on the causes of maternal mortality.

(2) Rates of maternal mortality, including rates distinguished by age, race, ethnicity, socioeconomic status, and geographic location within this State.

(3) Other factors the Department deems relevant for assessing and improving the implicit bias training program.

"**§ 130A-33.63. Rights of perinatal care patients.**

(a) A patient receiving care at a perinatal care facility, defined as a hospital, clinic, or birthing center that provides perinatal care in this State, has the following rights:

(1) To be informed of continuing health care requirements following discharge.

(2) To be informed that, if the patient so authorizes, and to the extent permitted by law, the hospital or health care facility may provide to a friend or family member information about the patient's continuing health care requirements following discharge.

(3) To actively participate in decisions regarding the patient's medical care and the right to refuse treatment.

(4) To receive appropriate pain assessment and treatment.

(5) To receive care and treatment free from discrimination on the basis of age, race, ethnicity, color, religion, ancestry, disability, medical condition, genetic information, marital status, sex, gender identity, gender expression, sexual orientation, socioeconomic status, citizenship, nationality, immigration status, primary language, or language proficiency.

(6) To receive information on how to file a complaint with the Division of Health Service Regulation or the Human Rights Commission or both about any violation of these rights.

(b) Each perinatal care facility shall provide to each perinatal care patient upon admission to the facility, or as soon as reasonably practical following admission to the facility, a written copy of the rights enumerated in subsection (a) of this section. The facility may provide this information to the patient by electronic means, and it may be provided with other notices regarding patient rights."

SECTION 2.2. This Part becomes effective October 1, 2021.

PART III. PROTECTING MOMS WHO SERVE

SECTION 3.1. The Department of Health and Human Services shall study the following issues affecting women who serve in the military:

(1) Coordinating effectively between veterans health care facilities and non-veterans health care facilities in the delivery of maternity care and other health care services.

(2) Facilitating access to community resources to address social determinants of health, including housing, nutrition, and employment status.

(3) Identifying mental and behavioral health risk factors in the prenatal and postpartum periods and ensuring that pregnant and postpartum veterans get the treatments they need.

(4) Facilitating access to childbirth preparation classes, parenting classes, nutrition counseling, breastfeeding support, lactation classes, and breast pumps.

(5) Reducing maternal mortality and severe maternal morbidity, with a particular focus on racial and ethnic disparities in maternal health outcomes.

SECTION 3.2. The Department of Health and Human Services shall consult with the Department of Military and Veterans Affairs (hereinafter "DMVA"), as necessary, in conducting the study required by subsection (a) of this section, and DMVA shall cooperate with the Department and provide any assistance or information requested.

SECTION 3.3. By April 1, 2022, the Department of Health and Human Services shall report its findings, and any recommendations for legislation, to the Senate Health Care Committee, Joint Legislative Oversight Committee on Health and Human Services, Joint Legislative Oversight Committee on General Government, and the Fiscal Research Division.

SECTION 3.4. There is appropriated from the General Fund to the Department of Health and Human Services the sum of one hundred thousand dollars ($100,000) in nonrecurring funds for the 2021-2022 fiscal year for the purpose of conducting the study described in Section 3.1. of this Part.

SECTION 3.5. This Part becomes effective July 1, 2021.

PART IV. COVID-19/PREGNANCY

DEFINITIONS

SECTION 4.1. The following definitions apply in Part 4 of this act:

(1) COVID-19 public health emergency. – The period beginning on the date that the United States Secretary of Health and Human Services declared a public health emergency with respect to COVID-19 under section 319 of the Public Health Service Act (42 U.S.C. § 247d) and ending on the later of the end of such public health emergency or January 1, 2023.

(2) Maternity care provider. – A health care provider who meets the following criteria:

a. Is a licensed or certified physician; physician assistant; midwife who, at a minimum, meets the international definition of a midwife and the global standards for midwifery education as established by the International Confederation of Midwives; a nurse practitioner, or a clinical nurse specialist.
b. Practices in the area of maternal or perinatal health.

(3) Maternity care services. – Health care related to an individual's pregnancy, childbirth, or postpartum recovery.

(4) Perinatal health worker. – A doula, community health worker, peer supporter, breastfeeding and lactation educator or counselor, nutritionist or dietitian, childbirth educator, social worker, home visitor, language interpreter, or navigator.

(5) Respectful maternity care. – Consistent with the term as used by the World Health Organization, refers to care organized for, and provided to, pregnant and postpartum individuals in a manner that meets all of the following requirements:
a. Is culturally sensitive and nondiscriminatory.
b. Maintains the dignity, privacy, and confidentiality of the individual receiving care.
c. Ensures freedom from harm and mistreatment.
d. Enables informed decision making and continuous support.

APPROPRIATIONS FOR DATA COLLECTION, SURVEILLANCE, AND RESEARCH ON MATERNAL HEALTH OUTCOMES DURING THE COVID-19 PUBLIC HEALTH EMERGENCY

SECTION 4.2.(a) It is the intent of the General Assembly to support data collection, surveillance, and research on maternal health as a result of the COVID-19 public health emergency, including support to assist with the collection and sharing of racial, ethnic, and other demographic data related to maternal health. To that end, there is appropriated from the General Fund to the Department of Health and Human Services the sum of five hundred twenty-nine thousand three hundred eleven dollars ($529,311) in recurring funds and the sum of three million five hundred thousand dollars ($3,500,000) in nonrecurring funds for the 2021-2022 fiscal year, and the sum of five hundred twenty-nine thousand three hundred eleven dollars ($529,311) in recurring funds for the 2022-2023 fiscal year, to be allocated as follows:

(1) $35,800 in recurring funds to support the work of the Task Force on Birthing Experience and Safe Maternity Care During a Public Health Emergency established in G.S. 130A-33.63, as enacted in Section 4.5 of this Part.

(2) $493,511 in recurring funds to hire five full-time, permanent positions to support the Department in the following efforts:
a. Collecting data about the impact of COVID-19 on pregnant, birthing, and postpartum individuals, disaggregated by race and ethnicity, including, but not limited to, data on the following:
1. COVID-19 testing, infections, hospitalizations, and vaccinations.
2. Health outcomes for pregnant, birthing, and postpartum individuals and their infants confirmed or suspected of being infected with COVID-19, including rates of morbidity and mortality from COVID-19, preterm birth, stillbirth, infant mortality, infants born with low birth weight, cesarean birth rates, and the impact of COVID-19 on infant feeding patterns.

b. Conducting public health education activities described in 4.3 of this Part.

(3) $1,500,000 in nonrecurring funds to support the establishment and operation of a one-year competitive grant program to ensure safe maternity care staffing levels at safety net hospitals and health clinics that provide maternity care services. The Department shall establish eligibility requirements for program participation which shall, at a minimum, require that applicants be safety-net hospitals, rural hospitals, federally qualified health centers, community health centers, or nonhospital affiliated independent medical practices that provide maternity care services to a disproportionately high number of low-income patients and patients from racial and ethnic minority groups. As part of this program, the Department shall award a total of 10 grants in the amount of one hundred fifty thousand dollars ($150,000) per grant to cover the cost of additional staffing to provide maternity care services. To the extent possible, the grant recipients shall reflect different areas of the State. By October 1, 2023, and October 1, 2024, the Department shall submit a report on the competitive grant program authorized by this subdivision. Each report shall include, at a minimum, a detailed breakdown of the funds expended for the grant program for the previous fiscal year and an assessment of the effectiveness of the program in improving maternity care staffing levels and infant mortality rates at safety net hospitals and health clinics that serve a disproportionately high number of low-income patients and patients from racial and ethnic minority groups.

(3) $2,000,000 in nonrecurring funds to acquire and distribute personal protective equipment to perinatal workers practicing in the following areas:

a. In noninstitutional settings that provide such equipment to their employees.

b. In communities that are disproportionately affected by COVID-19 and adverse maternal health outcomes.

SECTION 4.2.(b) Subsection (a) of this section becomes effective July 1, 2021.

SECTION 4.2.(c) From available funds, the Department shall partner with and award subgrants to the following entities for the following purposes:

(1) Clinical stakeholders, community-based organizations, and federally recognized Indian tribes, to assist with the collection and analysis of data on the impact of COVID-19 on pregnant and postpartum patients and their newborns, particularly among patients from racial and ethnic minority groups.

(2) Clinical stakeholders, community-based organizations, and federally recognized Indian tribes, to provide timely, continually updated guidance to families and health care providers on ways to reduce risk to pregnant and postpartum individuals and their newborns and tailor interventions to improve their long-term health.

In awarding subgrants under subdivisions (1) and (2) of this subsection, the Department shall give special consideration to eligible entities that meet the following criteria: (i) are based in, and provide support for, communities with high rates of adverse maternal health outcomes and significant racial and ethnic disparities in maternal health outcomes, (ii) are led by black women, and (iii) offer programs and resources that are aligned with evidence-based practices for improving maternal health outcomes for black women.

PUBLIC HEALTH INFORMATION AND EDUCATIONAL ACTIVITIES

SECTION 4.3.(a) The Department of Health and Human Services shall provide the public with evidence-based public health information and education about COVID-19 and

pregnancy, including risks and guidance for mitigating such risks in alignment with respectful maternity care, with a particular focus on pregnant individuals in communities disproportionately affected by maternal mortality and COVID-19.

SECTION 4.3.(b) Hospitals and health care facilities licensed in this State that provide maternity care services during the COVID-19 public health emergency shall provide patients with updated and accurate information about hospital policies that may affect patient care during pregnancy, labor, delivery, and postpartum, including hospital visitor policies. Such information shall be made available (i) on the hospital or health care facility website and (ii) in multiple languages.

ENSURING SAFE AND RESPECTFUL MATERNITY CARE BY HOSPITALS AND HEALTH CARE FACILITIES DURING THE COVID-19 PUBLIC HEALTH EMERGENCY

SECTION 4.4. Hospitals and health care facilities licensed in this State that provide maternity care services during the COVID-19 public health emergency shall do all of the following:

(1) Provide patients with updated and accurate information about hospital policies that may affect patient care during pregnancy, labor, delivery, and postpartum, including hospital visitor policies.

(2) Permit maternity care patients to have at least one support person with them during labor, delivery, and postpartum recovery.

(3) Make efforts to safely accommodate the presence of doulas during labor, delivery, and postpartum care and recognize doulas as members of patients' perinatal care teams, not visitors.

(4) Implement policies equitably, without discrimination on the basis of patient characteristics, such as race, ethnicity, income, age, language, sexual orientation, or marital status.

(5) Ensure that institutional policies and practices do not violate patients' rights to reject treatments or birth interventions.

(6) Integrate COVID-19 considerations into discussions with patients about the risks and benefits of health care decisions during informed consent processes.

ESTABLISHMENT OF THE TASK FORCE ON BIRTHING EXPERIENCE AND SAFE MATERNITY CARE DURING A PUBLIC HEALTH EMERGENCY

SECTION 4.5.(a) Part 5 of Article 1B of Chapter 130A of the General Statutes, as amended by Sections 1.1 and 2.1. of this act, is amended by adding a new section to read:

"**§ 130A-33.64. Task Force on Birthing Experience and Safe Maternity Care During a Public Health Emergency.**

(a) Establishment and Purpose of Task Force. – There is established the Task Force on Birthing Experience and Safe Maternity Care During a Public Health Emergency within the Department of Health and Human Services (Task Force). The purpose of the Task Force is to develop recommendations on respectful maternity care during the COVID-19 public health emergency and other public health emergencies, with a particular focus on outcomes for individuals from racial and ethnic minority groups and other underserved communities, and to make those recommendations publicly available in multiple languages. The Task Force recommendations required under this section shall address at least all of the following:

(1) Measures to facilitate respectful maternity care.

(2) Strategies to increase access to specialized care for individuals with high-risk pregnancies.

(3) COVID-19 diagnostic testing for pregnant individuals and individuals in labor.

(4) The designation of a companion during birthing.
(5) The ability to communicate using an electronic mobile device during birthing.
(6) With respect to an individual who has the virus that causes COVID-19 or a virus involved in any future public health emergency, procedures for the following:
a. Separating the individual who gave birth from the newborn after birth.
b. Ensuring safety while breastfeeding.
(7) Licensing, training, and reimbursement for midwives from racial and ethnic minority groups and underserved communities.
(8) Financial support for perinatal health workers who provide nonclinical support to pregnant individuals and postpartum individuals from underserved communities.
(9) The identification and treatment of prenatal and postpartum mental and behavioral health conditions that may have developed during or worsened because of the COVID-19 public health emergency or future public health emergencies, including anxiety, substance use disorder, and depression.
(10) Strategies to address hospital capacity issues in communities with an increase in COVID-19 cases, or cases caused by future public health emergencies.
(11) Options for maternal care that reduce cross-contamination and maintain safety and quality of care, including auxiliary maternity units and freestanding birth centers.
(12) Methods to identify and address racism, bias, and discrimination in treatment and support to pregnant and postpartum individuals, including the following:
a. Evaluating the training of hospital staff on implicit bias and racism and respectful maternity care.
b. Collecting demographic data.
(13) Any other matters the Task Force deems appropriate.

(b) Task Force Membership. – In making appointments or designating representatives, appointing authorities shall use best efforts to select members or representatives with sufficient knowledge and experience to effectively contribute to the issues examined by the Task Force and, to the extent possible, to reflect the geographical, political, gender, and racial diversity of this State. The Task Force shall be composed of the following members:
(1) Two representatives of the Department, one of whom shall be a representative of the Division of Public Health, to be appointed by the Secretary.
(2) Four representatives of State agencies that perform services related to maternal care, to be appointed by the Governor.
(3) Two representatives of a federally recognized Indian Tribe, to be appointed by the Governor.
(4) Two obstetrician-gynecologists or other physicians licensed to practice in this State who provide obstetric care, with consideration for physicians who are from, or work in, communities experiencing a high rate of mortality and morbidity from COVID-19, to be appointed by the Governor, in consultation with the Secretary.
(5) Two midwives certified in this State who provide obstetric care, with consideration for midwives who are from, or work in, communities experiencing a high rate of mortality and morbidity from COVID-19, one each to be appointed by the Speaker of the House of Representatives and the President Pro Tempore of the Senate.
(6) Two nurses licensed in this State who provide obstetric care, with consideration for nurses who are from, or work in, communities experiencing a high rate of mortality and morbidity from COVID-19, one each to be

appointed by the Speaker of the House of Representatives and the President Pro Tempore of the Senate.

(7) Two perinatal health workers, to be appointed by the Majority Leader of the House of Representatives.

(8) Two individuals who were pregnant or gave birth during the COVID-19 public health emergency, to be appointed by the Majority Leader of the Senate.

(9) Two individuals who had the virus that causes COVID-19 and later gave birth, to be appointed by the Minority Leader of the House of Representatives.

(10) Two individuals who have received support from a perinatal health worker, to be appointed by the Minority Leader of the Senate.

(11) Three independent experts with knowledge of racial and ethnic disparities, one each with a background in public health; maternal health, maternal mortality, and severe maternal morbidity; or respectful maternity care, to be appointed by the Governor, in consultation with the Secretary.

(c) Task Force Chair and Meetings. – The Secretary shall select a chair from among the members of the Task Force, and the Task Force shall meet at least quarterly upon the call of the chair.

(d) Task Force Report. – Not later than January 1, 2023, and every two years thereafter, the Department of Health and Human Services, in consultation with the Task Force on Birthing Experience and Safe Maternity Care During a Public Health Emergency shall submit to the Governor and the General Assembly a report on maternal health and public health emergency preparedness. In addition to the recommendations described in subsection (a) of this section, the report shall include all of the following:

(1) A review of prenatal, labor and delivery, and postpartum experiences of individuals during the COVID-19 public health emergency, including the following:

a. Barriers to accessing pregnancy, birth, and postpartum care during the COVID-19 public health emergency.

b. Information on public and private insurance coverage with respect to maternal health care during the COVID-19 public health emergency, including telehealth services.

c. To the extent practicable, maternal and infant health outcomes by race and ethnicity, including information about quality of care, mortality, morbidity, cesarean section rates, preterm birth, prevalence of prenatal and postpartum mental health conditions, and substance use disorders.

d. With respect to such health outcomes, the impact of federal and State policy changes during the public health emergency.

e. Contributing factors to population-based disparities in health outcomes, including bias and discrimination toward individuals from racial and ethnic minority groups.

f. The effect of increased unemployment, changes in health care coverage or delivery, and other social, economic, or policy changes that shape social determinants of health for pregnant and postpartum individuals during the public health emergency.

(2) Recommendations for improving the State's public health emergency response and preparedness efforts with respect to maternal health, with a focus on ensuring respectful maternity care and improving outcomes for pregnant, birthing, and postpartum individuals from racial and ethnic minority groups, including the following:

a. Improving research, surveillance, and data collection with respect to maternal health.
b. Factoring maternal health outcomes and disparities into decisions regarding distribution of resources.
c. Improving the distribution of public health funds, data, and information to Indian tribes and tribal organizations with regard to maternal health during a public health emergency.
d. Improving communications during a public health emergency with the following groups:
1. Maternity care providers.
2. Maternal mental and behavioral health care providers.
3. Researchers who specialize in maternal health, maternal mortality, or severe maternal morbidity.
4. Individuals who experienced pregnancy or childbirth during the public health emergency.
5. Representatives from community-based organizations that address maternal health.
6. Perinatal health workers."

SECTION 4.5.(b) This section becomes effective October 1, 2021.

PART V. EFFECTIVE DATE FOR ACT

SECTION 5.1. Except as otherwise provided, this act is effective when it becomes law.