

Transcript Prepared by Clerk of the Legislature Transcribers Office
Health and Human Services Committee January 19, 2022

ARCH: Good afternoon. Welcome to the first hearing this-- for this session for the Health and Human Services Committee. My name is John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. I'd like to invite the members of the committee to introduce themselves starting on my right with Senator Murman.

MURMAN: Hello. I'm Senator Dave Murmen from District 38 and I represent most of eight counties along the southern tier of the state and the middle part of the state.

WALZ: My name is Lynne Walz. I represent Legislative District 15, which is all of Dodge County and now a little bit of-- part of Valley.

WILLIAMS: Matt Williams from Gothenburg, Legislative District 36.

M. CAVANAUGH: Machaela Cavanaugh, District 6, west-Central Omaha, Douglas County.

ARCH: Also assisting the committee is one of our legal counsels, Paul Henderson, our committee clerk Geri Williams, and our committee pages, Jason and Chloe. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This afternoon, we will begin hearing three bills. We'll be taking them in the order listed on the agenda outside the room. The hearing on each bill will begin with the introducer's opening statement. After the opening statement, we will hear from supporters of the bill and then from those in opposition, followed by those speaking in a neutral capacity. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. For those of you who are planning to testify, you will find green testifier sheets on the table near the entrance of the hearing room. Please fill one out, hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. When you do come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. We use a light system for testifying. Each testifying will have five minutes to testify. When you begin, the light will be green. When the light turns yellow, that means you have one minute left, and when the light turns red, it is time to end your testimony. We will ask you to wrap up your final thoughts. If you wish to appear on the committee statement as having a position on one of those bills before us, you must testify. If you simply want to be part of the official record of the hearing, you may

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submit written comments for the record online via the Chamber Viewer page for each bill. However, those comments must be submitted prior to noon on the work day before the hearing in order to be included in the official record. Additionally, there is a white sign-in sheet at the entrance where you may leave your name and position on the bills before us today. With that, we will begin today's hearing with LB741 and welcome Senator DeBoer.

DeBOER: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Wendy DeBoer, W-e-n-d-y D-e-B-o-e-r, and I represent Legislative District 10, which is in northwest Omaha. I'm here to introduce LB741, a bill to include collection of data on stillbirths in the current review of maternal and child deaths. Several years ago, a change in the law resulted in data on stillbirths no longer being collected and reviewed by the Fetal Infant Mortality Review team, or FIMR, in the Douglas County Health Department. LB741 adds a definition of stillbirths and authorization to collect data in the Child and Maternal Death Review Act, authorization to collect data. It is not my intent in this legislation to require the Department of Health and Human Services to collect this data, only to authorize it in the statute because the Douglas County Health Department receives its authority to conduct the FIMR reviews through that same statute. It is my understanding that Douglas County will be able to do the required work with-- to review the stillbirth data. So there will be others that will testify after me about the process. I've worked with the department and have an amendment that will clarify the intention just to make sure it's absolutely clear. You have the amendment, I think, in front of you and this is what the department wanted. It tightens the definitions of stillbirth to those that resulted in a fetal death certificate so that they have the information and it clarifies that DHHS is not required, but only permitted to review the data. I appreciate DHHS working with me on the amendment and they have indicated to me that this amendment addresses their concerns so they won't be testifying on the bill, just got that email a little bit ago. So I want to thank all the groups that are working with me on this bill. We worked with First Five Nebraska, the Douglas County Health Department, the Catholic Conference, the March of Dimes, the Department of Health and Human Services, and others. Collecting this data so it can be reviewed by experts will go a long way in preventing stillbirths and leading to healthier pregnancies and children. So I'll be happy to answer any questions that you have at this time.

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ARCH: Are there questions? I guess I just have one. So the issue that you're trying to address is right now, they're not authorized to collect this information.

DeBOER: That's right.

ARCH: OK.

DeBOER: They need to have the authorization through the Department of Health and Human Services so that the sort of corresponding authorization for FIMRs is allowed to collect the data--

ARCH: OK.

DeBOER: --and aggregate the data.

ARCH: OK, thank you. Any other questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, Senator DeBoer. With the amendment and the comments that you have made concerning the department, does that change anything in the original fiscal note that was presented?

DeBOER: I believe it will because it is only permissive to collect the data and they are not required to do it. There was some confusion with the word "all." They thought maybe that made them have to collect the data. So we just wanted to be very, very clear. We added a statement that said nothing requires this data to be collected by the department. I believe that that will change the fiscal note, but--

WILLIAMS: OK.

DeBOER: --we'll have to wait and see, but you certainly could ask the department what they think.

WILLIAMS: Thank you.

ARCH: Other questions? Seeing none, thank you.

DeBOER: Um-hum.

ARCH: First proponent for LB741. Good afternoon.

ANN ANDERSON BERRY: Hello. Good afternoon, Chair Arch and members of the Health and Human Services Committee. I am Dr. Ann Anderson Berry. For the record, A-n-n A-n-d-e-r-s-o-n B-e-r-r-y. I'm a faculty member

of UNMC and the medical director of the Nebraska Perinatal Quality Improvement Collaborative, or NPQIC. However, I am not speaking as a representative of the university today. I am here speaking as an individual and on behalf of the Nebraska Perinatal Quality Improvement Collaborative, Collaborative, Nebraska Medical Association, and Children's Hospital and Medical Center. I am here testifying with regards to LB741. The Nebraska Perinatal Quality Improvement Collaborative works to reduce maternal and neonatal mortality and morbidity outcomes in our state through improvement science. The well-established process of maternal and pediatric mortality review involves the identification of opportunity for improvement by analysis of data, implementation of evidence-based practices that are likely to result in improvement, and then evaluation and adoption of strategies until sustained improvement is achieved. I am here to support the inclusion of fetal death reviews in this Nebraska statute. Due to a wording omission when these maternal and pediatric mortality reviews were last revised in 2013, we have not had the ability to review fetal deaths after 20 weeks, also called stillbirths. Without data from these reviews, we are unable to effectively and efficiently develop targeted initiatives to decrease fetal mortality rates. Here in Nebraska, we value families and this is one important way that we can support them. Fortunately, with your support and legislative approval of this bill, we will again have opportunities to conduct and perform stillbirth reviews. And with that process, all stakeholders can work together to ensure that evidence-based interventions are made to reduce preventable stillbirths, ensuring that more families can welcome their newborn babies into their homes. Approval of this bill will subsequently allow stakeholders to identify and then address perinatal issues that increase the risk of stillbirth. Several factors that may be identified in these death reviews include the need for implementation of effective interventions or increased monitoring of pregnancies with risk factors such as overweight, obesity, young or advanced maternal age, and smoking. Each of these has been identified as potential priorities for stillbirth prevention. Having Nebraska data would allow us to focus our resources where they will make the most local impact. Other free and simple interventions, such as counting fetal kicks in the third trimester, can be recommended to pregnant women and are most impactful with local data to support such initiatives. Nebraska can work alongside other states to implement these interventions only if we have our own data and transparency surrounding outcomes. NPQIC is ideally situated as an organization with a diverse board of directors, a statewide footprint, and a close working relationship with DHHS to implement recommendations. NPQIC's

past successes in statewide implementation of initiatives for at-risk perinatal populations speaks to our ability to contribute to the success of this proposed new initiative. In my professional life, I have personally cared for many families still grieving the stillbirth of past pregnancies as they deliver their newborn. These grieving families are grappling with mourning the loss of a child while celebrating the arrival of their newborn. There is even a phrase for these situations, delivering rainbow babies, seeing sunshine through the rain. Let's work together to ensure fewer stillbirths and more bright days for Nebraska families. Nebraska healthcare professionals can work together to avoid such devastating losses for families across Nebraska. The state is a necessary public health partner if we are to ensure and improve safety for Nebraska families. In conclusion, Nebraska's mother and babies need the work of not only our perinatal collaborative, but of all stakeholders, including, most importantly, our state governing bodies. NPQIC stands at the ready with the skills to work to improve pregnancy outcomes, but without data and support from the state, we are flying blind. With a statewide presence and our highly skilled staff and volunteers, NPQIC and Nebraska healthcare providers have the potential to provide an even greater impact in close partnership with the state of Nebraska. Together, Nebraska's perinatal collaborative will continue to work so that Nebraska will be a state where a great life starts with healthy moms and healthy babies. Thank you.

ARCH: Thank you. Questions? I, I have one. If, if the state is not required to collect this data, where will you receive the data?

ANN ANDERSON BERRY: So Douglas County has FIMR and they will-- they have a bulk of the, the population and so that will be the initial group that collects this. But we would hope that we can utilize the Douglas County system and expand these collections over the years. So, you know, Lancaster County is-- has a large population base. Up to 25 percent of stillbirths are deemed preventable and so the work that we do in Douglas County can be reflected across the state as well, but we need some data to get started.

ARCH: Thank you.

ANN ANDERSON BERRY: Yep.

ARCH: Any other questions? Senator Murman.

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MURMAN: Thanks for testifying. And I agree this would be a very valuable tool. I assume all of the information would not be individual specific, it would just be general--

ANN ANDERSON BERRY: Absolutely.

MURMAN: --data.

ANN ANDERSON BERRY: And that's why we start in the larger counties because when you get into our smaller counties and you have an instance of one, you know, that's really not reportable data, so we have to de-identify anything. And you can do that by either combining multiple years or by combining multiple regions. And so it could be that just having Douglas County and then maybe adding Lancaster County will give us enough local information that we wouldn't have to go to those smaller population states and worry about, you know, potentially de-identifying data that's private. And the processes involved are very, very cognisant of that and so there are lots of stipulations so that we, we make sure that health information is private.

MURMAN: Well, I agree. I would definitely want to keep it private, but it-- there would be possibly some useful information if there was like an environmental factor in a certain area.

ANN ANDERSON BERRY: Absolutely. And that's something that we're cognisant of in child health research as well. And so you have to balance that, that valuable information with the privacy information, and that's where grouping years together instead of grouping districts together can be helpful as well. And so we have data scientists that can help us guide through those rules and regulations to get the most impact out of the data that's available.

MURMAN: Thank you.

ANN ANDERSON BERRY: It's very important. Thank you.

ARCH: Other questions? Seeing none, thank you very much for your testimony.

ANN ANDERSON BERRY: I appreciate your time. Thank you.

ARCH: Next proponent for LB741. Good afternoon.

CHAD ABRESCH: Good afternoon. Good afternoon, Chairperson Arch and members of the Health and Human Services Committee. I am Dr. Chad

Abresch. For the record, C-h-a-d A-b-r-e-s-c-h. I'm a faculty member at, at UNMC. Today, however, I speak on behalf of myself. I have dedicated the past two decades of my career to partnering with cities and states to improve maternal and child health outcomes and this includes right here in the state of Nebraska, where I help to educate our future public health leaders and serve on Omaha's Healthy Start Community Action Network. I'm here today in support of LB741, which will allow, again, for the review of stillbirths in Nebraska. Under current law, the state only reviews child deaths that occur between ages zero to 18. This neglects an extremely important group of deaths, those that occur between 20 weeks gestation and birth. This bill will amend that language to allow for the review of these deaths, referred to here as stillbirths. While the proposed changes in LB741 may seem minor, amending the language in this law will allow us to have better accounting and review of stillbirths in our state, something that we lost, as you heard earlier in 2013, when the language was inadvertently changed. Accounting for stillbirths is critical because of at least three reasons. First, there are about as many stillbirths as there are infant deaths. I have included in Appendix A, on the flip side of your page here with my written remarks, data from the Centers for Disease Control and Prevention specific to Nebraska. These data demonstrate that over the course of the past 12 years, Nebraska's numbers for these groups are very, very similar. In fact, we had just 19 stillbirths more than infant deaths during these 12 years. So ignoring these deaths means that we're missing about half of the information. This would be like one of my students showing up for the final, having attended only half of the classes and done only half of the readings. To be sure they would be ill equipped to take that exam. Secondly, approximately 20 percent of stillbirths may be preventable in Nebraska by addressing community and medical factors. Prior to 2013, when the state statute was changed and we lost the ability to subpoena records and review stillbirths, we were making progress. I have included in Appendix D, which you can also see there, data that is directly from Douglas County and that shows decreasing rates of stillbirths weighing 1500 grams or more. You can see that in the pink boxes. These data come from a presentation that was delivered by Mary Balluff, who was directing maternal and child health programs for Douglas County Health Department in 2013 when that law was changed. And in this presentation, she stresses that stillbirths reviews had recently accounted for 75 percent of their prevention recommendations, 25 percent had come from infant reviews. So in fact, stillbirth reviews were consistently identifying prevention needs that were not discovered in the infant death reviews. The bottom line is this:

stillbirth reviews reveal needed prevention activities, which result in saved lives for Nebraskans. Third and finally, and this is, I think, most important, stillbirths matter for Nebraska families. I know close colleagues and friends who have experienced these painful losses, and in my own family, my wife and I lost a little one just prior to 20 weeks and we mourned his loss over many tears. I'm sure members of this committee could share similar stories. Here in Nebraska, I think that we do a pretty good job of caring for one another. It's part of what makes Nebraska the good life. LB741, I think, is more than a small language change in the statutes. It's, it's more than just about collecting data and enabling reviews. LB741 will better reflect the value and the care that we hold for one another. So I thank the senator for introducing it and I urge the committee to advance it. Thank you.

ARCH: Thank you. Questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, doctor. In your testimony, you talked about how the law changed in 2013 and you used the term "inadvertently changed." Can you explain that a little more what the rationale was, if there was any, to the change at that time?

CHAD ABRESCH: I believe, and we may want to ask Sara Howard as well, but I believe that the inadvertent change came simply from defining what a child death review was and putting in language that defined it from age zero to 18. So after that, you were no longer allowed to subpoena records from that 20-week gestation to zero. And members of the committee, this was an important question that came up before, too, about maintaining confidentiality. Members of those review committees were no longer protected from being called to testify on those cases. So this language will correct for that and help to maintain that confidentiality and allow for the subpoena of cases.

WILLIAMS: Thank you. That's helpful.

ARCH: Other questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. This is a, I guess, a medical classification. So stillbirth is 20 weeks and after. Is that a universal definition of a stillbirth or is that something that-- in Nebraska or how would-- how do you determine that?

CHAD ABRESCH: And this law-- in the-- this bill, in the language, defines stillbirth as 20 weeks--

M. CAVANAUGH: And then--

CHAD ABRESCH: --to gestation.

M. CAVANAUGH: And then--

CHAD ABRESCH: In, in public health circles, they would probably most commonly call that a fetal loss or a fetal death.

M. CAVANAUGH: OK. What is-- what would be the difference between calling it a stillbirth versus a fetal loss or fetal death?

CHAD ABRESCH: I think that the, the twen-- beyond 20 weeks gestation.

M. CAVANAUGH: OK. So anything before 20 weeks gestation would be a fetal loss?

CHAD ABRESCH: Could still be considered a fetal loss, yes.

M. CAVANAUGH: OK. Thank you.

ARCH: OK. Other questions? I have, I have one. The CDC data on-- in Appendix A identifies stillbirths in the state of Nebraska and, and we're saying that the department doesn't have to collect that, but obviously they're-- the, the CDC is collecting it, correct?

CHAD ABRESCH: Yeah and, and I would believe that that's submitted from the state to the CDC.

ARCH: OK.

CHAD ABRESCH: I don't have the specifics on how that information is transferred, how that data is collected or transferred.

ARCH: So would you anticipate-- if, if this were 2018, would you anticipate looking at all 105 stillbirths?

CHAD ABRESCH: So I would not for a couple of reasons. Number one, again, this, this proposed bill does not require the state to review at all.

ARCH: Right.

CHAD ABRESCH: What we're really interested in doing is making sure that, that Douglas County, which has a FIMR, which is a fetal infant mortality review, is able to review cases of fetal or stillbirth

deaths that happen within Douglas County. It would also allow the state to do it if, if they were to choose to do it. Most FIMRs will not review all cases of fetal or infant deaths. They, they purposefully select ones that might be more illustrative of some of the challenges that they're facing. So it's not about comprehensive review of all of them.

ARCH: All right, thank you. Senator Murman.

MURMAN: The bill, I guess, just authorizes DHHS to collect the data, so-- and but I hear subpoena come in. I guess I'm confused as to where that-- where subpoena comes into that.

CHAD ABRESCH: So this might be a question for someone that, that's more expert in legislative pieces rather than public health pieces. But my understanding here is, is that the, the FIMRs, the local FIMRs, will need that authority to be able to collect that information and, and for committee members who review it to not be able to be called to testify about it, which helps, again, maintain the confidentiality.

MURMAN: OK, thank you.

ARCH: All right. Any other questions? Seeing none, thank you very much for your testimony.

CHAD ABRESCH: Thank you.

ARCH: Next proponent for LB741. Hello.

LEAH CASANAVE: Hi. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Leah Casanave, L-e-a-h C-a-s-a-n-a-v-e, and I work at the Douglas County Health Department in Omaha. I have been employed there for about six years and have just recently been promoted to the division chief of community health, nutrition, and clinical services. So with that promotion, I have now been able to oversee our fetal infant mortality review program. And just a fair warning. I've been in this position for about three and a half, four weeks now, so I'm quickly learning. So I want to thank the senator for introducing LB741 and for her commitment to ensuring quality data is used to inform public policy and save lives. LB741 gives the state maternal and child death review team the authority to gather records related to stillbirth death outcomes, but does not obligate them to conduct the review themselves. Douglas County Health Department has a 15-year history of addressing fetal mortality between 2006 and 2013 and infant mortality from 2006 to currently, through the

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FIMR process. So authority for Douglas County femur comes through the Nebraska Child and Maternal Death Review Team. And the FIMR process involves data gathering, reviewing of medical records, and a maternal interview that is brought before the case review team to review. So this team consists of health professionals, social workers, pastors, educators, mental health providers, minority rights advocates, and public health. So this case review team works to examine confidential de-identified cases of infant deaths. The CRT works to identify barriers to care, services needed, consider social and economic issues that may have contributed to infant death, and provide recommendations for policy improvement as we strive to continually improve both maternal and infant outcomes. So some data for you: since 2009, infant mortality rates for Douglas County has been as high as 7.2 in 2016 and as low as 4.2 in 2012, with a significant difference in rates when we look at race and ethnicity. Infant mortality rates for black infants has been as high as 20.7 in 2016 and as low as 7.2 in 2014. Infant mortality rates for Hispanic infants has been as high as 9.9 in 2015 and as low as 4.7 in 2018. So State Statute 71-3405 specified child as birth to 18 years of age. As a result of this change, the maternal-- Child Maternal Death Review Team no longer had the authority to issue subpoenas for fetal death and was not able to extend this authority to the Douglas County FIMR. And since 2014, Douglas County has no longer reviewed the fetal deaths. So in looking at the numbers of fetal and infant deaths that occur in Douglas County, we can see that fetal deaths, stillbirths, still account for close to half of the infant and fetal deaths in our county and not including this in our case review team is a disservice to our community. Fetal deaths do not always have the same cause as [SIC] death as our infant deaths. So as we look at the factors, the impact, maternal infant fetal loss, such as mental health, early entry into prenatal care, previous fetal loss and pregnancy-related issues, it is imperative that we continue to review both fetal and infant deaths to identify contributing factors and provide policy recommendations for improved health outcomes for both mother, fetus, and infant. So thank you for your time and attention to this serious matter and your careful consideration. Any questions?

ARCH: Thank you. Are there questions? So I have a question.

LEAH CASANAVE: OK.

ARCH: Do you, do you have the capacity to, to review more cases?

LEAH CASANAVE: That is a great question. Currently, our public health nurse that was in this position of doing the fetal infant mortality

reviews actually retired about a month ago. So we're in the process of hiring for that position right now and we will. That is that person's sole purpose is to kind of lead this case review team that is consisting of outside entities coming in and kind of reviewing it.

ARCH: OK, great.

LEAH CASANAVE: Yeah.

ARCH: Thank you.

LEAH CASANAVE: Um-hum.

ARCH: Any other questions? Seeing none, thank you very much for your testimony.

LEAH CASANAVE: Thank you, guys.

ARCH: Next proponent for LB741. Good afternoon.

CHRISTIAN MINTER: Good morning, Chairperson Arch and members of the Health and Human Services Committee. I am Christian Minter. For the record, C-h-r-i-s-t-i-a-n M-i-n-t-e-r. I am manager of maternal and infant health initiative for March of Dimes, the leading nonprofit organization fighting for the health of all moms and babies. Thank you for the opportunity to offer testimony for LB741. So one of the key measures of a community's health and wellbeing is the health outcomes of infants, including the rate of infant mortality and stillbirth. In 2019, there were 24,755 live births in Nebraska. The infant mortality rate was 5 per 1,000 live births and infant mortality is defined as a death of a baby before one year of age, with the leading causes of infant mortality including birth defects, prematurity, low birth weight, maternal health complications, and sudden infant death syndrome. In 2019, the stillbirth rate was also 5 per 1,000 live births. Stillbirth is defined as the loss of a baby after 20 weeks of pregnancy and before birth. In many cases, the cause of stillbirth may be unknown. However, contributing factors may include complications of the placenta or umbilical cord, birth defects, and maternal health complications. Stillbirth is a shocking and sentinel event in the life of a family. Families are left stunned and numb by such an outcome. Parents who experience a stillbirth have a higher risk of reporting depression, anxiety, and post-traumatic stress disorder. Although the rate of stillbirth in Nebraska is similar to that of infant mortality, stillbirth does not currently receive the same priority for data collection, analysis, and reporting. This bill will enable a

comprehensive approach to collecting the relevant records needed to study the causes of stillbirth in our state. Access to this data is crucial to making meaningful recommendations for preventing future infant loss. This data can provide baseline information on infant health, identify existing health disparities, and measure the impact of interventions that are implemented to support families. March of Dimes supports efforts to improve data collection and data sharing on infant mortality and stillbirth, especially through the work of a fetal infant mortality review team. As you already heard, FIMR is similar to the State Maternal Mortality Review Committee and while the MMRC performs comprehensive review and recommendations in the prevention of maternal death, FIMR is focused on review and prevention of infant death. FIMR is a national quality improvement model that's facilitated locally by Douglas County Health Department to help communities improve the services and resources needed to help all babies survive and thrive. A team of multidisciplinary professionals review de-identified clinical findings and data regarding the circumstances surrounding a stillbirth or infant death and then make recommendations aimed at improving infant outcomes in Nebraska communities. LB741 will help further FIMR's work in developing effective recommendations and community action plans to reduce the rate of infant loss. On behalf of all the moms and babies we work to protect, the March of Dimes urges the Health and Human Services Committee to support LB741. Please help us bring all Nebraska babies to their first birthday. Thank you for all that you do to support the health of Nebraska residents.

ARCH: Thank you. Are there any questions? Seeing none, thank you very much for your testimony. Next proponent. Are there any proponents that would like to speak?

SARA HOWARD: Just the last one. Hello.

ARCH: Welcome.

SARA HOWARD: Welcome. Good afternoon, everybody. Nice to see you. OK, thank you for allowing me to testify today. My name is Sara Howard, S-a-r-a H-o-w-a-r-d. I'm a policy advisor at First Five Nebraska. I'm not going to look at Senator Walz right now. First Five Nebraska as a statewide public policy organization focused on promoting early-- quality early care and learning opportunities for Nebraska's youngest children. My work at First Five Nebraska is focused on maternal and infant health policy, a new area of focus for the organization, and recognizes what we all know already, that healthy moms and babies are

critical to ensuring the long-term success of children in our state. I'm here to testify in support of LB741, a bill to ensure that stillbirth deaths in the state are reviewed so that recommendations may be made to prevent these heartbreaking birth outcomes. I want to thank Senator DeBoer for introducing LB741 and for her commitment to ensuring quality data is used to help Nebraska families and babies. LB741 gives the State Maternal and Child Death Review Team the authority to gather records related to stillbirth deaths, but does not obligate them to conduct the reviews themselves. All right, so I'm going to stop reading now because this is, this is lovely, but-- OK, so I'm going to just give you the history of the Child Death Review team. So in 1993, Jesse Rasmussen. There were 300 unexplained child deaths in the state of Nebraska in 1993 and so they did an interim study and then decided to craft and create what was the original statute for the Child Death Review Team. And then in 2013, there was a new young whippersnapper senator who said, why are we not looking at maternal deaths? And that whippersnapper added maternal morbidity to-- mortality to the Child Death Review Team, to the work of the team. And when she was making those changes, she modified the definitions and statute of what the team was able to collect in terms of data. It was a mistake that I made my first year in the Legislature and I didn't realize I was making it. It was one of those things where, well, of course, you know, you're going to look at child deaths and that's zero to, to 18 that makes sense. If you look at the statute in its original, before I messed with it, they actually, spoiler, did not have the ability to gather stillbirth death outcomes. They were just gathering them. They just sort of had a very broad purview and so they were gathering them without authority. So what's nice about this bill and the work that Senator DeBoer and her office has put in is that this language gives them the authority to gather those records, but then they can share them with the FIMRs group. Now originally I thought, oh, they're gathering-- the state is gathering the records and they're sharing them. But if you look at the original statute, so I'll turn-- if you have your green copies, you can look at the bottom of page 5. And from the original 1993 statute, there was always the ability for the state to enter into an agreement with a public health department and the public health department acts as their agent. So in essence, Douglas County acts as an agent of the state and will collect the records and analyze the records. So the state will have nothing to do with the work of the reviews itself, not the data gathering, not the reviews. Rather, Douglas County Health Department will be doing this work on behalf of FIMRs. So that's the history, that's the background. That's-- I guess someday you guys will have to fix your,

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your bills as well from your first year. OK, so in my, in my view and from my understanding with DHHS, the amendment does address the fiscal note. What I will say is that part of those conversations were also around needing additional members of the team, which would-- members of the Child and Maternal Death Review Team, which would open them up to the opportunity, potentially if they wanted to start reviewing stillbirths on a statewide level, they could if they had just a few more volunteer members of the team. That being said, I would highlight right, right now, pending on General File is Senator Vargas' LB626, which you all advanced unanimously. That bill separates the teams, one for maternal mortality and morbidity, one for children, and then adds additional members of the team. So the language is very, very good for that bill, but it's pending on General File unanimously. If I had my druthers and I'm not in your seats anymore, but I would recommend that maybe you consider LB741 as a vehicle for LB626 and attach them together in committee. That would probably help Drafters and save them some headaches as well because of the complexity of the language within LB626 and the changes within the stillbirth data. I would also want to highlight two fund letters that you got: Dr. Bob Bonebreak-- that is his real name. He is the chair of the maternal mortality group. He sent a letter in support of this change and the Catholic Conference as well, who helped a great deal on the language and the definitions. So we worked with providers and the Catholic Conference and other stakeholders to make sure the definition was correct. Finally, you do have an opposition letter for Ms. Mary Sullivan from the Nebraska Association of Social Workers. I spoke with her this morning, clarified the intent of the legislation, and she has sent a subsequent, additional sort of note. She knows it will not go into the record. They have changed their position to neutral. If you did not get that note, probably not, but she sent it in because now it can't go on the record. If you do not get that note, she's happy to send individual emails to all of the senators on the committee to make sure you know that their position has changed from opposition to neutral. And with that, I just want to thank Senator DeBoer for introducing this bill. I do think this will be a big step forward for data collection in the state of Nebraska and prevention of stillbirth deaths, which we can only prevent once we know the causes. And I appreciate your time and attention to LB741. I'm happy to try to answer any questions for you. I'm the last person. You can ask the hardest ones you want. I'm, I'm here all day. Tip your waiters generously.

ARCH: Questions? Thank you. Senator Cavanaugh.

SARA HOWARD: Oh geez, oh geez.

M. CAVANAUGH: So this was a mistake you made your freshman year. Would you-- on a scale, would this be worse than taking a scope-of-practice bill or--

SARA HOWARD: Which was also a mistake I made my first year.

M. CAVANAUGH: Just-- I mean, I have you here, I may as well roast you.

SARA HOWARD: You know--

ARCH: [INAUDIBLE]

SARA HOWARD: It's just you learn a lot when you're-- you're just--

M. CAVANAUGH: You know I kid. You can plead the fifth. You don't have to answer that.

SARA HOWARD: Yeah, I don't know, which is-- well, yes.

M. CAVANAUGH: Thank you for making the fix.

SARA HOWARD: Thank you for, thank you for helping me make the fix.

ARCH: Other questions? Seeing none, thanks very much for coming today and--

SARA HOWARD: Thank you.

ARCH: --pleasure to see you.

SARA HOWARD: I'll be back.

ARCH: OK.

SARA HOWARD: You stay where you are.

ARCH: All right.

SARA HOWARD: I'll come back to you.

ARCH: All right, thank you. Any other proponents for LB741? Are there any opponents for LB741? Anyone wish to testify in a neutral position? Seeing none, Senator DeBoer, while you're, while you are coming, Senator Howard mentioned some of the letters received. I'll just grab

that piece of paper here. Let me just remind people, Dr. Bone-- these are proponents-- Dr. Bonebreak; Marion Miner from the Catholic Conference; Andy Hale, representing Nebraska Hospital Association; Scout Richters, representing the ACLU were proponents and there was one opponent, Mary Sullivan, the Nebraska chapter of National Association of Social Workers. So that's how the record reads, so--

DeBOER: That is correct. Senator Arch, thank you. Yeah, I just wanted to address Senator Murman's question. The subpoena power is the mechanism by which they get the data so that they can review it. So that's just the-- what the authority is called is it's a subpoena authority in order to-- for them to collect that data in order to be able to look at it. And then other than that, I just want to say I hope all of your bills, you get to have a final testifier like I did who was there and can tell the exact story of how it all went the way it did because that's pretty nice.

ARCH: Very good.

DeBOER: That's all I would think.

ARCH: Any final questions? Senator Murman.

MURMAN: So just to clarify, so if Douglas County wants to get certain information from a particular, I guess, hospital or stillbirth, they would-- could subpoena for that information?

DeBOER: Yeah, that's what it-- that's what you'd call it. It would be the subpoena power to get that information.

MURMAN: OK, thanks.

ARCH: Other questions? Senator Hansen.

B. HANSEN: Thank you. Sorry, I kind of missed your opening, but what's the purpose of the bill?

DeBOER: Well, the purpose of the bill is to collect data on stillbirths--

B. HANSEN: OK.

DeBOER: --so that we can prevent those stillbirths.

B. HANSEN: OK, based on information that you gather?

DeBOER: Yeah.

B. HANSEN: OK. There's no kind of unintended or kind of anything you might expect to do with the information later besides just help gather data to prevent stillbirths?

DeBOER: Yeah, so it's anonymized data that's, that's collected to be able to determine, like, some of the, the-- previous testifier said there might be-- in Nebraska, we might have more stillbirths related to smoking risks and so than we would say that and how do we, how do we address those? How do we basically put our interventions into those problems that we're seeing rather than putting interventions in place that we're not seeing?

B. HANSEN: OK, cool. I might have missed it in your opening, so I apologize.

DeBOER: No, no it's fine.

ARCH: Other questions? Senator Murman.

MURMAN: I realize it'd be difficult to collect information lower than 20 weeks, but I do feel that would be very useful information. Is that the reason that you don't try and do it lower than 20 weeks, just because it would be very difficult to get?

DeBOER: There's a lot of complexities with this in terms of gathering the data, collecting the data, having the data. There's some medicine that I don't not understand and won't try to pretend to understand at this point as well. One of the things you'll notice in the amendment that we had to add in was that the definition of a stillbirth is one in which a stillbirth death certificate has been requested, right, that's a legal measure because we thought, well, wouldn't you have the data in the mother's records to know that there was a stillbirth? Well, yes, that does exist, but how would anyone know to ask for a specific person's medical records to search through to see if one of the things that happened while she was in the hospital was that she had a, a, a stillbirth, right? So it's just trying to get it. It's just the logistics of it are, are plenty difficult. So we have to sort of have this very tight definition to make sure that we can get any-- and it will necessarily miss some because if you do not apply for a stillbirth death certificate, certificate, then there won't be a way for us to collect the data. So we will miss some, but we will get some. And so that which we get is better than nothing.

MURMAN: Thank you.

ARCH: Any other questions? Seeing none, thank you very much. Thanks very much for your testimony and, and the bill today. And that will close the hearing on LB741 and we will move to open the hearing on LB905, a bill introduced by Senator Walz. Welcome.

WALZ: Thank you. Good afternoon. Feels like it's been forever since I've been in this chair. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Lynne Walz, L-y-n-n-e W-a-l-z, and I proudly represent District 15. I'm here today to introduce LB905. This bill would recommend mental health screenings for mothers during and after pregnancy and task the Board of Medicine with crafting policies with providers around maternal depression screenings. Maternal mental health can severely affect both the mother and child. A mother dealing with depression during pregnancy has been linked to preterm births and low birth weight. Depression after pregnancy or postpartum depression is linked to delays in cognitive, linguistic, and social and emotional development in infants and toddlers. Maternal mental health concerns left undetected affects children in many ways, including learning and behavioral issues with family, friends, and in school. It's estimated that approximately one in seven new mothers experience depression during and after pregnancy. Unfortunately, suicide is not included in the Center for Disease Control's maternal mortality numbers, but maternal suicide is a leading cause in maternal mortality. Maternal mortality is on the rise in the United States. Maternal mental health and higher mortality disproportionately impacts women of color, those living in low-income communities and rural areas. We want to make sure that we're taking care of all mothers and children in our state consistently and comprehensively. And the best way to do this is by meeting mothers-- pregnant women and mothers where they're at, which includes their prenatal visits, postnatal visits, and pediatric well-child visits during the first year of the baby's life. Currently, Nebraska is only one in seven states that has nothing in statute regarding maternal mental health screenings. Twenty-seven states currently recommend mental health screenings, including Idaho, Wyoming, both North and South Dakota and Oklahoma, which this bill is mirrored after. This bill not only puts us on track with nearly the, with nearly the rest of the country, but supports our mothers and children. Let me walk you through the bill as written. Page 2 begins on line 5 with definitions of a licensed healthcare professional, perinatal mental health disorders, postnatal/prenatal care, and questionnaires. At line 21 on page 2, you'll find that-- language that states the Board of Medicine

may work with hospitals and providers to develop policies for maternal depression screenings and a referral network for when the mother has a positive screen. Starting at line 26 on page 2 through the end of the bill, a description of each visit is included, as well as clear guidance that the screening language must follow and recommendations of either the American Academy of Obstetricians and Gynecologists or the American Academy of Pediatrics. According to preliminary data provided by the Nebraska Department of Health and Human Services, there has been approximately one suicide a year since 2014 by expecting or new mothers. This bill has the capability of helping to stop suicides and keep mothers with their children. Checking on mothers' mental health starts by simply having them fill out a health screen at their visit. I have handed out a copy of a maternal depression, depression and anxiety screen, the Edinburgh, which is listed as a validated tool in the bill itself. These are filled out by mothers when they come in for a visit and then reviewed by the provider immediately. This bill is important because we can help begin the conversation regarding maternal mental health in Nebraska and start providing clinics and hospitals with the tools they need to address this very real issue. There are going to be several experts in the field following up after me, and unfortunately, one of the comments that was submitted didn't quite make it in time for the hearing, so I'd like to put that in the record that the Nebraska Psychological Association submitted a comment in support. I've also been working with the Nebraska Medical Association to address some minor concerns that they had with the original language. So the updated amendment is the last handout you have in your packet. Essentially, the original language includes advanced practice registered nurses, or APRNs, in the definition of licensed healthcare professionals, Section 2. The concern with including APRNs is that-- is its reference to the Medicine and Surgery Practice Act, which is an act that covers physicians, osteopathic physicians, and physician assistants. They ask that we remove APRNs from the original bill and mirror this bill by adding language in reference to the Advanced Practice Registered Nurse Practice Act. So the amendment language does not change, but is referenced now under two different acts: The Advantage-- the Advanced Practice Registered Nurse Practice Act and the Medicine and Surgery Practice Act. I can help answer any questions that you may have on this amendment, although Sara Howard will be here to testify and has been working with me and NMA on the amendment. With that, I'd be happy to answer any questions, although there will be many testifiers following me with much more in-depth information for you. Thank you.

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Health and Human Services Committee January 19, 2022

ARCH: Thank you. Are there any questions? Just, just so we're clear, AM1609 is now the bill, correct? The amendment is now the bill.

WALZ: Yes.

ARCH: OK, thank you. We'll call for the first proponent now.

ANN ANDERSON BERRY: We keep meeting like this. Hello. Good afternoon, Chair Arch and members of the Health and Human Services Committee. I am Dr. Ann Anderson Berry. For the record, A-n-n A-n-d-e-r-s-o-n B-e-r-r-y. I'm a faculty member of UNMC and the medical director of the Nebraska Perinatal Quality Improvement Collaborative, otherwise known as NPQIC. However, I am not speaking as a representative of the university today. I'm here speaking as an individual and on behalf of the Nebraska Perinatal Quality Improvement Collaborative and Children's Hospital and Medical Center. I am here testifying with regards to LB905. As you are likely aware, perinatal depression is common among women in Nebraska, impacting 18 percent of women during pregnancy and up to 12 percent of women in the postpartum period. The impact of perinatal depression is significant, with short and long, long-term effects on the mother, infant, partner and long-term impacts on child development through early adolescence. A large body of medical research shows that infants of mothers with untreated depression are at risk for early breastfeeding cessation, developmental delays, decreased family well-being, delayed infant feeding and development, and infant attachment problems. Later in childhood, children are at risk for attention deficit hyperactivity disorder and associated school performance and behavior issues. Additional information indicates that perinatal depression may increase risk for child abuse. An additional impact for families in 2020 and 2022 has been the COVID-19 pandemic. Preliminary data and research on the impact of the pandemic on rates of perinatal depression show increases in postpartum depression to 33 percent. Having one in three mothers suffering from depression will have a profound impact on our children over the next one to five years. It is well documented that perinatal and postpartum depression places families from all walks of life at risk throughout the first decade of life. Maternal major depressive disorders can lead to suicide and is one of the most common causes of maternal mortality in the US. Additionally, depression and anxiety in the perinatal period has been shown to decrease breastfeeding success for these mother-infant pairs. Decreased breast milk in the diet is associated with more infections, missed days at work, and higher healthcare costs than for those infants that are exclusively breastfed. As one of a handful of states

that has not hardwired postnatal depression screening, Nebraska simply can and must do better. This easy and freely available screen should be given to all mothers at the proposed times in order to recognize symptoms and refer mothers to treatment in a timely manner, leading to improved neurodevelopmental outcomes for the infant. In my hospital-based neonatal intensive care unit, we have been screening mothers and their partners for years. Perinatal depression presents as a mother who is so exhausted that she can't get up from the cot in her baby's room to change a diaper or soothe her baby when it's crying, despite urging by the nurses. Depression manifests as inability to eat and drink enough to keep up an adequate milk supply for the baby. Depression often means not being able to answer the phone when the doctor calls or to have a conversation or process the medical information given to you. Depression leaves you at home in bed, unable to come to the NICU to read, talk, and sing to your baby to help with their growth and brain development. Depression leads to increased conflict between partners at the infant's bedside and beyond. Depression makes it difficult to remember to take your hypertension medications from your complicated delivery, leading to risk of stroke, hemorrhage, and seizures. Emergency room visits and rehospitalizations are worse. And depression leads to thoughts of self-harm, even when you know that you have everything to live for in your new baby. I see these situations on a regular basis. I have screened mothers that I did not recognize as depressed and found them to be actively suicidal, needing to go to the emergency room. And most importantly, I have seen these same women and families improve and regain their ability to be amazing parents. Treatment isn't an easy fix, but it helps. And I have so many families who are thankful that we screened, referred, and cared enough to make this part of our standard of care. NPQIC works with all delivery hospitals in the state of Nebraska as NPQIC-member hospitals and their providers and we are actively working to increase screening for depression in this high-risk population. Our past successes in statewide implementation of initiatives for at-risk perinatal populations speaks to our ability to contribute to the success of these proposed new initiatives. The state is a necessary public health partner if we are to ensure best outcomes for Nebraska families indiscretion-- in depression screening. In conclusion, Nebraska's mothers and babies need the work of not only our perinatal collaborative, but of all stakeholders, including, most importantly, our state governing bodies. Supporting the maternal depression screenings will have an important impact on Nebraska babies and their families. Thank you to Senator Walz for introducing this legislative bill. Together, Nebraska's perinatal collaborative will continue to

work so that Nebraska will be a state where a great life starts with healthy moms and healthy babies. Thank you.

ARCH: Thank you. Questions? Senator Williams.

WILLIAMS: Thank you, Chairman Arch, and thank you, doctor. You cited some statistics for Nebraska early in your testimony. Would those be similar in other states?

ANN ANDERSON BERRY: They are similar. They vary from year to year and the pandemic has really made an impact, but those are generally accepted, ballpark, across the country. There are some studies that report higher. Depending on the subpopulations that you look at, you can see higher proportions. NICU parents tend to have higher proportions. And I think it's important, though, to remember that this really hits all walks of life. So we're not looking at increased depression if you have low resources and no depression if you are well resourced. This really isn't across the board. It's a biological issue, it's a medical issue, and really needs to be addressed for every woman who is pregnant and has delivered.

WILLIAMS: I think you also indicated, maybe you can help us with this, that we are one of a few states that does not provide some kind of screening like this.

ANN ANDERSON BERRY: We don't have any recommendations on our statutes to provide screening and other states have moved to that and this bill provides a recommendation. It's a may not a shall, so we're not mandating the practice of medicine, but we are encouraging providers, nurses, facilities to highly consider that this, this screening will be beneficial for their patients. You know, everything in medicine evolves over time. And even though we instituted this in my practice, it's been probably a decade ago, you know, acceptance of that, I think, in the medical community and acceptance of evaluating medical health and addressing medical-- mental health has been an, an uphill road for some practices. And so to have this nudge from the state to say, yes, this is part of your care. This is part of caring for a woman and her family while she's pregnant. And when you're caring for her child, it's necessary and it could be the nudge that will help us to get more uptake with, with screenings. The Nebraska Perinatal Quality Improvement Collaborative has had funding to work to implement this screening across the state and we've encountered some reluctance and this bill will help us to ensure providers that this is really

where they need to be in 2022 with a standard of care for care of this women.

WILLIAMS: Thank you.

ANN ANDERSON BERRY: Yes.

ARCH: Senator Hansen.

B. HANSEN: Thank you for testifying.

ANN ANDERSON BERRY: Thank you.

B. HANSEN: I know they give some examples of different types of questionnaires, the Edinburgh Postnatal/Postpartum Depression Screening Scale, Beck Depression, and the Patient Health Questionnaire. Is that pretty typical, what most hospitals would use?

ANN ANDERSON BERRY: Yes, those are the typical ones. And you know, I think it doesn't matter exactly which one of those approved screens you use. They're all validated in the population. You know, we, we would like to see a variety encouraged in the legislation because certain health systems may have access in their electronic medical records to one specific one that's built in or another, particularly as we have large healthcare systems that are multi-state. You know, this is, this is really a matter of doing it is-- doing it-- a way is better than doing it one single way.

B. HANSEN: Sure.

ANN ANDERSON BERRY: They all are validated. And if we can pick up on this, then we can start that cascade of identifying, getting treatment, following up, and ensuring that the women's health and the family's health is improved.

B. HANSEN: OK.

ANN ANDERSON BERRY: Thank you.

B. HANSEN: How many hospitals are currently do, do these kinds of tests? Do they-- is it pretty standard in the industry--

ANN ANDERSON BERRY: So--

B. HANSEN: --right now? Do you know of any hospitals that don't do this kind of stuff?

ANN ANDERSON BERRY: We do have hospitals that don't.

B. HANSEN: OK.

ANN ANDERSON BERRY: Sydnie Carraher, who is my project administrator, will be testifying after me and she'll give you some of those specific numbers.

B. HANSEN: OK.

ANN ANDERSON BERRY: So I'll defer to her. I don't want to misspeak.

B. HANSEN: Yeah, that's fine. And maybe if I can-- I got one more question--

ANN ANDERSON BERRY: Absolutely, I have all the time in the afternoon.

B. HANSEN: --and maybe she can answer this as well. What happens if someone takes the test because they've been asked and they fail, fail miserably, what happens?

ANN ANDERSON BERRY: So I can tell you what happens in our health system. There's a range of how high you can score for depression. And so, you know, some stress and some mood changes can be normal, particularly in a NICU where you're a high stress. If you score in a moderate range, then we have a referral system where we have resources ranging on your insurance type from you have no insurance and we have some free resources that we can refer to, all the way up to, you know, resources and doctors that accept your insurance or other types of insurance, and we work to help that mom to get an appointment scheduled.

B. HANSEN: OK.

ANN ANDERSON BERRY: If you tip to the highest scale, as I mentioned in my testimony, we'll walk the family down to the emergency room where they can receive critical care if they're actively suicidal. And we have to do that more than once a year--

B. HANSEN: OK.

ANN ANDERSON BERRY: --in our practice.

B. HANSEN: So say they fail some of these tests, I just got a couple of concerns. What I'm concerned about, so what happens to the information--

ANN ANDERSON BERRY: Uh-huh.

B. HANSEN: --when it is taken and then what if they say I don't want any treatment?

ANN ANDERSON BERRY: Yeah, that is their prerogative. And this is all in a healthcare setting, so it's all HIPAA protected. So everything stays within their medical record. Nothing is divulged to anyone. It's between the provider and the patient.

B. HANSEN: OK.

ANN ANDERSON BERRY: And it's anyone's prerogative to not accept treatment and we can provide the resources and we can do the education and sometimes they're not ready to think about treatment. And then over the course of a day, a week a month, they realize that that could be helpful. They talk to their family, they talk to their significant other, and they say, yeah, this might be a good thing for us, can I have those names again?

B. HANSEN: OK, yeah. And that's, that's kind of--

ANN ANDERSON BERRY: Yeah.

B. HANSEN: I think you kind of addressed part of that because I know sometimes they can not do very good on some of these tests and so then say the advanced practice nurse does this--

ANN ANDERSON BERRY: Uh-huh.

B. HANSEN: --and they don't do very good. She puts it in her file and doesn't tell anybody else about it--

ANN ANDERSON BERRY: She, if you are--

B. HANSEN: --if they deny treatment?

ANN ANDERSON BERRY: --actively-- if they deny treatment, no, because there's nothing that can be mandated for the patient.

B. HANSEN: OK.

ANN ANDERSON BERRY: You know, if you're actively suicidal, you can kind of escalate that, but you can't go telling--

B. HANSEN: Sure.

ANN ANDERSON BERRY: --the world about that.

B. HANSEN: Sure, I know there's variations of extremes in that and I just--

ANN ANDERSON BERRY: Exactly.

B. HANSEN: --just curious to know if they do fail, OK, so then it's our policy to contact a behavioral health specialist--

ANN ANDERSON BERRY: Uh-huh.

B. HANSEN: --that will then contact child services. I don't really know for sure sometimes where this goes.

ANN ANDERSON BERRY: No--

B. HANSEN: I assume not, but I just didn;t know for sure--

ANN ANDERSON BERRY: --nothing like that.

B. HANSEN: --the standard of practice, so.

ANN ANDERSON BERRY: No, this is within the provider-patient--

B. HANSEN: Confidentiality.

ANN ANDERSON BERRY: Confidentiality.

B. HANSEN: Cool. Thank you very much. Appreciate it.

ANN ANDERSON BERRY: Yes, absolutely. Those are good questions.

ARCH: Other questions? Senator Murman.

MURMAN: I know you talked a lot about prenatal, prenatal mental health screening and also postpartum screening. I was just curious how long of a period is typically included in the postpartum screening?

ANN ANDERSON BERRY: Yeah, up to a year of age for the peripartum depression. So it starts with pregnancy and goes through the child's first birthday.

MURMAN: OK.

ANN ANDERSON BERRY: And the AP has specific time points when they recommend that screening and it coincides with the first-year visits.

MURMAN: OK, but do-- does anybody include longer than, than one year postpartum? It seems like to me that might be important to go longer than that.

ANN ANDERSON BERRY: So I think mental health screenings should be a part of healthcare in general. I think that that's critically important. We're talking about the perinatal period here and perinatal screening and so this legislation really only covers the pregnancy and postpartum period.

MURMAN: Thank you.

ANN ANDERSON BERRY: Yes, but I, I agree with you.

ARCH: Other questions? This may not be a question for you, but I-- and maybe, perhaps somebody that follows you. I'd, I'd appreciate a little more explanation of the change to Section 7 regarding APRNs and, and NMA's issues with that, so--

ANN ANDERSON BERRY: Yes, I believe--

ARCH: --if you want to address it or--

ANN ANDERSON BERRY: NMA has a testifier and then--

ARCH: Great.

ANN ANDERSON BERRY: --Sara Howard will be testifying as our final testifier--

ARCH: Great.

ANN ANDERSON BERRY: --so they'll be able to speak to that in a little bit.

ARCH: Thanks.

ANN ANDERSON BERRY: Yeah, thank you.

ARCH: All right, seeing no other questions, thank you for your testimony.

ANN ANDERSON BERRY: I appreciate the time. Thank you.

ARCH: Next proponent for LB905.

SYDNIE CARRAHER: All right.

ARCH: Good afternoon.

SYDNIE CARRAHER: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. I am Sydnie Carraher, S-y-d-n-i-e C-a-r-r-a-h-e-r. I am the program administrator for the Nebraska Perinatal Quality Improvement Collaborative, or NPQIC, a member of the UNMC staff, and a neonatal nurse practitioner at CHI Health. I am here today to speak regarding LB905 in my role as a private citizen. Maternal depression, as you've heard, is one of the most common obstetric complications and a tragic and preventable cause of maternal and infant morbidity and mortality. In fact, suicide and overdose commonly associated with depression are among the leading causes of death for women in the first year following pregnancy. Nearly 100 percent of these deaths are deemed preventable. Approximately one in seven new mothers experience significant depression during pregnancy in the first year postpartum, disproportionately impacting mothers of color and those living in poverty and rural areas. In Nebraska, 18 percent of mothers experience depression during pregnancy and 12 percent of mothers experience depression during the postpartum period, according to 2019 data. Rural mothers have a higher incidence than urban, at 13 percent versus 11 percent, and Nebraska mothers of color also have a higher incidence of postpartum depression than white mothers: Blacks and Native Americans at 17 percent, Hispanics at 12 percent, and whites at 11 percent. Sadly, maternal depression often goes undiagnosed and untreated, increasing the risk of long-term negative impact on the physical, emotional, and developmental health of both the mother and child. In addition to adverse health consequences, there are significant societal costs of untreated maternal depression. For example, the estimated cost of untreated perinatal mental health conditions in Nebraska is greater than \$160 million each year due to mothers' lost wages and productivity in addressing poor health outcomes of mother and baby. In 2020, NPQIC launched a three-year statewide depression screening and referral

initiative. The goal is that mothers and fathers from all areas of Nebraska will be screened and, if necessary, subsequently treated for perinatal depression. Universal screening of pregnant postpartum mothers and fathers for depression is recommended by numerous medical professional organizations as a component of quality obstetric care and is considered best practice for infants and their families. Mothers should be screened at least once prenatally, at the postpartum visit, and then at the one-, two-, four-, and six-month well-child visits. Fathers should be screened at least once in the first six months after the birth of the baby. As you can see in Appendix A, despite these clear recommendations, significant gaps in screening practices exist across Nebraska. A survey conducted by NPQIC in early 2021 of clinics providing care to pregnant women revealed that only 65 percent screened prenatally and 78 percent at the 6 to 12-week postpartum visit. Of clinics providing well-child care, only 43 percent screen mothers at one month, 22 percent at two months, 14 percent at four months, and 12 percent at six-month visits. Just 3 percent of these clinics screen fathers within the first six months after the baby's birth. Clinics in urban areas are twice as likely to screen and refer for treatment during prenatal, postpartum, and well-child visits compared to clinics in rural areas. NPQIC's initiative aims to establish perinatal depression screening as the standard of care provided by obstetric and pediatric providers and to identify statewide treatment referral systems. Effective, free, and validated screening tools exist to identify mothers at risk for depression. Treatment is available and can have a significant impact on outcomes. The Edinburgh Postnatal Depression Scale, the EPDS, and the Patient Health Care Questionnaire, PHQ-9, are the most commonly used tools and have been validated for use in this population. Both are free, easily self-administered in less than five minutes, and are available in multiple languages. NPQIC identified 70 clinics that were not following the current screening recommendations. Despite numerous news releases, emails, and phone calls to physicians and clinics across the state, only 6 of those 70 clinics have joined the effort to implement screening. As a result of improved screening practices in these six rural clinics, mothers have been identified as depressed and are receiving the necessary treatment to recover. As the initiative continues, NPQIC will be monitoring the availability and saturation of mental health resources, especially for those that provide care regardless of insurance status and ability to pay. Maternal depression is a significant public health concern in Nebraska, and as you heard, 43 states and Washington, D.C. have state Medicaid policies that recommend, require, or allow maternal depression screening to be

provided as part of a well-child visit. Nebraska is one of seven states that does not have an active maternal depression screening policy in place. A hardwired screening system using a standardized, validated tool would ensure that all new mothers would be educated about and screened for depression, regardless of location. Treatment does not happen if a mother is not screened and identified as depressed. We have the power to make a positive impact, but it will take all of us working together to improve outcomes for new mothers, babies, and families in our state. Thank you.

ARCH: Thank you. Are there questions? I have, I have one question--

SYDNE CARRAHER: Yes.

ARCH: --and that is how long does a screen take and how is-- typically is it administered in the clinic?

SYDNE CARRAHER: It varies depending on what clinic you are in. The screeners themselves can be done by the mom while she's either waiting to go back for her visit, or it can be done while she's in the room with the provider. But they take less than five minutes. They're nine and ten questions, respectively for each one of those questionnaires. Some clinics have electronic medical records where those are built into those and so the mom can fill them out on a tablet where they're actually given a paper copy of the screen where it's filled out and then the provider scores it and then reviews the results with the mother after they've completed it during their visit.

ARCH: OK, thank you.

SYDNE CARRAHER: Yeah.

ARCH: Questions? Seeing none, thank you very much for your testimony

SYDNE CARRAHER: Yes, thank you very much.

ARCH: Next proponent for LB905.

PRISCILLA LA CROIX: Hello.

ARCH: Good afternoon.

PRISCILLA LA CROIX: Hi, Chairman Arch and members of the Health and Human Services Committee. Thank you for allowing me to testify in support of LB905. My name is Dr. Priscilla La Croix, P-r-i-s-c-i-l-l-a

L-a C-r-o-i-x. I am here representing myself. I am a community pediatrician and during this last year, I became a mother. By sharing my postpartum story, I hope to highlight the importance of maternal mental health. On the day my daughter was born, January 15, 2021, she almost lost her mom. I developed a complication from postpartum hemorrhage called disseminated intravascular coagulopathy, which caused me to lose almost half of my blood volume. If it was not for the healthcare team that reacted to my condition promptly, I would not be here today. The power to heal both physically and mentally from a traumatic delivery led me on a journey that helped me recognize the value of mental health screening as a tool to empower mothers. Given my medical professional background, I knew to utilize validated screening tools when I realized that I was struggling as a new mom. When I screened positive, my doctor had a social worker who connected me with licensed professionals. I was fortunate to have the support that allowed me to heal and strengthen the bond between myself and my baby. As I reflect on my own journey, I think about the mothers across our state who do not have access to screening or resources to help them during their most challenging moments. This is where I see an opportunity to help mothers. As a pediatrician, in the postpartum period, I see babies for their well visits at the two-week, the two-month, the four-month, the six-month, the nine-month, and the one-year-of-life visit. The one year of life is beautiful not only for how much a child learns within that first year from needing parents to do everything for them to being able to take their footsteps on their own. But when we take a step back, it is also so important to see the journey that two parents have made together. And what I recognize is that since there is no recommendation to check in with our parents, to check in with our moms to see how they're, they're doing, we are missing opportunities to help them. Through my own experience and the awareness that I learned from the struggles that I had, I was motivated to turn to the training that I had. I was trained in a state where screening was recommended and initiate that in my own practice. And there I saw transformation. I saw mothers who at the two-week visit were crying, who wanted to give up breastfeeding, who wanted-- who felt like a failure as a parent. And by pausing, using a validated screening tool to begin a conversation to help normalize mental health and the importance of prioritizing it, I saw them transform, transform and gain confidence as parents. And it's been one of the most rewarding things, something that I did not realize how beautiful it could be until beginning this consistent screening and connecting moms and letting them know that we're here. We're here to help. We're not just here for your baby. We're here for you. And we have the ability

here to improve the quality of care for our mothers and their babies in the state of Nebraska. By supporting LB905, we are investing not only in the health of all moms and babies, but also the health of our community. Thank you so much for your time. I welcome any questions.

ARCH: Thank you for your testimony. Questions? Seeing none, really appreciate you coming today. Thank you very much.

PRISCILLA LA CROIX: Thank you.

ARCH: The next proponent for LB905.

MELISSA ST. GERMAIN: Good afternoon. I am Dr. Melissa St. Germain, M-e-l-i-s-s-a, last name, S-t. G-e-r-m-a-i-n. I'm a medical director and vice president of Children's Physicians in Omaha. I'm also currently the president of the Nebraska chapter of the American Academy of Pediatrics and I'm testifying before you today as a content expert on, on behalf of both of those organizations, Children's and the Nebraska AAP. As the safety net provider for children in Nebraska, Children's is dedicated to improving the life of every child, relying on prevention and care coordination to identify challenges families face that can lead to negative outcomes for our patients. Throughout my 12 years as a practicing pediatrician, I've seen the impact that maternal healthcare can-- mental health can have on an infant. I've seen anxious moms who show up unnecessarily in the emergency department because they're so worried about their newborns that they feel they can't wait until the next day to talk to their pediatrician. I've cared for older children with behavior changes that coincide with the birth of a new sibling because it can be very overwhelming for a mother to care for both a new baby and a sibling at the same time. On occasion, I've had to contact CPS to assist in keeping babies safe when their moms aren't able to care for them. Early in my practice, I cared for an infant who was struggling to gain weight. He eventually required a feeding tube and foster care placement and we later learned that his mother had unmet mental health needs and couldn't adequately care for him or feed him. With earlier recognition and treatment of her symptoms, her child may not have needed the extreme interventions that were required to keep this baby self-- safe and healthy. Maternal depression screening can help reduce the incidence of these heartbreaking events. The American Academy of Pediatrics has a policy which recommends that all new mothers complete depression screening questionnaires during their baby's well-visits at one, two, four, and six months. Children's Physicians has been conducting depression screening for moms in our primary care clinics since 2019. Since that

time, our primary care clinics have used the screening tool called the Edinburgh Depression Postpartum Depression Scale, or the EPDS, which you heard about earlier. We've used this tool over 37,000 times since 2019 and identified over 3,000 women, about 8.5 percent of those who have been screened, who are suffering with symptoms of postpartum depression. The mothers of babies in Children's NICU have been screened as well, and about 20 percent of those women have a positive screen, which echoes what Dr. Anderson Berry said about mothers of babies in NICUs having higher rates of depression symptoms. Data from the AAP confirms that about 12 percent of women nationally experience symptoms of depression within the year surrounding a baby's birth. With the support of our social work team and patient care coordinators, we connect these parents with community resources to help them. Connecting these mothers with psychiatrists, counselors, mental health providers, or their own primary care physicians and obstetricians is key to getting these new mothers the help that they need to keep their children safe. I want to personally thank Senator Walz and Senator-- former-Senator Sara Howard for their dedication to a statewide approach for maternal depression screens for new mothers. As we as stakeholders continue to seek the resources that are necessary to achieve this goal, I want to emphasize the opportunity to be preventative for Nebraska families. Investments in early intervention reduce the likelihood of any significant harm children may face as their caregivers struggle with unmet mental health needs. At Children's, we're investigating how we can further offer these depression screens to both partners and across our continuum of care with deliberate scheduling. It's an honor to be sitting before you today about-- talking about this opportunity and I'm happy to answer any questions.

ARCH: Thank you. Are there any questions? Seeing none--

MELISSA ST. GERMAIN: OK.

ARCH: Thank you very much for your testimony. Next proponent for LB905. Welcome back.

CHRISTIAN MINTER: Good afternoon again, Chairperson Arch and members of the Health and Human Services Committee. I am Christian Minter, C-h-r-i-s-t-i-a-n M-i-n-t-e-r. I'm manager of maternal and infant health initiative at March of Dimes, a leading nonprofit organization fighting for the health of all moms and babies. Thank you for this opportunity to offer testimony for LB905. Many women experience mental health challenges during pregnancy and the postpartum period, such as

depression, anxiety, or post-traumatic stress disorder. Mental health issues are the most common complication of pregnancy and childbirth and can occur up to one year post birth. Approximately one in eight women in the United States report symptoms of postpartum depression and women of color are more likely to experience postpartum depression symptoms compared to their white peers. Postpartum anxiety is not as well documented, but it is estimated it affects as many as one in five women. In 2019, approximately one in five Nebraska women reported symptoms of depression during pregnancy and approximately one in eight Nebraska women reported symptoms of postpartum depression. A mother's mental health is directly connected to her physical health and the health of her baby. When left untreated, maternal mental health disorders can have serious medical, societal, and economic consequences for moms and their families. These condition can also impact the mother's physical health and ability to do daily life activities and affect bonding with and care of the baby. This, in turn, impacts the social, emotional, and neurological development of the baby. Fathers are also at a higher risk of postpartum depression when a mother is experiencing postpartum depression. Universal mental health screening is a critical component to identifying and treating perinatal mental health disorders. March of Dimes strongly supports universal screening of all pregnant and postpartum women using an evidence-based screening tool. It is recommended that screenings are incorporated into each trimester of pregnancy, a post-- first postpartum visit, and at a six-month postpartum obstetrics and primary care visit. March of Dimes also endorses the recommendation of the U.S. Preventive Services Task Force and the American Academy of Pediatrics that parents be screened by pediatric providers at the one-, two-, four-, and six-month well-child visit. This bill will encourage a standardized and consistent approach to supporting the mental health of pregnant and postpartum parents in Nebraska. Without this consistent screening, there could be many missed opportunities to provide mental health diagnosis, education, and treatment. When increasing access to mental health screening, it is also important to carry this out in an equitable and culturally relevant way. National data shows that women of color face greater challenges in mental healthcare due to fear of stigma, as well as increased barriers to receiving routine screening and initiating treatment compared to white women. Black and Latino women are more likely to experience physical symptoms of depression, such as headaches, gastrointestinal issues, or sleeplessness. And black women also have a higher risk of being unjustly reported to child welfare systems and they fear that asking for help will lead to their children being taken away. The mental

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health screening process should be implemented in a way that is sensitive to these fears and challenges that women of color may experience around mental health disorders. I encourage members of the Health and Human Services Committee to support LB905 and help improve access to universal perinatal mental health screening. Thank you for prioritizing the mental health of Nebraska moms and their families.

ARCH: Thank you. Questions? Seeing none, thank you very much for your testimony. Next proponent for LB905. Welcome.

DEXTER SCHRODT: Good afternoon, Chairman Arch, members of the committee. It's a privilege to be here with you on your first hearing day. My name is Dexter Schrod, D-e-x-t-e-r S-c-h-r-o-d-t. I'm vice president of advocacy and regulation for the Nebraska Medical Association. You already heard from several of our physician members here today on this bill, so I'll spare you any medical statistics or anything of that nature. We are in support of the bill with AM1609 that Senator Walz handed to you in her opening. We'd like to greatly thank Senator Walz and her Legislative Aide, Amanda, for being amenable to our concerns and listening, listening to what we noticed with the bill. I'll admit I saw several drafts of this bill beforehand, and I always went down to the meat and didn't think to look where the, the proposed language was being placed. So once I noticed that in the original bill, it was placing APRNs as a defined provider within the Medicine and Surgery Practice Act, which is reserved for physicians, osteopathic physicians, and physician assistants, that's when I did reach out to Senator Walz and her staff with that concern. And, and fortunately, they were gracious enough to listen to that concern and the amendment reflects that. So I guess I'll stop there and Senator Arch, if you have any questions on that, I'm happy to answer them.

ARCH: OK. I'll start with other members. Questions for Dexter? So Section 7 reads, in the, in the amendment, that the APRN may do the, do the following. Why do we need to, why do we need to specifically state that in statute that they may do this? And maybe you're not the one to ask this question and that's fine. I understand your issue of where, of where in statute this should be--

DEXTER SCHRODT: Um-hum.

ARCH: --but Section 7 seems to delineate these various things that an APRN may do--

DEXTER SCHRODT: Yeah.

ARCH: --which I'm assuming they may do now, but perhaps not.

DEXTER SCHRODT: Yeah, so I think that goes to what a few testifiers said before, is I believe we are looking to make this more of a recommendation than a mandate.

ARCH: Right.

DEXTER SCHRODT: And I will point out, Senator, that line 31 of page 3 in Section 15 also does the same for physicians and PAs. That's the section that's in the board-- or the Medicine and Surgery Practice Act. So it's not just the APRNs, they may do this, it, it is everybody included in the bill.

ARCH: Separating--

DEXTER SCHRODT: Separate out into their own practice acts, yep. As the actively practicing attorney for the medical association, I do like to keep our statutes, the medicine and surgery statutes, pretty clean. So that's why I did raise those concerns. And this bill, I think, perfectly addresses them. The APRNs have their own practice act with their own board and that's the board you see referenced there in Section 7 and then the Board of Medicine and Surgery is the board referenced in Section 15.

ARCH: That's very helpful. Thank you.

DEXTER SCHRODT: And oh, I will-- sorry, I'll add one more thing.

ARCH: Uh-huh.

DEXTER SCHRODT: The NMA does work rather closely, we communicate all the time with the Board of Medicine and Surgery, so we are looking forward to just seeing how this progresses down the line.

ARCH: All right. Other questions? Seeing none, thank you.

DEXTER SCHRODT: Thank you.

ARCH: Next testifier proponent for LB905.

CHRIS JONES: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Chris Jones, C-h-r-i-s J-o-n-e-s, and I'm the advocacy director for Nebraska Children's Home

Society. I'm here today in support of LB905. NCHS is a statewide accredited nonprofit with or-- with offices in six communities across the state. NCHS utilizes its 127 years of experience to put children's needs first through an array of services designed to build strong, supportive families and nurture children. Our core services include adoption, foster care, and family support. Postpartum depression can interfere with caregivers' ability to perform daily life activities and respond to an infant's needs. These interferences can have severe consequences for mom and baby if left untreated. Screening for depression is an important part of preventive pediatric care and can be provided at medical appointments and through early intervention services such as maternal, infant, and early childhood home visitation and family support services to prevent child abuse and neglect and entry into the child welfare system. Our home-visitacion services focus on prevention, working with families who are not involved in the state child welfare system, but would like to receive one-on-one support services. Additionally, we provide pregnancy, parenting, and adoption education and, and support before, during, and after the child's birth through the child's first year in all communities across the state. We do this through hospital, DHHS, Children and Family Services or Public Health, and community referrals with a blend of state, federal, and private funds at no cost to the caregivers receiving services. NCHS incorporates depression screening in all pregnancy, parenting, and adoption services and home-visitacion programming using evidence-based models and curriculum to assess indicators of maternal depression. We have two screening tools specific to each of our programs. Some have been mentioned today. For our mothers and babies curriculum, we use Patient Health Questionnaire and for our Healthy Families America program, we use the Center for Epidemiologic Studies' Depression Scale, or the CESD. We use the screening tool results to inform our engagement with mothers and other caregivers and make referrals to therapists in the community. In Nebraska, providers and families benefit from apps that facilitate sending and receiving electronic referrals, and these platforms ensure that communities and individuals can get seamless access to much-needed resources, including pregnancy, parenting, and adoption services in both urban and rural communities. As a community-based service provider, we believe in the importance of collaboration with families, other service providers, and policymakers. LB905 could be strengthened to support the engagement of fathers and other caregivers because postpartum depression can impact new fathers and adoptive parents as well. We recommend the term "may" be replaced with "shall" in reference to creating a network in Nebraska to develop policies,

procedures, information, and educational materials, and making the questionnaire a requirement rather than optional. I will just pause here to say that I, I have not yet seen the amendment, so there are some line references in my written testimony that may not sync up with the most recent draft. We support policies and programs designed to ensure families have what they need and there's no wrong door for accessing services and that the mechanisms of eligibility and funding streams don't get in the way. So LB905 is an important piece of legislation that has the potential to improve infant and maternal health in Nebraska by implementing a small, but vital screening tool at critical points of perinatal and postnatal appointments. We support LB905 and ask the committee to support it as well. We thank Senator Walz and the cosponsoring senators for this bill and I welcome any questions you may have.

ARCH: Thank you. Are there any questions? Seeing none, thank you very much for your testimony.

CHRIS JONES: Thank you.

ARCH: Next proponent for LB905.

SARA HOWARD: You know you're almost done. OK. All right. Good afternoon, Chairman Arch and members of the Health and Human Services Committee. Thank you for allowing me to testify today. My name is Sara Howard, S-a-r-a H-o-w-a-r-d. I'm a policy advisor at First Five Nebraska. First Five Nebraska is a statewide public policy organization focused on promoting quality early care and learning opportunities for Nebraska's youngest children. My work at First Five Nebraska is focused on maternal and infant health policy, a new area of focus for the organization, and re-- and recognizes what we all know already, that healthy moms and babies are critical to ensuring the long-term success of children in our state. I'm here to testify in support of LB905, a bill regarding maternal mental health screenings. First, I want to thank Senator Walz for introducing LB905 and for her true heart for moms and babies in Nebraska. By now, you know that maternal depression is one of the most common pregnancy and postpartum complications in America. And I want to highlight two statistics because a lot of the statistics, statistics you've heard today are either from providers themselves or from PRAMS, which is the Pregnancy Risk Assessment Monitoring System, you'll see it in your footnotes on a lot of your testimony. PRAMS is a survey that's sent out to moms postnatally and then not all moms in Nebraska. And then however many report back is how, is how they make their assessments. So it's

self-reporting, so it's not a comprehensive dataset. So I wanted to see one, how many completed suicides do we have of moms in the state of Nebraska? And so I did a vital records request. You have that in your hands and the average is about one a year. It doesn't account for unsuccessful suicide attempts. The other one I wanted to look at and Senator Walz really wanted to look at was removals. So how many babies are being removed in that first year because of mom's mental health issue? And so we did a formal request to the Foster Care Review Office and asked them. They, they found 350 babies that had been removed during their first year of life. They did a full review of 77 of them and you can see the, the, the reasons why those, those 77 were removed when, when mothers' mental health was involved. And what you see is mothers' mental health is there, but then you also see a lot of substance use disorder as well, which, which I think we know is a, is an issue. So these statistics, I think, also reveal that maternal mental health issues have a direct impact on mothers in our state. I will also say at our last hearing, we talked a lot about the Child Death Review Team and the Maternal Mortality Review Team. The Maternal Mortality and Morbidity Regroup-- Group just released a report last year and their number one recommendation was peripartum implementation of mental health and substance use screening assessment and referral. So there's really wide recognition that screening makes a big difference. What you heard from Sydnie Carraher from NPQIC, though, is that not every provider is doing a screen. So right now, we see 65 percent of providers are screening prenatally, 78 percent at that first postpartum visit, and then when we look at well-child visits, at that one month well-child visit, only 43 percent of pediatric providers are screening at that visit and it just goes down from there. So we know that there are a lot of opportunities for, for growth in this screening-- in this area of mental-- maternal mental health screening. I will say that the bill that you have in front of you is a really unique Nebraska solution. So I-- as you've heard before, there are seven states that do not mention maternal depression screenings or maternal mental health screenings in their statutes and we are one of them. So I went through and looked at all of their statutes. Most of them house them in their Medicaid statutes and require Medicaid to do these screenings. Our Medicaid is actually already paying for screenings at one, two, four and six. Other states also insert it into their insurance mandates. That's an option. I look at Senator Williams. He shakes his head, he says no. And so-- and other states actually insert it directly into their practice act. What you have before you is a really-- what I would consider a Nebraska solution. What we're saying is Board of Medicine, APRN board, you two

work on crafting policies with organizations. Right now, it's a "may." If we do not see change, then we would obviously come back to the Legislature and try to shift that "may" to a "shall." And then you're asking me, how do we see change when you've just told me that PRAMS is no good? It's very good, but First Five has partnered with CyncHealth to essentially annually get a data request around maternal mental health screenings. So we will be able to come back to the Legislature and tell you how many moms are getting screened and what happens after that screen in the state of Nebraska, so either a referral or an E.R. visit or a prescription for an antidepressant. And so we'll be able to give you more data, but the hope is that this sort of first step or baseline legislation will sort of raise awareness among providers that they need to be doing this consistently because the goal is really to make sure that moms are screened 100 percent, every single mother gets this screen prenatally, postnatally, and at that well-child visit. Thank you for your time and attention to LB905. I'm happy to answer any questions you may have.

ARCH: Are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you, Ms. Howard. It's hard to not accidentally call you Senator Howard. So I just wanted to have some clarification on PRAMS. So you said it's a survey?

SARA HOWARD: Yes.

M. CAVANAUGH: But the difference between PRAMS and this legislation is that this legislation is actionable immediately.

SARA HOWARD: Right and PRAMS is actually just data.

M. CAVANAUGH: Right.

SARA HOWARD: And this legislation, as written and even in the, the amendment where, where we did it, the amendment essentially is tasking the Board of Medicine and the Board of APRNs with working with organizations to get those policies in place. I look at Senator Arch because, you know, once a policy is in place in a hospital, that becomes part of your quality measures. That's how you know whether or not you were, you were successful at meeting your own policies. So PRAMS is a data set. It's very, very different.

M. CAVANAUGH: Very different thing.

SARA HOWARD: Very, very different.

M. CAVANAUGH: And this is something that's a tool for healthcare providers to immediately offer additional supports to parents?

SARA HOWARD: For screens, yes.

M. CAVANAUGH: Right, the screens--

SARA HOWARD: Yeah, the screens are.

M. CAVANAUGH: --give you that sort of immediate feedback instead of statewide survey data.

SARA HOWARD: Right.

M. CAVANAUGH: Different things.

SARA HOWARD: Different, totally different--

M. CAVANAUGH: Just to make sure we had that clear.

SARA HOWARD: Screens live in practice, PRAMS live in epidemiology.

M. CAVANAUGH: Thank you.

SARA HOWARD: Oh, yes, good clarification.

ARCH: Other questions? Seeing none, thank you very much for your testimony today.

SARA HOWARD: Thank you for your time today. I appreciate it.

ARCH: Any other proponents for LB905? Are there any opponents for LB905? Anyone wish to testify in a neutral capacity? Seeing none, Senator Walz, while you're coming up, I would mention that we have received 12 letters in support, no, no letters in opposition: Ashlei Spivey, representing Be Black Girl; Timoree Klingler in sync-- for CyncHealth; Sarah Forrest for Nebraska Alliance of Child Advocacy Centers; Scout Richters, ACLU; Andy Hale, representing himself; Amy Behnke, representing the Health Center Association of Nebraska; Tim Mussack, Center for Rural Affairs; Kurt Schmeckpeper, Nebraska Academy of Physician Assistants; Michaelyn Everhart, Nebraska Regional Organization of Child and Adolescent Psychiatry; Jo-- Joe Giles, Women's Fund of Omaha; Sadie Thompson, Nebraska Association of Behavioral Health Organizations; and Aimee Folker, League of Women Voters. There, 12.

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WALZ: Phew, got it. Well, thank you so much for your attention today and thank you to all the testifiers who came in support, in support of LB905. So just to briefly walk you through the bill again, we are recommending that providers screen mothers with a validated tool like the one I handed out in my opening. We would be recommending that screen-- recommending screenings at prenatal, postnatal, and pediatric well-child visits during the first year of a baby's life. Additionally, we're asking-- we are suggesting a referral network so that we can connect those rural providers and mothers to someone who would suit their needs. You will see that there is no fiscal note. Really, I think that encouraging physicians to screen new mothers is, is important. We all know that there are many times in our lives when there are events that cause emotional stress and depression. And, you know, being a new mother is, is no different. You think you can handle it, you just keep going, you just keep going, and a lot of times that's not something you want to talk about with others because there's a stigma attached. And sometimes it's just really hard to pick up the phone and ask for help. So those are times that you really need someone to just start the conversation and say, how are you doing? And I think that's exactly what this bill does. So with that, thank you for your time and I'll ask-- answer any other questions that you might have.

ARCH: Any final questions for Senator Walz? Seeing none, thank you very much. This will conclude the hearing for LB905. And we will now proceed to LB901, introduced by Senator Pansing Brooks. Welcome.

PANSING BROOKS: Thank you. Good afternoon, everyone. Thank you, Chair Arch and members of the Health and Human Services Committee. For the record, I am Patty Pansing Brooks, P-a-t-t-y P-a-n-s-i-n-g B-r-o-o-k-s, representing District 28 right here in the heart of Lincoln. I appear here-- I, I appear before you today to introduce LB901, which requires the Nebraska Department of Health and Human Services to develop and publish cytomegalovirus public education and prevention material for women who may become pregnant, expecting parents, and parents of newborn infants. Additionally, healthcare providers who are caring for pregnant women must, must distribute such materials at the appropriate time. Furthermore, LB901 provides opportunities for parents of infants following the initial CMV hearing screening test. CMV-- Cytomegalovirus is more commonly known as CMV and that's what I'll refer to it since it's such a complicated word. According to the CDC, in the United States, nearly one in three children are already infected with CMV by the time they are five years old. Over half of the adults have been infected in the, in the United

States with CMV by the age of 40. In some cases, CMV can cause mild illness, but also-- can also cause severe problems and illness in other cases. According to the CDC, babies born with CMV can have brain, liver, spleen, lung, and growth problems. The most common long-term health problems in babies born with congenital CMV infection is hearing loss, which may be detected soon after birth or may develop later in childhood. The increase in awareness and opportunities that this bill will bring to women who become pregnant, expecting parents, and parents of newborns-- newborn infants will allow for us to combat CMV more effectively here in the future in Nebraska. I brought this bill because hundreds of families are affected by this virus each year. It is a virus that not only causes issues at birth, but in the years following as well. After hearing the stories, and they were heartrending stories, from the individuals behind me, it, it pushed me to bring legislation that raises awareness, makes information-- and makes information more accessible, as well as helping families throughout the state. The help this bill will bring to women who, who become pregnant, who are expecting parents, or parents of infants is substantial and would greatly increase the health of women and newborns in every area of Nebraska. The testifiers behind me include medical professionals, as well as those who have been affected by CMV in a variety of ways. They will shed further light on why this expansion of information and opportunities is so important. I understand that there is some concern over the 21-day mandate, mandate-like language that's at the end of this bill and I've already been working on attempting to try to find an amendment with which everyone can agree and I'm happy to continue that work, that work and that effort. I ask that you move LB901 to General File. I want to thank Senator Arch for meeting with us a number of times on this issue with, with the, with the parents who have been most affected. And I also want to thank Senator Hansen for cosponsoring this bill with me. So with that, I'll be happy, happy to answer any questions that you may have that I can and otherwise, I will direct them to the experts behind me, but I can pronounce cytomegalovirus.

ARCH: Very good.

PANSING BROOKS: Thank you.

ARCH: Any questions? Seeing none, thank you.

PANSING BROOKS: Thank you very much.

ARCH: First proponent for LB901.

KIMBERLY WIDNER: Good afternoon, Senator Arch and fellow members of the Health and Human Services Committee. My name is Kimberly Widner, K-i-m-b-e-r-l-y W-i-d-n-e-r, and I live in Bellevue, Nebraska. I'm here today in support of LB901. Cytomegalovirus, commonly referred to as CMV, is a very common virus. By the age of 40, up to 80 percent of all adults have, have been infected with CMV. For most who are infected with CMV, they will experience common cold symptoms. However, if a pregnant woman is infected, CMV can easily be transmitted to the unborn child. This is referred to as congenital CMV. One out of every three pregnant women who become infected with CMV will pass the virus to their unborn child. However, only 9 percent of the population has even heard of CMV. One in 200 babies are born with congenital CMV and that's compared to Down syndrome, which is one in every 700 babies. The handout that you have before you shows the national occurrences of CMV compared to the other very common conditions listed there. One child is permanently disabled by congenital CMV every hour. My daughter, Bailey, age five, she's with us today back here too, is unfortunately one of those children. During my pregnancy, I was educated about the risk of Down syndrome, spina bifida, group B Strep, SIDS, toxoplasma, the danger of kitty litter, the danger of eating sandwich meat, but never once was CMV mentioned at any of my prenatal appointments. Bailey was not diagnosed with cCMV until last year at age four. Due to her CMV exposure in the womb, Bailey has single-sided deafness and a potential for further progressive hearing loss. During Bailey's cochlear implant candidacy review, we also discovered that Bailey has significant vestibular balance loss, white matter brain calcifications, and potential attention deficit issues. At this time, Bailey has a wonderful team of specialty doctors at Boys Town that are monitoring all of her conditions. As a parent, it's difficult to accept that such a common virus could cause my daughter's health issues. Why was CMV never mentioned during any prenatal appointments or any well-child visits with her pediatricians? Why were my husband and I not informed about CMV when my daughter failed her newborn hearing tests on her right ear? Why was I not given the opportunity to have Bailey tested for CMV and potentially receive an antiviral treatment? This past year has turned Bailey's world and my family's world upside down. Bailey is our brave, courageous, CMV warrior, but she's still tired of all the doctor's appointments she has to endure. Bailey will continue to fight the impacts of congenital CMV for the rest of her life. It's almost impossible to explain to a five-year-old why her ear is asleep and will never fully wake up or explain why her older sister doesn't have the same medical issues and doctor appointments or to let her know that yes, she will have to wear that

cochlear implant the rest of her life. I ask you to please vote in favor of LB901 to help raise awareness, education, and increase the diagnosis of CMV within Nebraska so that no other child or family will have to go through the same difficulties that we have faced thus far. I thank you for all of your time. Do you have any questions?

ARCH: Thank you. Are there questions? Seeing none, thank you very much.

KIMBERLY WIDNER: Thank you.

ARCH: Next proponent for LB901. Anyone else wish to testify?

MELISSA ST. GERMAIN: Hi. Good afternoon, everybody.

ARCH: Good afternoon.

MELISSA ST. GERMAIN: Thank you, Senator Arch and, and members of the Health and Human Services Committee. I'm Mel St. Germain, M-e-l S-t. G-e-r-m-a-i-n. I'm a board-certified pediatrician, the vice president of Children's Physicians at Children's Hospital and Medical Center, overseeing primary care offices, 14 of them across the state. I'm also currently the Nebraska chapter president for the American Academy of Pediatrics and I'm testifying you-- before you today as a content expert and on behalf of Children's and the Nebraska AAP. As a safety net provider for Children's in Nebraska-- for children in Nebraska, Children's is dedicated to improving the life of every child, relying on prevention and care coordination to identify challenges families face that can lead to negative outcomes for our patients. As a pediatrician, I help care for children who have been exposed to a variety of infectious diseases. These include cytomegalovirus, or CMV, which is a common virus that's generally harmless to people with healthy immune systems. In fact, most people, as you heard, have been exposed to CMV at some point in their lives without even realizing it or with having mild cold symptoms. There's many types of transmission, but for women who are pregnant, CMV infection can lead to adverse outcomes for babies. CMV can be transmitted to an unborn child from a mother with a primary recurrent CMV infection, known as congenital CMV. In other words, it's something that they're born with. Approximately 90 percent of all infants who are infected with CMV prior to delivery are born without any symptoms of viral infection. However, the remaining 10 percent of babies will have varying degrees of abnormalities, which include hearing loss and/or developmental delays. CMV can be hard to diagnose. Testing is usually accomplished

through a urine test that is done before 21 days of life. The hearing loss-- sorry, the treatments involve early intervention to address the possibility of hearing loss and the-- like the testimony we heard from our previous testifier. Currently, there is no standard evidence-based treatments that are available for an existing infection if it's found. It's more that by identifying those who have been infected with CMV, we can start them earlier on hearing services and any developmental services that they may need. We agree with Senator Pansing Brooks that informational materials promoted by the Department of Health and Human Services could be helpful for families. It's also critical that outpatient audiologists have information related to CMV for their patients who might fail that initial newborn hearing screen and then have their repeat hearing screening done at the audiologist appointment, that they receive information about CMV to create uniformity in our approach to diagnose and treat, which-- a virus which is sometimes difficult to diagnose. I want to thank Senator Pansing Brooks for her recognition of the unique needs of children and how we can better educate new parents on the impact CMV could have if it's not diagnosed early. I'm happy to answer any questions.

ARCH: Thank you. Are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you so much for being here. And I recognize that you're a pediatrician and not an OB, so if you-- if this is not the right question for you-- is there any prenatal screening that can be done to identify if a mother is CMV positive?

MELISSA ST. GERMAIN: There is not any routine screening that I think is recommended. Again, I would defer to my OB colleagues for, for further information. I know that when I had the CMV or, or suspected CMV when I was pregnant, there was a test that we could do because I was symptomatic.

M. CAVANAUGH: Um-hum.

MELISSA ST. GERMAIN: I don't think routine screening of asymptomatic moms is generally recommended.

M. CAVANAUGH: But it-- but I guess my question is it could-- there is a screening that exists.

MELISSA ST. GERMAIN: There-- you can test for CMV infection--

M. CAVANAUGH: OK.

MELISSA ST. GERMAIN: --in moms, yep.

M. CAVANAUGH: Because as a mom, you probably had a test for group B strep.

MELISSA ST. GERMAIN: Right.

M. CAVANAUGH: And then the next step in that is if you were to be screened, if there was a standard screening and you were screened and you were positive and you were asymptomatic, are there preventative steps that can be taken just like they do with group B strep?

MELISSA ST. GERMAIN: Not as easily.

M. CAVANAUGH: OK.

MELISSA ST. GERMAIN: No, there-- I think there are-- and that's why in my testimony, I, I mentioned that there's no approve-- like standard treatments.

M. CAVANAUGH: Sure.

MELISSA ST. GERMAIN: There are some antivirals more in the experimental phase. I didn't find in my literature search that there's any standard-of-care antiviral treatment, but there are some treatments like that available.

M. CAVANAUGH: And it really would just lead to an early intervention then? OK.

MELISSA ST. GERMAIN: Correct.

M. CAVANAUGH: Thank you.

MELISSA ST. GERMAIN: Yep.

ARCH: Questions?

WALZ: I have--

ARCH: Senator Walz.

WALZ: This may-- you may have the same, the same answer, but is there anything that can be done if it's found in a newborn?

MELISSA ST. GERMAIN: The-- it's the hearing-- supporting their hearing screen-- you know, with early intervention services, making sure that they-- if they, if they have total hearing loss, that they have alternate-- learn alternative ways of communicating. That's why we do those, those newborn hearing screens on everybody is because the sooner we recognize that, the sooner we can address it.

WALZ: Thank you.

ARCH: Other questions? Seeing none, thank you very much for your testimony.

MELISSA ST. GERMAIN: Thank you.

ARCH: Next proponent for LB901. Welcome.

JENESSA CRUZ-ALFARO: Thank you for having me here today. My name is Jenessa Cruz-Alfaro, J-e-n-e-s-s-a, last name, C-r-u-z-A-l-f-a-r-o. I live in La Vista, Nebraska, and I'm here today as a private citizen. When you go to your first obstetrician appointment, they tell you not to eat lunch meat, not to clean litter boxes, and to limit your caffeine intake. They tell you not to do heavy lifting and to take your prenatal vitamins. They don't tell you about a simple virus that can cause vision issues, hearing loss, microcephaly, seizures, and even death. They don't tell you not to share drinks or snacks with your toddler or preschool age child because they could be shedding this deadly virus for many months. Would it have made a difference? I don't know, but no one even tried to inform me about this. I should have been informed and so should all women, especially those who care for young children on a regular basis: our teachers, childcare providers, and mothers of young children. My daughter, Cailah, who you'll hear from shortly, was born in 2011. She passed her newborn hearing screening, but in the spring of 2017, around age five, she lost almost all of her hearing in her left ear. At first, no one believed me. The pediatrician even went to check the machine himself. Sure enough, she was profoundly deaf in her left ear. A few months later, she lost some hearing in her right ear. I remember sitting my five-year-old, who could not read yet, on the counter and explaining that if she woke up one day and could not hear, not to worry because mommy would figure it out and made up a sign for "I love you." I had no idea how I was going to figure it out. It was an awful day. Luckily, steroids were able to stop the progression of the hearing loss, at least for now. But we went from kindergarten roundup to being thrown into a world of IEPs, hearing aids, and cochlear implant

candidacy appointments. By Halloween, she was experiencing vestibular issues so severe that she would miss school and spend days dizzy and sometimes even vomiting. An MRI and antibody tests revealed the culprit, CMV. Despite being asymptomatic at birth, this virus that we had never even heard of was now causing multiple issues and had changed my daughter's life forever. By Christmas, she was writing letters to Santa asking for her hearing back. I think we can safely say that we ruined the day of the poor mailman who got to the unenveloped letter before I had the chance to remove it from the mailbox. After a cochlear implant surgery, speech therapy, and countless hours of counseling to deal with the grief of losing the normal life she was accustomed to, she's now a thriving ten-year-old. However, she still struggles to make friends, struggles to fit in, and struggles to hear. Expensive equipment, medical bills, accommodations requests, and the stigma of being different will forever be her new normal. This is what CMV does. This is what CMV takes away from children and families. And we're the lucky ones. Others have it so much worse. I don't know if there's anything that I could have done differently, but I would have tried. I-- my understanding is that you can test for antibodies and it's just that primary infection that is, is the most dangerous to babies. So maybe I would have, maybe I would have tested myself and, and known, you know, whether I had been infected before, what my risk factors were. Maybe I wouldn't have shared drinks with my preschool-age child. Maybe I wouldn't have let him stick his slobbery hand into my snack bag, whatever it was. Maybe it would have, maybe, maybe you would have made a difference. As Nebraskans, we can do better. Families deserve to be educated and infants deserve to be tested so that families have the option of trying antivirals if they choose to do so. We were told when she was diagnosed that at that point, because of her age, that, that it wasn't an option for us. The benefits out-- excuse me, the risks outweigh the benefits at that point. But had we known earlier, perhaps we could have done something different. And there were signs. There were absolutely signs. She didn't sit up as, as early as, you know, my son did, and I mentioned it to the pediatrician, Oh, well, it's the second child. Just different things that we missed along the way that had been educated, had I known more about it, might have been things that I might have been able, able to catch. So although universal testing would obviously be my preference, LB901 is a step in the right direction. And for these reasons, I ask that you vote in favor of LB901. Thank you for your time. Does anyone have any questions?

ARCH: Thank you. Are there questions? Seeing none, thank you very much for your testimony. Next proponent for LB901.

CAILAH CRUZ-ALFARO: Hi. My name is Cailah, C-a-i-l-a-h C-r-u-z-A-l-f-a-r-o. I'm ten years old and I have hearing loss and balance issues because of CMV. When I was young, I had a normal life, but that all changed because of CMV. CMV has made my life different in so many ways. I've gotten bullied for being deaf. Ever since I had to get my cochlear implant, I have felt like an outcast. I struggle to hear my friends and family. I also never get to do-- go to anything because I would get dizzy. To think that there's-- is a way to make it so someone else can end up not having to go through the same thing I did-- I went through would be amazing because there are over 360 million people in the world who are deaf in this law that can make sure that we can prevent that number from going up, that, that is why moms should know about CMV and babies can get tested for CMV. Thank you.

ARCH: Thank you. Thank you. Questions? Are there any questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you so much for coming here and sharing your story with us. What grade are you in?

CAILAH CRUZ-ALFARO: I'm in fourth.

M. CAVANAUGH: You're in fourth grade. So you're studying the state of Nebraska?

CAILAH CRUZ-ALFARO: Yeah.

M. CAVANAUGH: I have to tell you, I don't know of any other fourth graders who have come and testified in front of the Legislature. That's pretty impressive. And you're studying about how we have a Unicameral so now you can go and tell your classmates about that. That's really wonderful. And you're here advocating for yourself, so thank you.

CAILAH CRUZ-ALFARO: Thank you.

ARCH: Any other questions, comments? Yes, thank you very much, and you-- thank you for sharing your story. You did a great job. Thank you. Any other proponents for LB901?

TRICIA RIDDER: Hello.

ARCH: Hello.

TRICIA RIDDER: Good afternoon, Senator Arch and the Health and-- Health and Human Services Committee. My name is Tricia Ridder, T-r-i-c-i-a R-i-d-d-e-r, and I 100 percent support LB901. I thank you all for being here today and hearing us. We need this bill to pass so all babies and families in Nebraska know about CMV and how serious the consequences can be. CMV is an easily preventable virus. Children don't have to have hearing loss, vision loss, cerebral palsy, seizures, mental disabilities, microcephaly, etcetera due to CMV. All women at the childbearing age and all pregnant women have the right to know the risks of CMV and how to protect them, and how to protect themselves and their children. I was pregnant from March to November of 2020. I work in a healthcare setting and at the time, COVID was very new, so I took extra precautions to protect myself and my baby. Not once was CMV brought to my attention by my doctor. My pregnancy only made it to 32 and a half weeks. November 4, 2020, I had a 30-- I had my 32-week appointment. I measured 30-- I measured three weeks behind, so we did an ultrasound and found she was surrounded by fluid and there was an interruption in the umbilical cord. This was alarming, so my OB consulted with a high-risk doctor. I was told I'd either have a C-section in two days or two weeks. I was terrified, but I had faith everything would be OK. I drove myself to the hospital and they monitored her heart rate. It declined drastically, so I was prepped for, for an emergency C-section. Olivia was born at 1:26 p.m. I never heard her cry. I was taken back to my room and she went to the NICU. About an hour after she was born, two nurses told Tom and I that our baby wasn't doing well and they would take us to see her. I tried to run to her, but I couldn't. I was numb from surgery, so in the NICU, Olivia was hooked up to oxygen and was getting chest compressions. Reading the room and the tears in the nurses' faces, we knew it wasn't good. Her pediatricians said they can keep trying or stop because nothing was working to save her. Of course we said yes, keep working, but we knew it probably wouldn't make a difference. After a while, I asked them to stop so we could hold her. We baptized her and named her and said our goodbyes. I never imagined we'd say hello and goodbye all at once. My OB thought she died due to cytomegalovirus because she had [INAUDIBLE] in her nose or blueberry muffin syndrome, which are broken blood vessels. She suggested Tom and I do genetic testing and have an autopsy on Olivia. We did and the results confirmed that she had congenital cytomegalovirus. We buried Olivia on Veterans Day. Maybe if I didn't-- maybe if I had been informed about this common virus, I wouldn't be here today. Maybe I'd

have a happy and healthy 14-month-old daughter and she'd be playing with Isaac and Hayley, her first cousins that were born that same fall. I should have lost sleep from having a newborn, but instead I lost sleep from the guilt, anger, grief, depression, anxiety, and tears. I wasn't given the opportunity to protect Olivia and myself because I wasn't informed. Give mothers the chance Bailey, Olivia, and all the other children never had. CMV is common and it is preventable. Thank you.

ARCH: Thank you. Any questions? Seeing none, thank you for your testimony.

TRICIA RIDDER: Thank you.

ARCH: Next proponent for LB901.

MARY RIDDER: So anxious to get up here. Good afternoon, Senator Arch and Health and Human Services Committee. My name is Mary Ridder, M-a-r-y R-i-d-d-e-r, and I am testifying in support of LB901. I got the first call when I was waiting in line at Gateway Mall for a COVID test. More calls came as I rushed down the interstate and by the time I arrived at Kearney Regional Hospital, my daughter, Tricia, was just out of her emergency cesarean. Her baby, my granddaughter, Olivia Grace, was in another room with nurses and doctors fighting to save her life, but they couldn't. That was the first time I had heard of CMV or cytomegalovirus. How could it be that something more common than Down syndrome or sudden infant death syndrome had such a low awareness factor, that fewer than 10 percent of women knew about it? These two women who just spoke with you, Kim and Tricia, didn't have the opportunity to protect themselves or their babies from CMV. They'd never heard of it. They were not informed about CMV in their OB appointments. So if they carry guilt, they should not. What they do carry is an incredible determination that no other parents face, but they faced. Children born with congenital CMV may develop permanent medical conditions and disabilities such as deafness, blindness, cerebral palsy, mental and physical disabilities, seizures and death. You see, CMV is a very sneaky thing. It can cause symptoms when children are born or later in their infant life. And in some infants, symptoms and problems can arise months or even years after birth. I find it remarkable that congenital CMV is more common than the combined metabolic and endocrine disorders currently in the U.S. core newborn screening panel. Women can be screened for CMV before becoming pregnant. Babies can be tested and diagnosed within their first 21 days of life. If positive for CMV, there are treatments available, but

for every single one of these options to take place, there must first be education. So my ask is to please help protect Nebraska babies and prevent CMV so that we can prevent CMV from changing their lives forever. Finally, regarding the last sentence in the bill, I understand there's concern that a follow-up audiology appointment is a mandate. I can assure you that was not our intent. I've suggested rewording the sentence to read its most advantageous for the audiology appointment take place within 21 days after birth due to the timeline for CMV and treatment. And I know that the Nebraska Medical Association plans to come up here later and testify against this bill. I understand they have concerns that there are some other places there may be the sound of a mandate. I believe that Senator Pansing Brooks will be happy to work with them on making that amenable to everyone because the moms and the families want this bill to pass. Because if you don't have the knowledge and the education, how can you prevent it? So questions anyone?

ARCH: Thank you for your testimony.

MARY RIDDER: You're welcome.

ARCH: Are there questions? Seeing none, thank you very much. Other proponents for LB901? Is there anyone who'd like to testify in opposition to LB901?

DEXTER SCHRODT: Chairman Arch, members of the Health and Human Services Committee, my name is Dexter Schrodt, D-e-x-t-e-r S-c-h-r-o-d-t. I'm vice president of advocacy and regulation for the Nebraska Medical Association. I'm here to testify in soft opposition to LB901. I would like to thank Senator Pansing Brooks. We do have a line of communication open on this bill. Unfortunately, our member physicians do have a standing policy for us to oppose mandates, as you've heard a couple of times today, in proposed legislation that would dictate the practice of medicine. In addition to subsection (2) of Section 3, which the previous testifier just mentioned being a mandate, we also view subsection (1) of Section 3 as a mandate, as well as Section 2. All of those sections direct providers or facilities to, to do something. But I want to make it very clear that the physician members I spoke with, I spoke with a couple of OBs and a couple pediatricians, they fully support the dissemination of information and the production of information by the state or by the facility to increase the awareness of CMV. But as you've heard, it's really hard to detect CMV, to Senator Cavanaugh's point. The only way to truly know is to, as I understand, test the mother during

pregnancy, which as I believe is actually a requirement in Europe. I was told by one of our OBs. That's the, the true way to know what we're working with with these children that are infected with CMV. And as you heard from Dr. St. Germain, there's no clinically proven treatment after the infants are born with CMV. So for those reasons, there's a lot, I think-- well, I shouldn't say that because I'm not a physician, but it seems there is quite a bit still unknown about CMV and possibly some other, you know, research methods, any treatments still to be developed, hopefully to address this heartbreaking disease. However, we do have to, to be opposed as written. If we get to a spot where we're satisfied that the mandates are taken care of, but still accomplishing the goal of disseminating that information to the women of Nebraska that may become pregnant and so they know about CMV, along with the other information they're given during pregnancy, we're more than happy to work on that with Senator Pansing Brooks. And we can communicate with the committee if our position changes, of course.

ARCH: Thank you. Are there questions? Senator Cavanaugh.

M. CAVANAUGH: Thank you. Thank you for being here. OK, so you're in opposition because of mandates. So how is it that screenings then become part of the process? Because through my pregnancies, I was screened for lots of different things. Was that legislated? Did the Board of Health come to that conclusion?

DEXTER SCHRODT: Yeah, so usually when that happens, it's the specialty society of the, the physician. So either ACOG, which is the national specialty society of obstetricians, or AAP, which is the national specialty society of pediatricians. They have boards and panels that look at the standard of care and all of the relevant scientific information that's available at the time. And that's the recommendations they make so that physicians can remain board certified in that specialty. So that's generally how that type of change comes about.

M. CAVANAUGH: So in Nebraska, could our Board of Health require these screenings?

DEXTER SCHRODT: I'm not sure if they would have the authority unless you granted it, the Legislature granted the Board of Health the authority.

M. CAVANAUGH: The authority to--

DEXTER SCHRODT: Yeah, I'd have to look up that--

M. CAVANAUGH: --the screenings.

DEXTER SCHRODT: --that question on authority, but that's where my mind goes with that question.

M. CAVANAUGH: OK. And then the, the piece more specific to this actual bill about the educating, when you're released from the hospital--

DEXTER SCHRODT: Um-hum.

M. CAVANAUGH: --you are required to watch multiple videos on a lot of the illnesses that are on this list. And it's shocking to me, but I'm happy to see it, the Department of Health and Human Services said they can absorb the cost, I assume, because it would be just part of that.

DEXTER SCHRODT: Sure.

M. CAVANAUGH: So how do we get past the--

DEXTER SCHRODT: Yeah. we--

M. CAVANAUGH: --NMA having an issue with the shall--

DEXTER SCHRODT: Um-hum.

M. CAVANAUGH: --too? Why can't we just include this in that exit--

DEXTER SCHRODT: No, if, if the Department Health and Human Services includes it in their already existing materials, then we would definitely be in sort-- support of that.

M. CAVANAUGH: Well, that's what the fiscal note indicates to me is that they are in support of including it in their materials.

DEXTER SCHRODT: Excellent, but there are other sections in the bill that do go further than that. For example, Section 3 subsection (1) was a major concern for both our pediatricians and an obstetrician because the statute that's cited is the initial newborn hearing screening test.

M. CAVANAUGH: Uh-huh.

DEXTER SCHRODT: And it's my understanding that infants can fail that for a variety of reasons. And that's why there's a two-day follow-up,

one-week, two-week follow-up, which is still within that 21 days so they can continue doing that and making that medical decision on what the diagnosis is. But that's where they objected to this information being handed out at that time because infants can, as I said, fail that test for a number of reasons, including the ears being clogged at that moment in time.

M. CAVANAUGH: So how do we get to the point-- and maybe this is a broader discussion--

DEXTER SCHRODT: Um-hum.

M. CAVANAUGH: --not to have today, but how do we get to the point where screening for this in mothers becomes the standard and screening this in newborns becomes the standard? Because if it's screening a urine sample--

DEXTER SCHRODT: Um-hum.

M. CAVANAUGH: --it seems like that's a good thing for us to be doing.

DEXTER SCHRODT: Sure, so I think to the department's point, I think Section 1 takes care of what would add that into the department's information that's already disseminated. As far as improving the standard of care, that's something that physicians would have to take upon themselves and work through their specialty society to update those standards of care.

M. CAVANAUGH: So a 409 process--

ARCH: 7.

M. CAVANAUGH: 407?

DEXTER SCHRODT: No, no. So it's not a--

M. CAVANAUGH: I'm sorry.

DEXTER SCHRODT: No-- oh, it's OK.

M. CAVANAUGH: I'm just thinking about, you know--

DEXTER SCHRODT: Clearly you are, yes.

M. CAVANAUGH: --bacteria, yes, the 407 process.

DEXTER SCHRODT: No, so it's not a scope-of-practice issue because physicians technically don't have to define scope because they are the practice of medicine. So they would have to work through their specialties, so ACOG or AAP--

M. CAVANAUGH: OK.

DEXTER SCHRODT: --to get that as a national standard of care.

M. CAVANAUGH: Got it.

DEXTER SCHRODT: Yep.

M. CAVANAUGH: Thank you.

ARCH: Other questions? Seeing none, thank you for your testimony.

DEXTER SCHRODT: Thank you.

ARCH: Is there anyone else that would like to speak in opposition to LB901? Is there anyone else that would like to speak in a neutral capacity to LB901? Seeing none, Senator Pansing Brooks. And while you are coming up, we have received six letters in support: Andria Head, representing herself; Leah Ridder, representing self; Elizabeth Muller, representing self; Thomas Campbell, self; Amanda Devereaux, representing the National CMV Foundation; and Elizabeth Kelly, representing herself.

PANSING BROOKS: Thank you. Thank you very much, Chairman Arch and members of the committee. I-- this is a little bit of be careful what you wish because I called the, the hospitals-- or the, the medical-- the, the Nebraska Medical Association to have them come in support because I thought they'd be wholeheartedly in favor of this. And I guess the language, even with the amendment that we created, wasn't soft enough. So I'm definitely willing to work with Mr. Schrodts and the Nebraska Medical Association. Unfortunately, because this hearing was scheduled so quickly, we had, we had both OB-GYNs and pediatricians that were coming from Omaha, but were unable to because this came so quickly. And their testimony would have said yes, there is treatment available. It's my understanding that the-- that federally, they are going to add information to be required in their screening and their statistics. So anyway, we are happy to move forward and work. We did not intend to create mandates. We intended to get these-- this information produced and disseminated to new parents. And there was one comment at one point earlier today when I was

talking to some people and they said, oh, well, we just don't want to get the parents worried. Well, if this is a potential, you know, this is-- knowledge is power. And if we do not inform parents about these issues, they're also-- the, the doctors we have talked about, some of the treatments are, are available. They're very difficult treatments and the parents have to decide what they would do. It's similar to a child that's going through cancer treatments. It's very difficult on the child, but that's up to the parents. We believe in the power and the ability of parents to make their decisions with good information. So that's why I brought this. I think it's important. I had three children. I had no idea that this existed and most of the women with whom I've spoken have no idea about it, either. So I feel really proud of this bill. I care about the people who've testified today. I'm sure you all do. And I will be happy to work with the Nebraska Medical Association to figure out what language helps them not to have heartburn. I wish they'd come in neutrally, but we'll go forward from there. And I do thank you, Senator Hansen, for helping sign on and we'll get it organized and I'll work with you on it and make sure you know as well.

B. HANSEN: Sure.

PANSING BROOKS: Thank you.

ARCH: Thank you. Are there any final questions?

PANSING BROOKS: Thank you all.

ARCH: Seeing none, thank you very much.

PANSING BROOKS: Appreciate it, have a good day.

ARCH: That will close the hearing for LB901 and close the committee hearings for the day.