This Bill establishes the Maternal Mortality Review Program in the Department of Health and Human Services. The director must develop a system, in consultation with the Maternal Child Health Advisory Board, to:

1. Identify maternal death cases
2. Review records and data
3. Contact appropriate individuals to collect additional data
4. Consult with experts
5. Make recommendations concerning preventability
6. Develop recommendations for the prevention of maternal mortality
7. Disseminate findings and recommendations to policy makers, health care providers, health care facilities and the general public.

**Description**

The bill details reporting requirements and access to death certificates and relevant medical and records in cases where maternal death is suspected. A health care provider or facility may not be held liable for civil damages to subject to criminal or disciplinary action for good faith efforts to comply with the bill’s requirements.

**Whereas:**

Maternal deaths are a serious public health concern and have a tremendous family and societal impact, Maternal deaths are significantly underestimated and inadequately documented, preventing efforts to identify and reduce or eliminate the causes of death.
No processes exist in the state for the confidential identification, investigation or dissemination of findings regarding maternal deaths

Be it resolved that:
There is a need to establish a maternal mortality review program to review maternal death and to develop strategies for the prevention of maternal deaths.

Definitions

**Aggregate data:** used to develop information about groups of patients. It allows healthcare professionals to identify common characteristics that might predict the course of the disease or provide information about the most effective way to treat a disease.

**Individually identifiable information:** Information including demographic information that relates to the individual’s identity or for which there is a reasonable basis to believe it can be used to identify the individual

**Maternal mortality:** The death of a woman during pregnancy, childbirth, and the post partum period (up to 365 days from the end of pregnancy).

**Maternal death:** The death of a woman while pregnant or within 42 days of termination of pregnancy, regardless of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

**Pregnancy-associated death:** The death of a woman while pregnant or within one year of the termination of pregnancy, regardless of the cause. These deaths make up the universe of maternal mortality: within that universe are pregnancy related deaths and pregnancy associated deaths but not related deaths.
Pregnancy associated, but not related death: The death of a woman while pregnant or within one year of termination of pregnancy due to a cause unrelated to pregnancy (e.g. a pregnant woman dies in an earthquake).

Pregnancy-related death: The death of a woman while pregnant or within one year of termination of pregnancy, regardless of the duration and site of pregnancy from any cause related to or aggravated by her pregnancy or its management, but not form accidental or incidental causes (e.g. a pregnant woman dies due to eclampsia)

Pregnancy-related mortality ratio: The number of pregnancy-related deaths per 100,000 live births (the numerator is not a subset of the denominator)

Severe maternal morbidity: Unintended outcomes of the process of labor and delivery that result in significant short-term or long-term consequences to a woman’s health

Sentinel Event: Any unanticipated event in a healthcare setting resulting in death or serious physical and psychological injury to a patient or patients, not related to the natural course of the patient’s illness

Establishment of Committee
The Maternal Mortality Review Committee is created in the Department of Health and Human Services.

Members of the Committee
The Committee shall be multidisciplinary and composed of such members as designated by the department or by a designee of the department. The committee may develop subcommittees to carry out the purpose of the committee.

The department will endeavor to include members who reflect the racial, ethnic, and linguistic diversity of the state, members
who are working in and representing communities that are
diverse with regard to race, ethnicity, immigration status,
English proficiency and from different geographic regions in the
state, including both rural and urban area.

**Duties of the Committee**
The Maternal Mortality Review Committee (MMRC) will:
Identify, study and review **all cases** of maternal deaths
Review medical records and other relevant data including birth
and death certificates, autopsy, hospital ER, medical transport,
social services, and mental health and law enforcement records.
Develop recommendations for the prevention of maternal
deaths
Disseminate findings and recommendations to policy makes,
health care providers, health care facilities and the public.

MMRC is authorized to
1. Consult with experts and stakeholders to evaluate
   records, and to promote the **highest possible collection and quality of data**.
2. Contract with outside parties to assist in collecting
   analyzing and disseminating the maternal mortality
   information.
3. Contract with outside parties to organize and convene
   meetings of the committee
4. Other tasks as may be incident to these activities.
5. The Committee also may review cases and trends in
   severe maternal morbidity as they are considered
   sentinel events.

**Authorization to Access Data**
Data for the Committee’s review and reporting shall be provided to the committee, upon the request of the committee, from health care providers, health care facilities, clinics, laboratories, medical examiners, coroners, social services, professions and facilities licensed by the Department of Health and Human Services, local health jurisdictions, law enforcement agencies, any other agencies or officials having information that is necessary for the committee to carry out its duties.

**Confidentiality and Immunity**

All information, records of interviews, written reports, statements, notes, memoranda or other data obtained by the department, the committee, or other persons, agencies, or organizations so authorized by the department under this section shall be confidential.

No person participating in such review shall disclose in any manner, the information so obtained except in strict conformity with such review project.

A member of the committee or person employed by or acting in an advisory capacity to the committee and who provides information, counsel or services to the committee is not liable for damages for an action taken within the scope of the functions of the committee. This section does not provide immunity for a violation of state of federal law or rule relating to the privacy of health information of or the transmission of health information, including HIPAA.

All proceedings and activities of the committee, opinions of members of the committee formed as a result of those proceedings and activities, and records obtained, created, or maintained under this section, including records of interviews,
written reports and statements procured by the department or any other person, agency or organization acting jointly or under contract with the department in connection with requirements of this section shall be confidential and shall not be subject to the Nevada State Public Records Act relating to open meetings and inspection of records, or subject to subpoena, discovery or introduction into evidence in any civil or criminal proceedings; however, nothing in this section 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 independent of the proceedings of this committee.

Information, records, reports, statements, notes, memoranda or other data collected pursuant to this section shall not be admissible as evidence in any action of any kind in any court or before any other tribunal, board, agency, or person.

**Dissemination of recommendations**

On or before December 31st of even years, the commissioner of health shall submit a report to the house committees on health care and on human services and the senate committee on health and welfare containing at least the following information.

1. Description of the adverse events reviewed by the panel during the preceding 12-24 months, including statistics and causes
2. Corrective action plans to address, in the aggregate, such adverse events
3. Recommendations for system changes and legislation relating to the delivery of health care.
Reports of aggregated nonindividually identifiable data shall be complied on a routine basis for distribution in an effort to further study the causes and problems associated with maternal deaths. Reports shall be available to the General Assembly, health care providers and facilities, key government agencies, and others necessary to reduce the maternal death rate.

By December 31, 2019, the Secretary of Health and Human services for the state of Nevada shall adopt and promulgate rules to carry out the provisions of this act.

The first public report will be due on 1/15/2021

**Funding**

The legislature additionally finds that comprehensive reviews of maternal deaths are a matter of ongoing concern. Because the program reviews much be sustainable, the legislature recognizes the need to provide funding to conduct maternal death reviews not only in the current biennium but in subsequent biennia as well.

The department shall apply for and use any available federal money to fund the duties of the department and the MMRC.

The Department may accept gifts and grants from any source to fund the duties of the department and the MMRC.