

Transcript Prepared by Clerk of the Legislature Transcribers Office
Health and Human Services Committee September 14, 2021

ARCH: Good morning and welcome to 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 Murman from District 38, representing 7 counties to the east, south and west of Kearney and Hastings.

WALZ: Good morning. My name is Lynne Walz, and I represent Legislative District 15, which is all of Dodge County.

WILLIAMS: Matt Williams from the Gothenburg, Legislative District 36: Dawson, Custer and the north portion of Buffalo Counties.

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

ARCH: Thank you. Also assisting the committee is one of our legal counsels, Paul Henderson; our committee clerk, Geri Williams; and our committee pages, Bobby and Patrick. A few notes about our policies and procedures. First, please turn off or silence your cell phones. This morning, we will be hearing two interim study resolutions, and we'll be taking them in the order listed on the agenda outside the room. The hearing on, on each study will begin with the introducer's opening statement. After the opening statement, we will hear from a number of invited testifiers, and I'll call those up in order, followed by anyone else who may wish to testify on the study. The introducer of the study 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 and hand it to one of the pages when you come up to testify. This will help us keep an accurate record of the hearing. We use a light system for testifying. Each testifier 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. When the light turns red, it is time to end your testimony and we'll ask that you wrap up your final thoughts. And when you come up to testify, please begin by stating your name clearly into the microphone and then please spell both your first and last name. With that, we will begin today's hearing with LR221. Welcome, Senator Vargas.

VARGAS: Good morning, everyone.

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ARCH: Morning.

VARGAS: Morning, Chairman Arch, members of Health and Human Services Committee. For the record, my name is Tony Vargas, T-o-n-y V-a-r-g-a-s. I represent District 7 in downtown and south Omaha, the communities of downtown and south Omaha in the Nebraska Legislature. First I'd like to thank you for hosting this interim study hearing so that Senator Cavanaugh and myself continue to have these important conversations about maternal and infant mortality and morbidity. I do have this, which I'll hand out here in a second, which is just an update on LB626. It's a one pager, so if you just hand this out. LR221 is an interim study resolution to examine maternal and infant mortality and morbidity so that we as policymakers are better equipped to make recommendations that will improve the quality and care for mothers and babies. First, what is mortality? Mortality is another term for death. The mortality rate is the number of deaths due to a disease or catastrophic event divided by the total population. While morbidity does not mean death, mortality and morbidity are related that are used in tandem to describe the progression and severity of a health event. Now, what is morbidity? Simply put, morbidity is another term for illness. Morbidity technically includes any physical or psychological or physiological and psychological state considered to be outside the realm of normal well-being, so the term is often used to describe illness, impairment or degradation of health. If someone has a high morbidity, they have a shorter expected lifespan compared to healthy individuals. Now, while morbidity is often discussed in regards to chronic diseases, morbidity doesn't necessarily mean that an illness is immediately life threatening. If morbidity progresses, it may increase the risk of mortality. Now the bulk of this LR221 reinforces the conversations that we have had, or we started having, when I introduced LB626 and that many past senators have also worked on in this subject area. Now LB626 puts into statute what is already in practice. Earlier this year you all voted LB626 unanimously out of committee. Thank you for doing that. I'm very grateful for your support with moving this important piece of legislation forward. And I also provided you with this one pager that just provides a brief overview of LB20-- LB626 again if you need to jog your memory. Now, right now, the statute lays out that we have a Child and Maternal Death Review Team. A couple years ago, the group split and the Maternal Death Review Team became kind of a subcommittee under the umbrella of the Child Death Review Team. If passed, LB626, which has been put to General File, would make this organizational realignment more formal by officially splitting the two teams and ensuring that committee members who are selected to serve on them have subject matter expertise in the appropriate areas. Now, while the Child Death

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Review Team was established in 1993 and then expanded to include the maternal death reviews in 2013, the goals of the teams were stated to be: to identify patterns of preventable deaths; to recommend changes in system responses to deaths; to refer to law enforcement any newly suspected cases of abuse, malpractice, or homicide; and to compile findings into reports designed to educate the public and the policymakers about child and maternal deaths, which actually is one of the most important ones, in my opinion, for what we're doing. Now these goals can't be met without timely access to data. This is what we talked about in the LB that I introduced. And we as policymakers can't make informed decisions about potentially necessary changes in public policy if we don't receive these annual reports with accurate and updated information. Now there are testifiers behind me that can talk more about the importance of this topic and how the Child and Maternal Death Review Teams work now and why these changes are important and necessary. Again, I want to thank you, because the bill that we-- that you all voted unanimously out is the beginning and continuing conversations on the subject matter, but are really trying to reinforce that we need timely data. We need to make sure to update the review teams and create some efficiencies, or at least codify them in statute, and also make sure we're continuing to bring this up as a point of conversation and an education to the committee, because at the end of the day, these data trends are the only trends that we have to inform what we know are likely overrepresenting people of color, communities of color, and other groups that are overrepresented in terms of maternal and child mortality, morbidity. And so I just appreciate you. I really thank Senator Cavanaugh for her leadership in this as well. And we will have some experts behind us, and I really appreciate them coming today to then share more information and updates regarding the subject matter and this LR. So thank you very much.

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

VARGAS: Thank you very much.

ARCH: First testifier this morning, Dr. Bob Bonebrake.

ROBERT BONEBRAKE: If it's OK, I'm going to remove this so I can speak clearly without fogging.

ARCH: You may, yes. Welcome, Dr. Bonebrake.

ROBERT BONEBRAKE: Thank you. My name is Robert Bonebrake, R-o-b-e-r-t B-o-n-e-b-r-a-k-e. Chairman Arch, members of the Health and Human

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Services Committee, my name is Dr. Bob Bonebrake. I'm a maternal fetal medicine specialist at Nebraska Women's Hospital, where I serve as director of Perinatal Services. I'm here on behalf of the Nebraska-- Nebraska Medical Association and Nebraska Perinatal Quality Improvement Collaborative, where I serve as co-medical director. Thank you for hosting this interim study hearing on maternal and infant morbidity and mortality. In addition to my involvement with the organizations I previously mentioned, I also serve on the state's Maternal Mortality Review Committee as the chair of the committee and on the Child Death Review Team. I'm here as a member of those committees, but not representing them. In these committees, we are tasked with reviewing each of the deaths of a mother or child and from this identifying patterns of preventable death, recommending changes in both the healthcare and social service systems' responses to these deaths, and ultimately reporting to the public and policymakers, such as yourselves, about these maternal and child deaths in our state. I would like to focus my remarks here today to the Maternal Mortality Review Committee. Although maternal mortality review has been attempted in the state for a number of years, it is only since 2018 when the current Maternal-- Maternal Mortality Review Committee was formed and implemented that maternal mortality review has been undertaken in a systematic, uniform, and interdisciplinary manner with the guidance from the CDC. The committee is made up of staff from DHHS, as well as volunteer members from various professions in our state. These members take on the burdensome and difficult task of reviewing the deaths of the mothers in our state with great responsibility and care, in hopes to uncover information and data that will lead to statewide measures that will improve safety and health of the mothers in Nebraska. This is a time-consuming and a very emotionally difficult process and duty for these members of the MMRC. In the time the state has been working on this issue, there has been much data and statistics used and thrown around about the maternal mortality rate in Nebraska and how we compare to other states in our nation. Although this has been done well intentioned, I believe that it has been done erroneously and as the information and-- as the information and data that has been used for these comparisons was from less-than-optimal reviews done prior to 2018 and, therefore, not using accurate or appropriate data or information. In my opinion, the current-- at the current time, we don't know what we don't know about our true maternal mortality rate. This is vitally important to understand, given the fact there are few things more important than data in regards to identifying etiologies and trends and using this information for education and the implementation of-- of system-based care improvements. It is this data, education, and implementation of interventions that will lead to the saving of mothers' lives in

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Nebraska. Obtaining proper data is vital to understanding not only why Nebraska mothers are dying in pregnancy, but also can ultimately identify factors that may be involved in severe maternal morbidity, thus hopefully allowing interventions that prevent and reduce severe maternal morbidities. The MMRC is currently finalizing the data on the maternal reviews of 2014 through 2018 and is in the process of accomplishing real-time reviews to have current and accurate data. During my tenure as the chair of the MMRC, I have seen a committee of individual professionals grow into an engaging, insightful, inquisitive, and challenging group that has taken on ownership of this process and the goal of truly trying to protect every mother in our state of Nebraska. I've seen a group that have been deeply touched and pained by the deaths of these mothers and profound responsibility they feel to these and all mothers. If you've ever seen one of the reports issued by the Child Death Review Team, you'll notice that it is heavy on data because nothing is more powerful than identifying trends in education on those trends than quality data. Obtaining proper data is vital to understanding not only why Nebraska infant mortality rate re-- remains concerningly high, but also why maternal deaths occur, either during or after pregnancy. Data on the state's children also helps to identify trends in our middle and high school-age population, such as suicide or the impact of vehicle crashes, as well as the impact of abuse on children of all ages. As you can see, the breadth of information that can be gleaned about this topic is fairly wide, but so are the lessons that can be learned by policymakers and other stakeholders in order to improve Nebraska's mortality rates for its mothers. It is crucial that the work of the Maternal Mortality Review Committee be prioritized through adequate funding and resources, so that the-- so that Nebraska can support and improve the lives of mothers and subsequently their children in the state. There is certainly room for improvement in our maternal mortality rates. And I will tell you that as a physician who has dealt with the death of mothers and their unborn children, as well as a husband and father, that the death of one mother is too many. It is because of this, as well as a goal of reducing the incidence of death of mothers and their children, that I ask for the support of all policymakers. Thank you again for hosting this hearing on this topic. I look forward to continuing to work with all of you and making Nebraska a safe place for mothers and their babies. I'm happy to answer any questions that you might have in regards to the MMRC, as well as maternal depression or Child Death Review Team. Thank you.

ARCH: Thank you, Dr. Bonebrake. Questions? Senator Williams.

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WILLIAMS: Thank you, Chairman Arch. And thank you, Doctor, for being here. In your testimony, you talked about the-- I think the lack of being able to rely on some of the internal reviews that have previously been-- been conducted. Can you describe that a little more fully so we can understand that better?

ROBERT BONEBRAKE: Yes, Senator. So prior to 2018, when the current MMRC was set up, there were reviews attempted to be done, and I-- and I think well intentioned, very honestly. But the process that was set up was such that it was not well organized. It was not uniform or systematic. Essentially what was done was there were a group of volunteers-- again, I think, very well intentioned-- that would be sent a case of a maternal death and they would-- with whatever little data they had, and typically at that point they just had kind of a-- a brief overview. And then they would take it and then they would write their review in a paragraph and send it in, and that's basically what the review consisted of. Currently, we go through every review we have. We meet quarterly for a whole afternoon. Prior to that, we receive data to review so that we can have very in-depth, open, and interactive discussions about that. We have not only medical professionals; we have epidemiologists. We have multiple areas of-- of medical professionals, including those of maternal-fetal medicine, OB/GYN, pathology, cardiology, OB anesthesia. We have family practice; we have nurses, nurse mid-- we have many different areas and it's all come together to bring that information together, if that helps.

WILLIAMS: Thank you.

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

ROBERT BONEBRAKE: Thank you very much.

ARCH: Next testifier, Chad Abresch from CityMatCH.

CHAD ABRESCH: Good-- good morning, Chairperson Arch and members of the Health and Human Services Committee, I'm Dr. Chad Abresch, for the record, C-h-a-d A-b-r-e-s-c-h. I'm faculty member of UNMC. However, I'm not speaking as a representative of the university today. I also serve as executive director of CityMatCH, which is a national public health equity organization that works with 170 cities across the country. We do that to advance equity and improve the health of women, children, and families. I'm here today speaking as an individual who has dedicated the past two decades of my career to partnering with cities and states to advance equity and improve the health of families. In preparation for today's hearing, I'm reminded of a close

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colleague, Dr. Bill Callahan, who often says we count what matters. It's a simple thought, but Dr. Callahan stressed it routinely. We count what matters. Now, before he retired, Dr. Callahan was an OB/GYN and he was chief of reproductive health at CDC. It was Bill's idea to fund state perinatal quality collaboratives around the country because he believed that the way that we were counting maternal deaths did not align with the value of those lives. Bill felt that we should scrutinize every detail of a maternal death, much like an investment broker pores over every company in their portfolio. They count their investments closely because dollars matter to brokers. So we should ask, how are we doing at counting in Nebraska? Does the way that we are counting maternal and infant deaths adequately emphasize the value of those lives? If the families who have lost mothers and little ones were to know the full details, would they be satisfied? I don't believe that they would be. In fact, if they knew the details, I think these families would be disappointed for two reasons. First, annual resp-- reports submitted in response to 71-3407 are incomplete. The law requires these reports from the work of the Maternal and Child Death Review Team include two components: number one, statistical studies of the causes and incidence of maternal and child deaths; and number two, the team's findings and recommendations. The most recent report, dated June 29 of this year indico-- indicates, and I'm quoting here, acquiring records for a calendar year of deaths, reviewing and analyzing the information, and developing recommendations typically takes 18 to 24 months. The team is currently finalizing the full report of deaths from 2015, end quote, So by the agency's stated time requirements, the 2015 full report has been delayed 45 months and counting. Second reason I believe that Nebraska families would be disappointed is because we have been ignoring fetal deaths. Fetal deaths are important because there are about as many fetal deaths as there are infant deaths. Also, 20 to 50 percent of fetal deaths are preventable based on social determinant disparities. And finally, the prevention strategies are not always the same as they are for infant deaths. But more than anything else, fetal deaths are important because those losses matter to Nebraska families. Even without the full release of state data, we know from national data sets that we have areas that are in need of desperate improvement. Unfortunately, infant mortality inequities-- those are unfair differences in health-- in-- infant mortality inequities in Nebraska are bleak, according to CDC statistics. For example, black infants in our state have been dying at an alarming rate for years. In fact, Nebraska is among a handful of states with the worst outcomes nationally. Our most recent black infant mortality rate is 12 deaths per 1,000 live births. In other words, for every 1,000 black babies born alive in Nebraska, about 12 will not see their first birthday. The same data indicate

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that white infant mortality rate in Nebraska is under 4, under 4 deaths per 1,000 live births. More than three times as many black babies die in Nebraska compared to white babies. If you look at Omaha, just specifically Douglas County, and hear this, ranks two 296 out of 314 counties for non-Hispanic black infant mortality. Unfortunately, we cannot legitimately call Nebraska the good life when it's one of the most likely places to die if you're black. These data make it clear we must act and we must succeed. I have two specific recommendations for you today: Enforce 71-3407. Insist the annual reports are full and complete. DHHS has talented epidemiology-- epidemiologists who, if empowered, could give us detailed and actionable reports, complete with the review team's recommendations. And number two, en-- enable localities to conduct fetal death reviews and allow the State Child Death Review Team to review a small sampling of fetal deaths when they see a need to do so. I've included several links in my comments with good model language from four other states. Thank you for the opportunity to talk with you today and for undertaking this important interim study.

ARCH: Thank you. Are there questions? Seeing none, thank you for your testimony. Dr. Ann Anderson-Berry, please.

ANN ANDERSON-BERRY: Good morning, 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 am a faculty member of UNMC and the co-medical director of the Nebraska Perinatal Quality Improvement Collaborative, NPQIC. However, I am not speaking as a representative of the university today. I am here speaking as an individual and on behalf of NPQIC, the Nebraska Medical Association, Children's Hospital and Medical Center, and the Nebraska Hospital Association. I am here testifying with regards to LR221. Maternal mortality is rising in the U.S., more than doubling in 30 years from 7.2 deaths per thous-- 100,000 live births in 1987 to 17.3 deaths per 100,000 live births in 2017. According to the recent Surgeon General's call to action to improve maternal health, black women die of pregnancy-related causes at a rate three times higher, and American Indian/Alaska Native women at a rate two times higher than white women. NPQIC works to reduce disparities in maternal and neonatal mortality and morbidity outcomes in our state through improvement science. This well-established process of maternal and fetal 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 evaluation and adoption of the strategies until sustained improvement is achieved. Without data, we are unable to effectively and efficiently use state resources to

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target initiatives to improve mortality rates, putting families at continued risk with women not delivering live newborns and infants without mothers to raise them. The most recent full-data reported is for the year 2014, so we're-- we are completely uninformed of our state's mortality details, rendering us blind in approaching the problem. It is my expectation that maternal mortality will have a dramatic increase in 2021 with poor vaccination rates in this population and preliminary data showing pregnancy is independently associated with a three-fold increased risk for ICU admission and a one-point-sevenfold increased risk of death due to COVID-19 compared with symptomatic nonpregnant patients with COVID infections. We have already seen COVID-19-associated maternal mortality in Nebraska and are likely to see more as Delta variant continues to spread in Nebraska. Fortunately, we have opportunities to conduct work that will improve processes for maternal morbidity reviews and work that can lead to decreased maternal mortality and morbidity. NPQIC works with all delivery hospitals in the state of Nebraska. These member hospitals actively participate in quality improvement initiatives. Our plan is to utilize timely, available data to expand the scope of NPQIC's work based on reported outcomes from an active and robust Maternal Review Committee to meet national goals for reduction in mortality. We recommend that state target-- the state target specific resources towards these efforts, as outlined in the 2020 U.S. Surgeon General's report on maternal mortality in the U.S. In the Surgeon General's plan is an outline for the U.S. to decrease maternal mortality by 50 percent in five years. Nebraska can work alongside other states to implement these interventions only if we have 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 successes of these proposed new initiatives. Senator Vargas' LB626, on General File, if passed in the upcoming session, will provide infrastructure to gather data that will allow stakeholders to address perinatal issues that develop long before hospital admission for delivery, decreasing both untoward outcomes, such as death and morbidities for the maternal and neonatal populations, as well as decreasing the costs associated with these expensive conditions. The state is a necessary public health partner if we are to ensure safety for Nebraska families. In my professional life, I have personally sent home too many newborns who-- after the death of their mother. These infants go home with grieving families who are grappling with planning a funeral for the mother while also mourning the loss of a multitude of dreams: a lifetime of being a

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family; plans to provide mother's breast milk for optimal neonatal development change to wondering how to afford necessities on one income; wondering who will care for the newborns and siblings when the surviving parent has to return to work and how extended family of grandparents, aunts, and uncles can juggle their schedules to help fill the role of the mother. Whether the cause of death is cancer, infection, hemorrhage, hypertension, mental health crisis, or a host of other causes, it is critical that we work to discover root causes and prevent further loss and heartache. A newborn's arrival should be filled with joy, not overshadowed by unimaginable heartbreak of maternal death. I will work endlessly to ensure that I and other neonatologists are not faced with caring for families with this type of heartache again. 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. NPQIC stands at the ready with skills to work to improve neonatal outcomes, but without data and support from the state, we are flying blind. Thank you for your time.

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

ANN ANDERSON-BERRY: Thank you.

ARCH: --for your testimony. Next testifier, Peggy Brown. Good morning.

PEGGY BROWN: Good morning, Chairman Arch and members of the Health and Human Services Committee. I'm Peggy Brown, P-e-g-g-y B-r-o-w-n, a staff member of UNMC and program administrator for the Nebraska Perinatal Quality Improvement Collaborative. I'm a registered nurse with a doctorate degree and certification as a healthcare quality professional. I'm testifying LR221 in my role as a private citizen. The Nebraska Perinatal Quality Improvement Collaborative, known as NPQIC, collaborates with stakeholders throughout the state to address maternal and neonatal morbidity and mortality through improvement science. I'd like to start by explaining the difference between mortality and morbidity. Mortality refers to deaths, whereas morbidity refers to specific illnesses or conditions. Women who are pregnant or who-- who have recently been pregnant may experience severe morbidity conditions such as kidney failure, stroke, heart failure, and hysterectomy. Newborns, most often those who are premature or low birth weight, experience morbidity conditions such as lung disease, bowel damage, brain hemorrhages, and serious infections. These morbidity conditions, res-- result in short- and long-term consequences, contributing to human suffering and increased healthcare costs. Today I'm focusing on maternal morbidity. NPQIC is working to

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implement severe maternal morbidity reviews. This is a national best practice for monitoring morbidity. The process for doing these reviews was established by the American College of OB/GYN and the Alliance for Innovation on Maternal Health. When a mother experiences a severe morbidity condition with pregnancy, a team of professionals at the hospital where she received care is assembled to analyze her case to determine if the morbidity could have been avoided and if any changes need to be made to prevent it from happening to another mother. The team's findings are recorded on a standard data collection tool and uploaded to a central database for annual analysis. By studying these cases, we will be able to fully focus to prevent future cases of maternal morbidity and mortality. There are five hospitals who will begin piloting this process soon. When the pilot is complete, near the end of 2022, we will be working with the Nebraska Coalition for Patient Safety to analyze the data. Then, in 2023, we intend to engage birthing hospitals to voluntarily do these reviews and submit their findings for statewide analysis. At that time, there will need to be a report established summarizing maternal morbidity in the states. In the future, legislation may be needed to get full participation from hospitals in performing these reviews; however, we're too early in the process to know if hospitals will voluntarily participate. There are physicians from 11 hospitals throughout the state on the work group that's developing the plan for reviews, and all 11 are supportive. Their main concern is confidentiality of the review process and findings. That is why the data for the pilot will go to the Nebraska Coalition for Patient Safety, which is our state patient safety organization for which federal and state laws already ensure the protection of confidentiality for patients, providers, and hospitals. In the future, if the Nebraska Department of Health and Human Services is able to publish the maternal death report, as required by law, it may make sense to involve them in the morbidity review analysis. It is essential to ensure that morbidity review results are available to guide quality improvement. At this time, we can't be certain that-- that the data would be available from DHHS for analysis or reporting. Another national best-- national best practice is known as maternal safety bundles, and it has already been successfully implemented to reduce maternal morbidity in Nebraska. A safety bundle is a collection of practices proven through research should be effective. The Alliance for Innovation on Maternal Health, the same organization that established the process for morbidity reviews, has developed several of these maternal safety bundles. Over the past two years, NPQIC led the implementation of the bundle addressing severe maternal hypertension. As a result of this work, and even though only 28 of our 51 birthing hospitals participated, severe maternal morbidity due to hypertension was decreased by 50 percent in our state. I conclude by

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telling you that the initiatives led by NPQIC are effective in reducing perinatal morbidity and mortality and emphasize the importance of adequate funding to continue these efforts. Thank you for your time today. I'm happy to answer any questions.

ARCH: Thank you. Are there questions? I-- I have-- I have a question. So the LB626 refers to the Child and Maternal Death Review Team. Is-- is this organization parallel to that process or do those-- those processes ever meet up at some point?

PEGGY BROWN: NPQIC is hoping to get results from the Maternal Death Review Committee so that we know what we need to do to improve care for moms in the state. And-- and we have been looking forward to getting that. We have data that just gives the number of deaths, but we don't know where those deaths are occurring, any of the factors associated with the deaths. So, you know, we're just flying blind. We need that information so we know exactly where to focus our energies.

ARCH: So the-- the-- the review team, the Maternal Death Review Team would gather data and-- and provide it to you for further analysis?

PEGGY BROWN: No, for mortality, which is what that one is, they publish-- are to publish their annual report. NPQIC would obtain that report and then base our initiatives on that report.

ARCH: I see.

PEGGY BROWN: Now the area that I was focusing on today is morbidity reviews, which is where we look at those moms that have heart failure or kidney failure to see what can we learn from those cases that can-- that we can take action on, because we know that we will get those results and we will analyze it and we will have that data to act on right away.

ARCH: OK, so that's and that would be in a collaborative where you're hoping hospitals will volunteer to provide that data and-- and work together to do that.

PEGGY BROWN: Yes.

ARCH: OK.

PEGGY BROWN: And at this point, we do have 11 providers from across the state that are very interested in this. They're on the planning group and five of them, which are the larger hospitals, are going to pilot the process.

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ARCH: OK, very good. Thank you. That's helpful to clarify that. Any other questions? Seeing none, thank you very much. Christian Minter. Good morning.

CHRISTIAN MINTER: Good morning. 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'm a manager of maternal/infant health initiatives 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 regarding LR221. The United States is experiencing a maternal and infant health crisis. Approximately 700 women die each year from pregnancy-related causes. Sixty percent of those deaths are believed to be preventable. An additional 50,000 women are experiencing severe maternal complications that may have lasting impacts on their health and well-being. There are over 20,000 infants in our country that are dying before reaching their first birthday, and the threat of mortality and morbidity is especially acute for women and infants of color. Black mothers of all ages are three times more likely to die from pregnancy-related complications than their white peers. The rates of pregnancy-related death for black and Indigenous women over the age of 30 are four to five times higher than their white peers. Black babies are more than twice as likely as white babies to die for their-- before their first birthday, and women of color are up to 50 percent more likely to give birth prematurely. Nebraska is not immune to this crisis. The state received a grade of D+ on the 2020 March of Dimes report card due to the high number of preterm births. One in ten babies in our state are born premature or before 37 weeks of pregnancy. In 2018, the infant mortality rate for the state was 5.8 per 1,000 live births. And similar to what we see in national data, infants of color in Nebraska are experiencing a higher risk of adverse outcomes. Over 13 percent of black babies and 14 percent of Indigenous babies are born premature, compared to their 9.6 percent of white babies. And black babies and more than twice as likely as white babies to die before their first birthday. The infant mortality rate for black babies in Nebraska was 12.2 deaths per 1,000 live births in 2018, compared to 5.2 for white babies. In looking at data from 2017, the infant mortality rate for Indigenous babies was 8.3 deaths per 1,000 live births. We know that the health and well-being of infants are inextricably linked to the health of their mothers. However, Nebraska is currently lacking comprehensive and publicly available data on maternal mortality and severe maternal morbidity. Access to this data is crucial for everyone in our state who provides care to mothers and babies. Data help provide a baseline information on current maternal health, identify populations that need to be prioritized to eliminate health

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disparities, and measure the impact of programs and interventions that are implemented. March of Dimes supports efforts to improve data collection and data sharing on maternal mortality and severe maternal morbidity, especially through the work of perinatal quality collaboratives and Maternal Mortality Review Committees. Both entities are an integral part of a multifaceted approach to reduce preventable deaths and promote optimal health and well-being. As you have heard in other testimony today, the Nebraska Perinatal Quality Improvement Collaborative and Nebraska Maternal Mortality Review Committee are making progress in improving how we access maternal health data in Nebraska, but there is still much work to be done. The Health and Human Services Committee has demonstrated support of maternal mortality review by moving LB626 to General File in the One Hundred Seventh legislative general session, and I encourage the Legislature to continue to move the bill forward and to take the next step by providing the necessary resources to improve data collection and sharing. If we more adequately tell the story of what Nebraska moms and babies are experiencing, then we can more adequately support those needs and paint a different picture in the years to come. Thank you.

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

CHRISTIAN MINTER: Thank you.

ARCH: Next testifier, Sara Howard.

SARA HOWARD: Thank you. All right, good morning.

ARCH: OK. Well, we can't help but say welcome back, Senator Howard.

SARA HOWARD: Longtime listener, first-time caller in this position. [LAUGHTER] All right. [INAUDIBLE] thank you for having me. OK, so thank you for allowing me to testify today. I'm-- my name is Sara Howard, spelled S-a-r-a H-o-w-a-r-d-- I was 100 percent sure I would forget that-- and I am 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, and their interest in these issues pertaining to maternal and infant health policy are centered around the fact that healthy moms and babies are critical to ensuring the long-term success of children in our state. I'm here to testify on Senator Vargas' interim resolution, LR221, and I want to thank him for his in-- his interest in these issues. He's really been a champion around these things. I'm not going to read you my testimony, which is probably very exciting for my boss. I just want to give you just a little bit of

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history around the Child Death Review Team, because I think that's relevant to the work that you're being-- you're being asked to consider today. And then I'll give you some policy options, because always when I would sit in hearings, I would say, just give me something concrete that I can do and fix. So the Child Death Review Team was started in 1993. In 1993, Nebraska had a spate of child deaths and they were-- they couldn't figure out why. It was over 300 deaths. And so legislators got together. They had an interim study. And from that interim study, they decided to allow the state the-- to have the ability to subpoena records around infant and child mortality so then the state can subpoena the records and conduct the reviews. So they put together a team to conduct the reviews. The statute itself hadn't been touched until 2013. In 2013, a young whippersnapper of a legislator decided to modify the statute and bring it up to sort of the more modern views of child death review teams, and that was the point when we added the Maternal Death Review Team. So the review teams then were looking at children and moms at the same time, and the state was able to subpoena those records. When we drafted that statute-- you've been hearing a lot about records, fetal records, right? You heard it from Chad Abresch. You might have heard it from a couple other testifiers. When we made those revisions in 2013, we actually omitted the ability for the state to gather fetal data by-- through the definitions. So the definition in statute literally says a live birth, so previously they were able to subpoena the records of stillbirths. And then in 2014, the Child Death Review-- the Maternal and Child Death Review Team now was unable to gather that fetal data. So I brought with me two letters. One is from the Omaha Women's Fund. It's very nice. The second one is from the Douglas County-- Douglas County Health Department. The Douglas County Health Department has a CDC-funded group called FIMRs, which sounds like a bone. It is not. It stands for the Fetal/Infant Mortality Review Team. And since 2014, because of those revisions, they have not been able to get their fetal data that they need in order to do their reviews, so they've only been able to do infant mortality reviews in Douglas County. So one of the statutes that you may be asked to consider is looking at the definition or adding the definition of "fetal" into the Maternal and Child Death Review Team statute in order to allow the state to subpoena those records and subsequently share them with their review partners in Douglas County. This is a very concrete action that you can do and not very controversial. It was a mistake. Honestly, it was a mistake that I made when I did that-- that bill. The other two pieces that-- that are something to consider, the first is obviously LB626. You moved that unanimously. It is a great bill. It really reflects the actual function of the Maternal and Child Death Review Team and makes the statute align with how they're actually working,

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which is looking at both of these instances of mortality and having a reviewer-- a review team for both equally. The final thing is what Peggy Brown from NPQIC was talking about, and this is something to consider in the future, looking at morbidity, so looking at those health status issues. We as a state have the Mortality Review Team in place. It will be a logical next step in the future to give them the opportunity to look at morbidity, and that way they can subpoena records, they can spot trends, and they can guide groups like the Perinatal Quality-- Perinatal Quality Improvement Collaborative. It can guide their work into figuring out ways to prevent illnesses, to prevent mortality, because that's really their function. So those are the three things: FIMRs, those stillbirth fetal reviews, passing LB626, and then considering in the future, not immediately, because we want to make sure that the work that NPQIC is doing around morbidity has the opportunity to sort of be beta tested before the state intervenes, having those severe-- severe mor-- maternal morbidity reviews come under the function of the state. I see I have my red light, which I've never gotten before.

ARCH: Could you wrap up your comments, please. [LAUGHTER]

SARA HOWARD: I will wrap up my comments by saying it's lovely to see all of you and-- and I'm so thrilled that we have the opportunity to have these hearings today. Thank you for having me. I'm happy to stand for any questions.

ARCH: Any hard questions for Senator Howard?

SARA HOWARD: Tough-- the tough ones.

M. CAVANAUGH: I have [INAUDIBLE]

ARCH: Senator Cavanaugh.

M. CAVANAUGH: Former Senator Sara Howard--

SARA HOWARD: [INAUDIBLE]

M. CAVANAUGH: --thank you for being here today. This has been very informative. Just my question is, are you aware that Marian is the far superior all-girls school [INAUDIBLE]

SARA HOWARD: Oh, my goodness. Wow. OK, we've got a whole other hearing, and I don't-- I don't want to burn a bridge, but I think we all know that Duchesne Academy is, I mean--

M. CAVANAUGH: Agree to disagree.

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SARA HOWARD: Yeah, we're just-- we're not going to be able to move on from this.

M. CAVANAUGH: Thank you for-- thank you for this.

SARA HOWARD: Thank you for having me.

M. CAVANAUGH: This is very helpful.

SARA HOWARD: Any other questions for me?

ARCH: Questions? Seeing none--

SARA HOWARD: Perfect.

ARCH: --thank you very much for your testimony.

SARA HOWARD: Thank you so much for your time. I'll see you in a minute.

ARCH: OK. Is there anyone else that would like to testify on LR221? Seeing none, Senator Vargas, you're welcome to close.

VARGAS: OK. So I just want to thank every-- all my testifiers for coming here and thank the HHS Committee. Thank you, Chairperson Arch, and actually special thanks to former Senator Sara Howard for her work on this in the past. Think she was referencing herself as she-- she mentioned at-- at the end-- and also the actionable part. The only thing I'm going to add here is hopefully it's very clear to you that the bill that you-- you pushed forward, my bill from last year, is an important and noncontroversial thing, and I appreciate your support and help with that. And we can hopefully get this over the finish line this next year because, as you can see, it's very-- gonna be really frank. You heard from the testifiers. Without data, we're flying blind, and that's probably the most important thing to leave us with. We're not talking about completely revamping a program. We're not talking about putting in an endless amount of-- of funding in-- into something. What we're trying to solve is you can't make informed decisions when we have reports that are coming from 2015 data that are 2017 reports. And-- and if you're flying blind and our experts are sitting and-- and are asking for that, we have a real big problem on our hands. And as a state, when we talk about our long-term health effects and we're looking at the disparities that already exist and these inequities are clearly within people of color, women of color, and infants, it is very clear that we have something that we can do about it. But data is the only thing that enforces whether or not we

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can make any legislative or even nonlegislative changes for-- and this is-- this is the really important part of why that perinatal group is-- is so important to driving policy. So I appreciate your work on making sure that we are improving the data that we have, that you see the urgency in this. I could have said this myself, but I-- that's why these-- think these interim hearings are so important, because we get to hear from the experts that, again, I-- even hearing it from them again that they're flying blind is just reminding me that this is an urgent, urgent call to action for us. There's other recommendations that you can see from some of the letters and the testimony and also that Senator-- former Senator Howard mentioned. And the last thing I'll just say, and some of you've heard this if you've been in-- in-- in my introduction from this bill last year, my connection to this isn't only because I care about this. It's largely driven because my wife had preeclampsia and postecclampsia, and it really shed a light onto, for me, seeing these inequities firsthand. And we asked ourselves a question. My wife has certain things that-- she has healthcare access. She has certain availabilities that are-- that-- that she's been able to take advantage of and others do not. And I also thought about everything that led up to the point and to whether or not my wife and other-- other sort of unique identifiers that could have contributed to that. And also from the other side, I-- I was born premature and so was my-- my daughter. So this is a little-- beyond it being personal to me, I also see the data and then I see the communities that we serve and, being from Omaha and serving one of the most diverse communities, south Omaha-- and also north Omaha is not my district, but I-- I've seen the health inequities for years. Senator Cavanaugh and I, when we-- we talk about this a lot, it-- it is abundantly clear. And so this is beyond being personal to me. The data also shows that this is clearly a public health crisis. Can't do anything about it without the adequate data and improving some of these statutory changes, and hopefully that's something we can do in the future. And I do like that over-- over the course of time we'll look at morbidity as well, because if you're looking at other states, other states have gone down this route of including that in their review teams. I'll say this frankly. I support what Sen-- former Senator Howard said, because I don't want to go too fast until we fix the current data problem that we have right now. So thank you very much. I appreciate the hearing. Thank you very much, HHS Committee.

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

VARGAS: Thank you very much.

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ARCH: For the record, we had two letters of support that were submitted, one from Douglas County Health Department and one from the Women's Fund of Omaha. And with that, this will close the hearing for LR221 and we will open the hearing for LR142. And we will welcome Senator Cavanaugh to-- to open the interim study.

M. CAVANAUGH: Thank you, Chairman Arch. Good morning. Members of the Health and Human Services Committee. I am Senator Machaela Cavanaugh, spelled M-a-c-h-a-e-l-a C-a-v-a-n-a-u-g-h, I'm from Legislative District 6. I would like to thank the Chairman Arch and the committee for scheduling this hearing. Before I start on my, my piece here, I just want to reiterate my thanks to Senator Vargas and former Senator Sara Howard for bringing the previous interim study. It also is very close to my heart. A dear friend of mine in Omaha died seven years ago while giving birth to her daughter, and it was the first time I had experienced something like that. And she was not a person of color and she was a person of means. And so just to know how that can happen in, in the best of circumstances and to think of the people that don't have the access that she had, it's something that I've always been very passionate about. So today we are here to learn-- listen and learn about maternal depression and postpartum period. We've heard stories of maternal depression. However, we don't know much about how it affects children. We know even less about paternal depression. But studies show that both can have lasting effects on the development and behavior of children. Parental depression can contribute to failure to thrive in an infant, up to development delays and even aggressive behavior in young children. In August 1, 2021, the World-Herald had a local Omaha pediatrician who told her story of postpartum depression and, in her case, PTSD. Dr. Priscilla LaCroix had a vascular complication during the birth of her daughter that necessitated emergency surgery in which she lost half her blood volume. Afterwards, she was unhappy that she lost that bonding period time directly with the birth and had difficulty breastfeeding. She had flashbacks, flashbacks of watching her own vital signs dropping and suffering from depression. Thankfully, her OBGYN and social worker encouraged her to seek treatment, which she did. She's quoted as saying that now she is better-- she better understands the importance of checking on moms during pediatric visits. Dr. LaCroix's experience is an example I mention to illustrate why we need to hear from the testifiers here today about postpartum depression and the effects on children. We will hear about how we track the incidents of postpartum depression and the deficiencies in our current tracking system. At the end of this, I hope that LR142 will provide this committee an opportunity to learn if there's more we can do to track maternal depression and to help

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families deal with postpartum depression. And with that, I am happy to take any questions.

ARCH: Thank you, Senator Cavanaugh. Any questions? Seeing none, thank you very much. First testifier for LR142, Dr. Ann Anderson-Berry. Welcome back.

ANN ANDERSON-BERRY: Good morning again, senators, Chair Arch and members of the Health and Human Services Committee. I am still Dr. Ann Anderson-Berry, for the record A-n-n A-n-d-e-r-s-o-n-B-e-r-r-y. I am a faculty member of UNMC and the medical director of the Nebraska Perinatal Quality Improvement Collaborative, NPQIC. However, I am not speaking as a representative of the university today, I am here speaking as an individual and on behalf of NPQIC and the Nebraska Medical Association. I am here testifying with regards to LR142. 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 postpartum depression is significant, with short and long-term effects on the mother, infant and partner; and long-term impacts on child development through early adolescence. A large body of medical research shows consistently that infants of mothers with untreated depression are at risk for early breastfeeding cessation, developmental delays, poor family well-being, poor infant feeding and development issues, and infant attach-- attachment. Later in childhood, infants and 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, 2021 has been the COVID-19 pandemic. Preliminary 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. What does this data mean for our family? I can describe what I see in my hospital-based neonatal intensive care unit, where we have been screening mothers and their partners for years. Perinatal depression looks like 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 an inability to eat and drink enough to keep up an adequate milk supply for the baby, and pumping milk for every three hours around the clock is insurmountable. Depression often means not being able to answer the phone when a doctor calls, or, if you can answer, not being able 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

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read, talk and sing to your baby to help with their growth in 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 your risk of stroke, hemorrhage and seizures. Emergency room visits and rehospitalizations are worse. Depression leads to thoughts of self-harm, self-harm, even when you know that you have everything to live for in your new baby. I have seen all of this on a regular basis. I have screened mothers that I did not recognize as depressed and found them to be actively suicidal and 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 absolutely helps. And I have family after family who are thankful that we asked, screened, referred and cared enough to make this part of our standard of care. I ask you, does Nebraska care about its moms and babies? I certainly hope so. NPQIC works to improve health and well-being in mothers and infants in our state through improvement science, implementing evidence-based practices, followed by evaluation and adaptation of strategies until sustained improvement is achieved for these mothers. It is well-documented that perinatal and postpartum depression places families from all walks of life at risk through the first decades of life. Maternal major depressive disorders can lead to suicide and is one of the most common causes of maternal mortality in the U.S. Additionally, depression and anxiety in the perinatal period has shown to decrease breastfeeding success for these mother-infant pairs. Decreased breast milk in the diet is associated with more infections, missed days of work and higher health care costs than for those events that are exclusively breastfed. As one of a handful of states that has not hardwired postnatal depression screenings, Nebraska simply must and can 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 her infant. NPQIC works with all delivery hospitals in the state of Nebraska to increase screening for depression in this high-risk population. 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, and our past success in statewide implementation of initiatives for at-risk perinatal population speaks to our ability to contribute to the success of these proposed new initiatives. The state is a necessarily-- necessary public health partner if we are to ensure the best outcomes for Nebraska families in depression screening. Supporting postnatal maternal depression screening as, at infant well-checks will have an important impact on Nebraska babies and their

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families. This action will help your constituents by decreasing developmental and behavioral problems, likely decreasing the need for some school-based interventions; will promote successful breastfeeding, improving nutrition of infants and the associated improved health outcomes and decreased health costs for Nebraska infants. Together, Nebraska's Perinatal Collaborative will work so that Nebraska will be a state where a great life starts with healthy moms and healthy babies. Thank you, I'm happy to take any questions.

ARCH: Thank you. Are there any questions? I have one. So is the screening done at infant well-checks then? Is that when it's done or--

ANN ANDERSON-BERRY: The screening--

ARCH: --is it done in the hospital?

ANN ANDERSON-BERRY: The screening should be done throughout pregnancy. It's actually peripartum depression. And so obstetricians should start that. In the NICU, which is a special situation for about 10 percent of families, we do intensive screening because they're at higher risk. But then for the general population, screening should be done in pediatricians' and family practice offices. Some pediatricians' offices are already doing this and have been for years, and others don't have it on their radar. And so what we need the state to do is to standardize this so there aren't haves and have-nots. You know, it's, it's easy, it's inexpensive and it can really make an impact.

ARCH: So that was my question, obviously was, was it-- while it's not required, what's the practice? What's the practice in, in OBGYN? What's the practice in pediatricians? Do we have an idea as to what percent and is it done when symptoms are observed or is it done automatically? I mean--

ANN ANDERSON-BERRY: It's in, in our experience in Nebraska, it's done in major metropolitan areas and it's less impact, impacted in rural areas where there are fewer resources.

ARCH: OK.

ANN ANDERSON-BERRY: And so we really, as NPQIC, we're working to bring this out to rural providers. But if we had this recommendation from the state there, you know, there would be more impetus to put it on the radar. It's a bandwidth issue. Nobody doesn't want to do it, but it's hard to bring it to their attention. And it can make such a huge difference in a child's life and in a family's life.

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ARCH: Yeah. OK. All right, thank you.

ANN ANDERSON-BERRY: Thank you.

ARCH: Any other questions? Seeing none, thank you very much. Dr. Melissa St. Germain.

MEL ST. GERMAIN: Good morning.

ARCH: Good morning.

MEL ST. GERMAIN: I am Dr. Mel St. Germain, M-e-l S-t. G-e-r-m-a-i-n, I am a board-certified pediatrician and the vice president of children's physicians at Children's Hospital and Medical Center. And I oversee 14 of the primary care offices across the state. Senator Arch, you teed it up perfectly for me, because that's kind of what I was going to talk about, is how we do these screenings at Children's. And so I'm here today as a content expert on behalf of Children's, also on behalf of the Nebraska chapter of the American Academy of Pediatrics, of which I'm the current president. As a 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 mental health can have on infants. I've taken care of moms who are so anxious that they show up unnecessarily in the emergency department because they don't feel like they can wait until the next morning to talk to their pediatrician. I've cared for older children who have behavior changes that coincide with the birth of a new sibling because it can be overwhelming for mom to care for both the new baby and a sibling. And 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 struggled to gain weight. He eventually needed a feeding tube and foster care placement. His mother had unmet mental health needs and couldn't adequately care for or feed him. With earlier recognition and treatment of her symptoms. Her child might not have needed those extreme interventions that we had to do to keep him safe and healthy. Maternal depression screening can help reduce the incidence of these heart breaking events. The American Academy of Pediatrics recommends that all new mothers complete depression screening questionnaires at the intervals of one month, two months, four months and six months. There's a policy statement from the AAP from 2019 that details all of these recommendations. Children's physicians conducts depression screening for moms in our primary care clinics, and since 2019 our primary care clinics have used this screening tool. We use one called

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the Edinburgh Postpartum [SIC-- Postnatal] Depression Scale. We've done that over 37,000 times and identified over 3,000 women, which is about 8.5 percent of those who have been screened who suffer with symptoms of postpartum depression. The mothers of babies in Children's NICU are screened as well. And as Ann mentioned, those mothers have a higher rate of depression. We see about 20 percent of those women that screened positive for depressive symptoms. The data from the AAP confirms that about 12 percent of women nationally experience symptoms of depression in the year of a baby, surrounding a baby's birth. I didn't include the data in the statement, but there are some data that, that show that women of color and women of lower socioeconomic status bear a, a disproportionate burden of that, those depressive symptoms as well. At Children's, with the help of our social work team and patient care coordinators, we're able to connect parents who screened positive for depression with community resources to help them. We connect these mothers with psychiatrists, counselors, mental health providers or their own primary care physicians and obstetricians. And these are keys to getting new mothers the help that they need to keep their children safe. I want to personally thank Senator Cavanaugh and former Senator Sara Howard for their dedication to a statewide approach for maternal depression screening for new mothers. As we as stakeholders continue to seek what resources may be 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 significant harm that children may face as their caregivers struggle with unmet maternal health needs. At Children's, we're investigating how we can further offer these depression screenings to both partners and across our continuum of care with deliberate scheduling. It's an honor to be sitting before you talking about this opportunity, and I'm happy to take any questions.

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

MEL ST. GERMAIN: Yeah?

ARCH: How long does it take to conduct the screening?

MEL ST. GERMAIN: We generally do it on a tablet, so when the mothers check in with their babies, they have to fill out a couple of different questionnaires. And then that's one that's on the tablet. I would say it takes most of them three to five minutes.

ARCH: And so it's, it is a self-reporting type of a screen?

MEL ST. GERMAIN: That's correct.

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ARCH: Thank you. Yes, Senator Walz.

WALZ: All right, thanks for coming today. You mentioned that you do these screenings at one month to four and six months. Anything done prior to the mom leaving the hospital?

MEL ST. GERMAIN: Not currently, no.

WALZ: OK. And then I have another question. Is there any follow up, once you refer them to a mental health provider or wherever they're going to be referred to, is there then any follow up from that provider back to you so you can--

MEL ST. GERMAIN: Good question. No, currently most of the referrals, you know, we, we-- our referrals to the community providers depend on which community or which part of the community we're in. We don't typically hear directly back from those providers, but the women who screened positive go into a special group that our social workers follow up with. So anyone that screens positive for depressive symptoms, we have our social workers follow up with them afterwards.

WALZ: All right. Thank you.

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

MEL ST. GERMAIN: Thank you.

ARCH: Sydnie-- and I'm sorry, you'll have to pronounce your--

SYDNIE CARRAHER: Carraher.

ARCH: Carrer-- Carraher. OK, well, thank you. Sorry.

SYDNIE CARRAHER: All right. Well, good morning, 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 a neonatal nurse practitioner at CHI Health and a member of the UNMC staff. I also serve as the project coordinator for the Nebraska Perinatal Quality Improvement Collaborative, or NPQIC. I am here today to speak regarding, on regarding LR142 in my role as a private citizen. Maternal depression 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

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significant depression during pregnancy in the first year postpartum, disproportionately impacting mothers of color and those living in poverty and rural areas. In Nebraska, 18.4 percent of mothers experience depression during pregnancy and 12.3 percent of mothers experience depression during the postpartum period, according to 2019 data. Rural mothers had a higher incidence than urban at 13.7 percent, compared to 11.2 percent. Nebraska mothers of color also have a higher incidence of postpartum depression than white mothers. Blacks at 17.3, Native Americans at 17.2, Hispanics at 12.2, and whites at 11.2 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 and 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 a 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, 82 percent of the 6 to 12-week postpartum visit. Of clinics providing well-child care, only 48 percent screened mothers at one month, 22 percent at two months and 14 percent in four and six month visits. Just 3 percent of these clinics were screening 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 the 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

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Scale, or the EPDS, and the patient health questionnaire, PHQ-9, are the most commonly used tools and have been validated for use in this patient population. Both are free, easily self-administered in less than five minutes, and available in multiple languages. And I did provide copies of both of those tools for you. NPQIC identified 65 clinics that were not following current screening recommendations. Despite numerous news releases, emails and phone calls to physicians and clinics across the state, only four of those 65 clinics have joined the effort to implement screening. As a result of improved screening practices in these four rural clinics, mothers are being identified as depressed and receiving the necessary treatment to recover. As the initiative continues, NPQIC will be monitoring the availability and saturation of mental health services, especially for those that provide care, regardless of insurance status or ability to pay. Maternal depression is a significant public health concern in Nebraska. Forty-three 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 hard-wired 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 for your time.

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

SYDNIE CARRAHER: Thank you.

ARCH: Christian Minter.

CHRISTIAN MINTER: Good morning again, Chairperson Arch and members of the Health and Human Services Committee. I am Christian Minter, for the record, Christian Minter, I'm manager of maternal-infant health initiatives for March of Dimes's, leading nonprofit organization fight, fighting for the health of all moms and babies. Thank you for this opportunity to offer testimony for LR142. A mother's mental health is directly connected to her physical health and the health of her baby. Many women experience mental health challenges during pregnancy and postpartum period, such as depression, anxiety or post-traumatic stress disorder. Mental health issues are the most common complication of pregnancy and childbirth. And when left untreated, maternal mental health disorders can have serious medical,

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societal and economic consequences. In the U.S., approximately one in eight women report symptoms of postpartum depression, which can occur up to a year after birth. Women of color are more likely to experience postpartum depression, symptoms compared to their white peers. However, women of color also face greater challenges and mental health care due to fear, stigma and barriers to receiving routine screening and initiating treatment compared to white women. When women of color are screened, sometimes the tools are not culturally relevant. For example, black and Latina women are more likely to experience physical symptoms of depression and screening tools that focus only on feelings of sadness may not accurately assess depression exhibits as headaches, gastrointestinal issues or sleeplessness. Black women also have a higher risk of being unjustly reported to and penalized by child welfare systems, and often fear that asking for help will lead to their children being taken away. In 2019, approximately one in eight Nebraska women reported symptoms of postpartum depression, and approximately one in five reported symptoms of depression during pregnancy. However, in spite of these numbers, we are still in need of more comprehensive data to fully determine the existing health disparities in maternal mental health. March of Dimes strongly supports efforts to improve screening, diagnosis and treatment for women with maternal mental health disorders. Most maternal mental health disorders can be treated once identified and diagnosed, and March of Dimes has identified several key elements that are critical to addressing this issue. I will highlight three of those key elements today. The first is access. Women need access to insurance coverage for all types of in-person and telehealth mental health care in order to receive the appropriate diagnosis and treatment. To achieve this, perinatal mental health needs to be a high priority for both public and private health insurers. Medicaid coverage should be extended to one year postpartum to ensure women with public insurance have access to mental health care throughout pregnancy and the full postpartum period. The second is universal screening. Mental health screenings are critical components to identifying and treating maternal mental health disorders. March of Dimes strongly supports universal screening of all pregnant and postpartum women using an evidence-based screening tool. Screening can be incorporated into each trimester of pregnancy, at the first postpartum visit, and at a six-month postpartum obstetrics or primary care visit. March of Dimes also endorses the recommendations of the U.S. Preventive Services Task Force and the Centers for Medicare and Medicaid Services, that parents be screened by pediatric providers at the one, two, four and six-month well-child visits. The third element is surveillance. In order to support research and treatment initiatives, March of Dimes supports robust funding to support tracking maternal mental health disorder, as well

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as data collection, on maternal mental health screening initiatives and treatment outcome. It is also important to make sure all this data is broken down by race, ethnicity and other key demographics to ensure that agencies are able to identify and strategically plan to address inequities in the health outcome and experiences with health care systems. Nebraska is long overdue in putting a spotlight on the mental health of moms in our state. I thank you for this opportunity to share policies and strategies to improve screening, diagnosis and treatment of maternal mental health.

ARCH: Thank you for your testimony. Are there any questions? Senator Day.

DAY: Let me get this mask off. Thank you, Ms. Minter, for being here today. I really appreciated you mentioning screening tools that focus on feelings of sadness may not accurately assess depression that exhibits as headaches, gastrointestinal-- gastrointestinal issues or sleeplessness. So is that a suggestion that maybe the screening tools need to be more well-rounded in terms of like, you know, Dr. St. Germain mentioned that, you know, it's a self-reporting system, you fill it out on a tablet when you come in for your visits. But many of the questions relate to feelings and emotional issues. But there's no questions related to physical symptoms. Is that, is that accurate?

CHRISTIAN MINTER: Yeah. So I'm, I will say I'm not a clinical-- I'm not a clinician.

DAY: Sure.

CHRISTIAN MINTER: So I'm not an expert on all the different tools that are available. But I, I bring this up to bring awareness that there are different ways that people experience depression and they're commonly the focus-- main focus is on feeling sad. And so it's important that as clinicians especially, when we think about expanding the type of providers that are screening for these mental health issues, they need to be also trained and aware that there are different ways that women of color are experiencing depression, and so to be able to incorporate that in how they ask questions--

DAY: OK.

CHRISTIAN MINTER: --and make sure they're tracking all that data as well.

DAY: OK, yeah, that's helpful. Thank you very much.

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CHRISTIAN MINTER: You're welcome.

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

CHRISTIAN MINTER: Thank you.

ARCH: Sadie Thompson.

SADIE THOMPSON: Good morning, thank you. Members of the Human Services Committee, my name Sadie Thompson, S-a-d-i-e T-h-o-m-p-s-o-n. I'm testifying on behalf of Well-Being Initiative, we are a advocacy and education organization for behavioral health consumers and agencies; and the Nebraska Association of Behavioral Health Organizations. I'm here representing both of those and just wanted to talk a little bit from two different perspectives. First, as a behavioral health provider and then from a personal perspective. So I think it's important to note that most moms who receive Medicaid from pregnancy to delivery will, their Medicaid will end after two months. But 22 percent of women who have postpartum depression and mood disorder issues won't start displaying symptoms of that until after six weeks. Most women aren't seeing a doctor again after six weeks for their OB appointments. And so that's nearly a quarter of women that may start exhibiting those symptoms and not have coverage to receive the support that they need after they've had those symptoms start. So that's a piece of, that I find really, really important. If people can't get the services they need for the symptoms they're experiencing, then screening for the symptoms is pointless. Also, there's-- it's unclear right now if mood disorder screenings are reimbursable. And so having some clarity on that, I think would be helpful. And, well-baby visits, there's not really a current standard in Nebraska for screening tools. And that's, that's concerning. And I think, you know, many of the previous testifiers have, have mentioned this, but maternal depression, and I, I also like to acknowledge postpartum mood disorders, look different to everyone, feel different to everyone, and aren't recognizable to everyone. And so a simple depression self-reporting tool might not catch things like postpartum mania or psychosis that don't just, that don't have symptoms that look like depression. So kind of being aware of that and making sure that our tools are comprehensive is a really important thing. I think I also want to talk about the fact that Nebraska doesn't have very many services specifically for postpartum mood disorder treatment. Nebraska Medicine has a postpartum behavioral health support department, but there isn't much else outside of that as far as large agencies go that support specifically women in postpartum mood disorders. And that treatment for that can look a lot different than normal behavioral

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health treatment, right? Because the cause is different, the symptoms might be different, the stressors are different. And so the treatments are often different. And so I think in, in this study, we will probably see that education for behavioral health providers regarding postpartum depression is very low in Nebraska and we might be able to do something about that. As a behavioral health educator, that's something that I'm passionate about, and I've already started working on. But definitely a piece that needs to be acknowledged here. So speaking from a personal perspective, seven months ago, I gave birth to a little boy and have had experience with behavioral health before. In my first screening, I was lucky enough to have private insurance and rec-- and see a midwife. So I was screened, screened. And in my first screening, no symptoms. Between my first and second screening, I recognized that I was having postpartum depression, and I was already connected to service providers and able to call them up, get back into services and support myself in that. I am a professional mental health educator, advocate and mental health professional, so I'm very privileged in that. By the time I would have gone to my six-week appointment, I probably would have been in really bad shape. And I'm afraid that my relationship with my son would have been deeply affected because of our attachment ability if I hadn't sought those services. So keep in mind that I'm very privileged and I see that kind of thing happening, you know, that people that aren't as lucky as me will also. Thank you for your time.

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

KIM ANDERSON: Good morning, Chairperson Arch and committee members. My name is Kim Anderson, K-i-m A-n-d-e-r-s-o-n, and I'm the chief program officer for Nebraska Children's Home Society. We are a statewide accredited nonprofit with offices in six communities across the state of Nebraska. Nebraska Children's Home Society, or NCHS, utilizes its 127 years of experience to put children's needs first through an array of services designed to build strong support of families and nurture children. Our core services include adoption, foster care and family support. NCHS's home visitation 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. We provide pregnancy, parenting and adoption education and support before, during and after the child's birth through the child's first year in 93 counties across the state. For pregnant and parenting mothers and fathers over 19 years of age and living in poverty in Douglas County, NCHS utilizes the Healthy Families America, or HFA, program model. HFA is one of the leading evidence-based home visitation programs in the

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United States. The HFA model focuses on preventing child abuse and neglect and supporting positive relationships. Through the federal Family First Prevention Services Act, we provide a Healthy Families America child welfare protocol specifically tailored to families at risk of foster care involvement. These services that are-- and support are provided at no cost to caregivers and are funded through a blend of contracts through the Department of Health and Human Services and passed through federal funds such as TANF. We utilize evidence-based models to deliver services such as Healthy Families America and Growing Great Kids and the Mothers and Babies curriculums to provide supports through programs with proven success records. NCHS incorporates depression screening in all pregnancy, parenting and adoption services, and home visitation programming to assess indicators of maternal depression. We utilize two screening tools specific to each program. For Mothers and Babies, we use the patient health questionnaire 9, or PHQ-9. And for Healthy Families America, we use the Center for Epidemiology-- I knew I was going to have trouble with this word-- Epidemiologic Studies depression scale, or CESD. We use a screening tool results to inform our engagement with mothers and make referrals to therapists in the community. We partner with Unite Nebraska, a shared technology platform that facilitates sending and receiving electronic referrals sponsored by the Nebraska Health Information Exchange. This platform ensures that communities and individuals can get seamless access to much-needed resources, including pregnancy, parenting and adoption services in both urban and rural communities. Between our pregnancy, parenting and adoption program and the Healthy Families America programs, we have 30 staff members trained in Mothers and Babies and four staff that are trained as trainers. This curriculum offers a toolkit of approaches for women to observe their mood, note effects, factors affecting their mental state, and make changes in their daily-- daily lives to impact the area specifically of recognizing the signs and symptoms of postpartum depression, reducing stress, improving social support, promoting healthier ways of thinking, and encouraging more engagement in pleasurable activities. Postpartum depression can interfere with caregivers' abilities to perform daily life activities and respond to an infant needs. These interferences can have severe consequences for mom and baby, if left untreated. Screening for depression is an important part of preventative pediatric care and can be provided in 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. Thank you, Senator Cavanaugh, for introducing this important interim study. And thank you, senators, for the opportunity to testify today. I'm happy to answer any questions you may have.

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ARCH: Thank you. Are there any questions? Seeing none, thank you very-- oh, Senator Day.

DAY: Thank you, Chairman Arch. So I just wanted to ask you maybe if you understand the screening tools a little bit better. Do any of those questionnaires include-- or are they all surrounding emotional things or is there questions about physical symptoms as well?

KIM ANDERSON: Ms. Minter is correct in saying that most of them do focus on more of the emotional and thoughts and feelings. There are maybe one or two questions on both questionnaires that really speak to the sleeping.

DAY: OK.

KIM ANDERSON: If they're sleeping too much or too little. It also we'll speak to their appetite, if they have an appetite or do not have an appetite. And that's one of the things that we do in our programs is talk about it may not show up of what you typically might think of or society thinks of depression.

DAY: Right.

KIM ANDERSON: How is it impacting you? What's different? What do you notice? Another question that's on the screening tool is about energy. And I think that's a little, that can mean a lot of different things for different people, but--

DAY: Right. OK.

KIM ANDERSON: --it's definitely there's-- yeah.

DAY: OK, thank you very much.

KIM ANDERSON: You're welcome.

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

KIM ANDERSON: Thank you.

ARCH: Next testifier, Sara Howard.

SARA HOWARD: OK, last time.

ARCH: Ever?

SARA HOWARD: You're not so lucky as that, Senator.

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ARCH: OK.

SARA HOWARD: All right.

ARCH: Well I was, I was hoping not.

SARA HOWARD: 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 adviser 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. First Five Nebraska's interest in issues pertaining to maternal and infant health policy are centered around the fact that healthy moms and babies are critical to ensuring the long-term success of children in our state. And I'm here to testify on Senator Cavanaugh's interim study, LR142. First, I want to thank Senator Cavanaugh for really digging into maternal depression. This is an issue that this committee hasn't really had the opportunity to discuss and consider. And then also in your packets, I've brought you hard copies of some letters. So one from the Omaha Women's Fund. One from the Douglas County Health Department, who runs a WIC clinic and actually did some maternal depression screening in their WIC clinics. So there really interesting stats there from them. The family practice physicians, as well as the Health Center Association of Nebraska. So the federally qualified health centers. I will give you sort of my four policy recommendations for you to consider. And the first one I want you to look at is actually this map, so the orange and pink map, that's the second sheet in your packet. This is from the National Academy for State Health Policy. When you look at this map, Nebraska is in gray because it is one of the only-- it's only seven states that do not recommend or require a maternal depression screen at that well-child visit. So most states have really have sort of come to the realization that maternal depression has long-lasting impacts for baby. I mean, we're talking about attachment disorders, developmental delays. And so when we don't identify maternal depression and then subsequently treat it, we're really putting kids at a disadvantage. The second-- so the first policy would be to recommend that screen in statute, at the well-child visit at that one, two, four and six-month well-child visit. The second policy piece you may wish to consider and should consider is on the back side. So this is the purple and blue map. Once again, Nebraska is in gray. We are one of a handful of states that do not require or recommend a validated tool. So this means that if we don't require or recommend a validated tool, you can use any tool that you would like. You can say, are you happy or sad? Is the sky blue? And consider that a maternal depression screen. And for purposes honestly

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of billing, that's not a best practice. It's not a best practice for care, it's not a best practice for billing. So we want to make sure that as policymakers, you're considering recommending a standardized, validated tool. OK? The third policy piece that a lot of states have moved into is allowing the depression screen to be administered for a primary caregiver. So not just mom. What we see are a lot of grandmas who are taking care of kids or a father figure or a father, right? They should be taking care of kids. But their, their depression and their mood disorder can also impact development of the child. And so we want to make sure that as we think about depression screens, we also consider partner screens. My testimony is actually wrong. Right now it says 14 states recommend a partner screen. It's gone up to 20. So even our neighbors in Iowa do recommend a screen for dad or grandma or primary caregiver. And finally, and this is something that's a new-- it's new-ish. And this is an extension of postpartum coverage for moms. So right now, under Medicaid, if you are a mom and you are covered under the pregnant women category in Medicaid. And this is old news for you, but just, just for the record, right, Medicaid requires a categorical eligibility. You have to not only be poor, but you also have to fit into a category in order to be eligible for Medicaid. So age, blind or disabled, a child or a pregnant woman, are now with the expansion category up to 138 percent of the federal poverty level. If you are in the pregnant woman category, your coverage actually stops after 60 days. So think about it. You've just given birth, 60 days, you have a new baby and now you're not covered anymore. And so under the American Rescue Plan, the ARPA bill, they offered states a five-year state plan waiver where they can extend that coverage up to a year. That would line up mom's coverage with baby's coverage, because when baby is born, they go on to CHIP and their coverage goes for a year. And then this would address some of the concerns that may come up with, so we're screening, right? But how are we covering services? What's great in Nebraska is that we are paying for screens and Medicaid, but we do it under the child's, the child's Medicaid coverage as opposed to mom's, because often mom doesn't have that coverage anymore. So extending that postpartum coverage would align mom and baby, and then it would also provide that seamless coverage that mom needs in order to get screened for maternal depression and then subsequently treated for it. So I see I have a red light. Those were my four recommendations. I'm happy to try to answer any questions you may have.

ARCH: Thank you. Are there any questions? I have one.

SARA HOWARD: Yes.

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ARCH: So in the other states that recommend the screening, is that, is that done statutorily? Is that done within DHHS recommendations? How is, how is that done?

SARA HOWARD: They're all done by statute. And often what I've seen, what I've been seeing is that states will start with a recommendation to sort of alert providers that they're interested in this issue and then they'll move to a mandate. It helps, I think, with Medicaid, especially in managed care environments, for them to, to be able to bill out. So, so right now, most states will start with a recommendation, but they're all in statute. We're only, we're only one of seven that have nothing in statute, no definition, no recommendation. Nothing.

ARCH: Thank you.

SARA HOWARD: It is pretty rare actually.

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

SARA HOWARD: Perfect. Thank you.

ARCH: Is there anyone else that would like to testify with regards to LR142. Seeing none, Senator Cavanaugh, you may come and close. Senator Howard mentioned the four letters of support, Douglas County Health Department, Health Center Association of Nebraska, Women's Fund of Omaha, and the Nebraska Academy of Family Physicians.

M. CAVANAUGH: Thank you, Chairman Arch and members of the committee. I'd like to say that I'm very grateful to all of our testifiers today for both of the interim studies, and for the wealth of information and knowledge that they bring to this, these two important issues. I won't belabor the point too much. I think we learned some really interesting things here and we have some great policy opportunities here. I do, I always think it's important to use the opportunity when I have it to share things that normalize behavior. So I have suffered from postpartum depression and I've talked about it before and on the floor of the Legislature that I take medicine for anxiety. And I actually continue to do that even though my children are no longer infants. But it is, I think it's really important to normalize that for people and for society and for individuals to see others that, that struggle with that. And I know that we heard that from a testifier as well. And it's something that I didn't even realize with my first child how traumatized I was from giving birth. I had postpartum hemorrhaging and also she had complications as well. And it was on her first birthday when I really reflected, I didn't seek treatment at that time. And it

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was her first birthday where I was really upset on her birthday, which is such an odd thing. And it, it just hit me that I have never dealt with the trauma of that moment. It was such a great moment, but also such a, a scary moment. So when my second child came along and I had struggles, I did seek help and it made a world of difference. So I just think it's important to share those things. Thank you so much. I'm happy to answer any questions you may have.

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

M. CAVANAUGH: Thank you.

ARCH: This will conclude the hearing for LR142 and will conclude the hearings for the morning.

ARCH: Well, good afternoon. Welcome to the Health and Human Services Committee. This afternoon, it will be a committee of one. I am the committee this afternoon. We have hearings going on for redistricting in Grand Island. The Education Committee, Committee is meeting at the same time and, and other issues with some of our other members. So I'll be conducting this hearing. I'll be the one that will be asking, asking the questions today. My name is John Arch. I represent the 14th Legislative District in Sarpy County and I serve as Chair of the HHS Committee. Also assisting the committee is one of our legal counsels, T.J. O'Neill; and our committee clerk, Geri Williams; and our committee page, Jason. A few notes about our policies and procedures. First, please turn off or silence your cell phones. And this afternoon we'll be having hearings on ten gubernatorial appointments and taking them in the order listed on the agenda outside the room. Eight of those appointments will be for the Health Information Technology Board. And so we're going to do it a little bit differently today. Normally, it's, it's, it's an opportunity for some free-flowing questions. I've actually prepared three questions for-- and, and it'll be the same three questions that I'll ask to each of the appointees for the, for the Health Information Technology Board. So when you hear him the first time, I'm sorry for the first person up, but when you hear them for the first time, you'll know exactly what the questions are that'll be asked as you come up as, as well. But if you would begin with an opening statement telling us a little bit about yourself, and then we'll proceed from there with, with the questions. If there are supporters or anybody in opposition to appointments, they'll also be given an opportunity to speak after, after the questions have been answered. If you do plan on testifying, there are green testifier sheets located on a table near the entrance to the hearing room. You can hand it to the page when you come up to testify.

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Please do state your name clearly and spell your name. That helps the transcribers very much. The committee does have a strict no props policy. And with that, we will begin today's gubernatorial appointments with Manuela Banner, who is joining us by telephone. Welcome, Ms. Banner.

MANUELA BANNER: Thank you very much. Good afternoon, Senator Arch. It's very nice to talk to you again.

ARCH: Yes. So if you could start and tell us a little bit about your background and your interest in being on the Health Information Technology Board.

MANUELA BANNER: Sure. My name is Manuela Banner, M-a-n-u-e-l-a, last name, B-a-n-n-e-r. I am the CEO and president of Memorial Community Hospital and Health System in Blair, Nebraska. But I'm also a registered nurse by profession. I appreciate the opportunity to speak with you today. And I want to thank you for allowing me to do so in a phone call from our vacation destination here. My career in healthcare began when I was a teenager in Germany as a Red Cross nurse and EMT. And after my move to the United States continued in central Nebraska as a volunteer EMT and firefighter. Later on, I had the opportunity to further my education to become a registered nurse working at small critical access hospitals in south central Nebraska. Finally, I was given an opportunity to become a nurse leader and later a hospital CEO. In 2018, I accepted my current position in Blair and moved to the eastern part of the state which is also closer to my two grandchildren. Throughout my career, I've been actively involved with the creation and implementation and the use of an electronic health record system. When the HITECH Act actually passed in 2009 and we saw health information exchanges emerge, I was very hopeful that this would actually give us the functional ability to exchange meaningful health data and do right by our patients, especially in the emergency room when patients often did not remember or were unable to give us the medical history. I truly believed that by 2014, the state exchanges would be hopefully able to interconnect and truly allow healthcare providers to provide better informed care to our patients. As we all know, we still struggle to a meaningful-- to have meaningful access and exchange of health data today. I also understand that whenever there is a large amount of data accessible, there's also opportunity for misuse. I'm hoping that this appointment to the HIT Board allows me to bring meaningful knowledge to this body in order to help provide oversight over collection, access, and use of the data in order to serve patients in receiving affordable and comprehensive care, but also to help ensure that the privileged, highly personal

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data is protected. With this, I ask that you support my appointment to the HIT Board. And at this point, do you have any questions for me?

ARCH: Yes, thank you. Thank you. Thanks for that background. You-- what, what value do you believe that the health information exchange, the CyncHealth now, brings to the state of Nebraska into the practice of medicine healthcare?

MANUELA BANNER: I actually see that in practice now. We have access to information, like I mentioned in my statement, that we didn't have years ago. And it just allows us to make better clinical decisions in treating patients. And it also allows to prepare for value-based medicine as we look forward to better population health initiative.

ARCH: OK. And you come from an administrative background, your, your experience with health information within the hospital, how have you seen that change over the years?

MANUELA BANNER: I started years ago charting on paper and there was obviously no exchange of information data other than sending faxes and calling each other on the phone, especially as we talk about prescription drug monitoring. Obviously, that was not available at all. And then we kind of moved into this age of where we had internal health information technology that was not interconnected. It was definitely taking great steps to a better way to connect, but I just don't think we're there quite yet.

ARCH: OK. I, I apologize to the other appointees in the room. I am, I am immediately changing my mind. I'm digressing here for a moment. [LAUGHTER] These are the same questions I'll be asking you. Do you see, do you see in the rural area, and, and you serve in Blair as, as a hub for many communities for healthcare there, do you, do you see that value starting to appear for information exchange?

MANUELA BANNER: We definitely are starting to see that value appear in part through the health information exchange, but in part also through interconnectivity up within our own EHR.

ARCH: OK. OK. In the, in the future, as you-- this is an oversight board, obviously, over the, the health information exchange. Do you see, do you see other opportunities than what we're doing right now with our, with our HIE?

MANUELA BANNER: I definitely do. I see that in several different areas. One of them being the quality of care that we can provide more information, better quality care. But I also see some more in there a

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place where value for a patient will play into those, whether that's in a, a way to connect cost of services or possibly even coverage by health insurance.

ARCH: OK. Thank you. Thank you. Well, thank you very much for being willing to serve and, and volunteering to do that. I-- to, to you and to the other appointees in the room, I know that this was a, this was a, a-- an issue that we thought was very important in the Legislature and needed very good people to serve on this board who have technical knowledge. It, it, it will be a, it will be a technical board. And as you know, and having served, served as CEO in that hospital, you-- there are many, many technical issues related to the, the storing and sharing of information. And so really appreciate your expertise of and your willingness to bring that to the board. So with that, I'll, I'll close the questions only to say that we will as a, as a committee, we will, we will vote on these appointments probably tomorrow afternoon late. We have another, we have another gubernatorial appointment hearing tomorrow afternoon. We'll probably hold an Executive Session after that because we do want to move these appointments quickly as we can, which-- and now that the Legislature is in session, in special session, they will be able to vote on these appointments. So with that Ms. Banner, we will be getting back to you as quickly as we can with your appointment. And thank you again.

MANUELA BANNER: Thank, thank you very much for your time. And I will go ahead and hang up.

ARCH: Thank you. Is there anyone that would like to speak in support or opposition? Seeing none, we'll move to the next appointment, Ashley Newmyer. Good afternoon.

ASHLEY NEWMYER: Good afternoon.

ARCH: Tell us a little bit about your background and what you would bring to the, to the board.

ASHLEY NEWMYER: All right. So Chairman Arch and members who are not present here of the Health and Human Services Committee, so my name is Ashley Newmyer, A-s-h-l-e-y N-e-w-m-y-e-r, and I am the chief data strategist for the Department of Health and Human Services. I'm here to offer a few remarks about myself for a confirmation to the Health Information Technology Board as the representative for the Department of Health and Human Services. I'm a lifelong Nebraskan. I attended Centura Public Schools and grew up in Cairo, Nebraska, which is just west of Grand Island. I earned my undergraduate and graduate degrees from the University of Nebraska system. I currently reside in Crete,

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in Crete, Nebraska, and most of my family members still live throughout the state. While I was in undergrad, I worked as a nurse aide on the night shift at Madonna Rehabilitation Hospital here in Lincoln. During that time, I cared for people who are rehabilitating from serious brain and spinal cord injuries. At the time, paper-based patient charts were common. This was often, often cumbersome and a challenging way to document, monitor, and share information with other members of the patient care team. Additionally, while I was in graduate school, I participated in a research project that conducted chart reviews on people with cancer. Throughout that chart review, glaring problems with patient-- with paper health record included little consistency and where to locate information and the comprehensiveness of the information. At the time, I was strongly considering medical school and thought often about the time intensive process for a healthcare provider to gather and review the chart of a new patient. As the chief data strategist for the Department of Health and Human Services, I am responsible for the data that is collected and used in our agency. As a steward of the information that we are required to collect, the quality and appropriate application are key duties and are of the utmost importance to me. I'm familiar with both state and federal laws governing the collection, use, and release of health data. I have dedicated my career to helping improve the health of Nebraskans and will bring that perspective to this role. I have served Nebraskans through my work at DHHS for the last 10, almost 11 years. The majority of my work has been in the Division of Public Health. My first job within the Division was managing the Nebraska Trauma Registry. The Trauma Registry collects information on people hospitalized in Nebraska for injuries at any, at any of the Nebraska trauma centers. The majority of my time was spent managing the data system where hospitals had to manually extract and enter patient information into our registry so that we could assess their performance indicators or areas for system improvement. This manual process was resource intensive for the hospitals, some of which were starting the transition to electronic health records and some were not. This was my first experience with the challenges of health information exchange. In another Division of Public Health initiative, I led the partnership with CyncHealth, NeHII at the time, to enhance Nebraska's prescription drug monitoring program. This partnership has offered a patient safety and patient care improvement tool for our healthcare providers. The Nebraska Prescription Drug Monitoring Program collects all prescription drugs dispensed in Nebraska. With this tool, providers are able to view the list of prescription medications both for medication reviews as well as in emergency situations, where knowing if a person is on a blood thinner can be vital in the treatment of their injury. In my current role as the

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chief data strategist and as a DHHS representative on this board, I see my duty as to bring a public health and human services perspective to board discussion. I will provide education to the other board members on any DHHS governance issues that may impact the board's decisions as well as offer my experience in trying to solve issues in exchanging health information for public health. Thank you for the opportunity to offer a few remarks today and I'd be happy to answer your questions.

ARCH: OK. Thank you. Thank you. So we've seen the PDMP and we've seen the value of the PDMP. That's probably the big, the big piece of the HIE that, that is obvious of value. As you look to the future, do you-- what, what other value do you see coming with the HIE?

ASHLEY NEWMYER: So I think as, as additional hospitals, hospitals continue to onboard and participate, I think it's really important and something that is pretty vital in the care of patients for a physician or a healthcare provider to be able to see, if possible, a longitudinal health record, regardless of where that patient has been previously in our state. I think it's, it's really important for healthcare providers to have the information they need to make a, a safe and important treatment plan or safe and effective treatment plan for a patient. So that's, that's probably one of the biggest things. The other thing that I see, and that's really important to me personally, is offering people like a, a citizen's ability to pull down their own health record instead of requesting it from all of the previous providers they've seen or from the previous hospitals, potentially, that they've been admitted to.

ARCH: OK, all right. And as far as, as far as the department, DHHS, the use of that data, how do you anticipate, how do you foresee DHHS using that, that data, that data as well?

ASHLEY NEWMYER: Yeah. So as, as you know, with the Prescription Drug Monitoring Program, that's something that we're already a key partner with CyncHealth on. But also, as I touched on in my statement, we have several public health registries that it's in statute that the department is required to collect this information. And I see the department as appropriate partnering with CyncHealth to help reduce that reporting burden on providers and still reporting the public health information that we need at the department to do surveillance, but not have it be such a cumbersome process for healthcare providers.

ARCH: OK. All right. Thank you. Well, you're an appointment from DHHS, the representative. So I want to thank you for being willing to serve on the, on the board as you're appointed. Your professional experience

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obviously is, is, is a lot in data management. Is that the, is that the technical side or more the, the systems side, the, the, the end user, or, or were you actually in the, in the, the data itself?

ASHLEY NEWMYER: Yeah. So I would say it's been mostly analysis of the information. But with, you know, my first role in the department, I was more of a on the technical side helping to manage the system that collected that information. So a little bit in those two aspects, not much on the actual end user side where plugging in the information. So, yeah.

ARCH: OK. All right. Very good. Well, thank you. I think that'll end the questions for you and--

ASHLEY NEWMYER: All right.

ARCH: --thanks, thanks for coming today.

ASHLEY NEWMYER: Thank you.

ARCH: Is there anybody that would like to speak in support or in opposition? I see none. We'll move to the next appointee, and that is Felicia Quintana-Zinn.

FELICIA QUINTANA-ZINN: Hello. Good afternoon.

ARCH: Hi.

FELICIA QUINTANA-ZINN: Good afternoon, Chairman Arch and, well, members of the Health and Human Services Committee. My name is Felicia Quintana-Zinn. It's F-e-l-i-c-i-a Q-u-i-n-t-a-n-a hyphen Z-i-n-n, and I am the Division of Public Health's deputy director of Health Data for the Department of Health and Human Services, DHHS. And I'm here to offer a few remarks about myself for this confirmation hearing to the HIT Board as an individual with experience in operating the Prescription Drug Monitoring Program. My family and I moved to Lincoln, Nebraska, to begin my role as the drug overdose prevention epidemiologist for the Division of Public Health in 2016. And I am proud to now consider myself a Nebraskan. I grew up in Queen Creek, Arizona. It's a small rural farming community outside of Phoenix with a lot of the same-- a lot of similarities to rural communities here in Nebraska. By the time I was in high school, I knew that science and mathematics and finding ways to improve health outcomes was what I wanted to focus my career on. And during high school, I completed a multiyear internship at the-- sorry, at Arizona State University with a focus on E. coli and other similar bacteria working to find new ways

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to combat these infections. I then earned my undergraduate degree in microbiology from the University of Arizona, and during this time I worked in laboratories studying a variety of different microbes that affect human health and performed quality control tests at the University of Arizona Foods-- Food Product and Safety Lab to ensure safe food products for a local food industry and consumers. And after my degree completion, I pursued opportunities in banking and finance. And during this period, it really helped me define where I would like to focus my passion of science and improving health outcomes. And I earned my graduate degree from the University of Massachusetts in Amherst in epidemiology, which included a graduate assistantship focusing on promoting healthy behaviors and a brief intervention for college students with alcohol and drug violations. During this time, I experienced how often referrals to clinical or mental health services were needed, oftentimes with manual processes to perform the referral. And this manual process is-- in some cases led to delays in the referral of the student, an issue of continuity of care particularly if the individual was experiencing substance use disorder issues. This work further solidified my desire to pursue a career in how data and public health practice can be utilized to improve the health and well-being of people. In the five years that I've served Nebraskans through my work at DHHS, I have been responsible for the Nebraska Prescription Drug Monitoring Program, the Office of Injury Surveillance, including the Nebraska Violent Death Reporting System and Crash Outcomes Data Evaluation System. And finally, in my current role as the deputy director of Health Data overseeing work on close to 100 different public health registries, systems and data sets, including the PDMP. It's through this progressive work, I've become familiar with state and federal laws, a variety of funding mechanisms, the use and release of health data, as well as the practical implementation of each. And as the drug overdose prevention epidemiologist and subsequently the state's injury epidemiologist, one of my primary duties was the development, implementation, and operation of the Nebraska PDMP in collaboration with the Nebraska Health Information Initiative, which is now known as CyncHealth. The Nebraska PDMP is the only drug monitoring program in the United States that collects both controlled and noncontrolled dispensed prescription drugs. This gives Nebraska medical providers a unique and comprehensive tool to support the care and treatment of their patients. I have spent countless hours meeting with pharmacists, with nurses, physicians, veterinarians, among others, to fully understand their needs for the PDMP to meet statutory reporting requirements and to determine how Nebraska can implement a PDMP that provides the most up-to-date and comprehensive prescription drug information for medical providers across the state that is as user friendly as possible.

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Through its development and implementation, we work through each of the nuances and identified additional methods to further promote the use of the PDMP and the wealth of data contained within it while still protecting the privacy of Nebraskans. In my current role as the deputy director of Health Data, my PDMP experience and as the PDMP representative on this board, I see it as my duty to provide information, context, and perspective on developing, implementing, and operating the PDMP as well as my experience working with a variety of health data sets to the board's discussions. I will provide education and information on the-- on my experience to others on the board regarding governance, reporting, collection, collaboration, distribution, and use of the PDMP data. I appreciate the opportunity to come before the committee today and thank you for your time and I'd be happy to answer your questions.

ARCH: Thank you. Thanks for that. I-- you have a very rich and deep background in data, obviously, many data bases. When you look at, and, and, and, and your interest is outcome, when you, when you look at our HIE, how do you think in the future we can better use that information to impact health outcomes?

FELICIA QUINTANA-ZINN: I think the, the big piece is to, to actually to get more and more providers to use it and to submit their data into the HIE providing a really comprehensive look as to what has happened for that patient. So if, for example, if I went to a facility here in Lincoln, but then needed to go to Omaha for something else, making sure that that physician or that provider in Omaha knows what treatment I reached and what I had here in Lincoln to help better develop the plan for moving forward so I'm not duplicating treatment, not duplicating tests or laboratory tests that are done, images, whatever that might be, but then also using, like, PDMP data so that if there is a contraindication to a medication that I'm not getting prescribed that. A broader use of the data or use of the information, I think, for providers is the biggest thing that I would love to see, and across the state, not just in the Omaha or Lincoln areas, but also for those providers that are in rural Nebraska, if they're in Valentine, making sure that they know kind of what their patients are doing if, if they have to go out to Scottsbluff or another area to get treatment.

ARCH: Interesting. I, I think we would all agree we have a unique opportunity given the-- that we-- the state of Nebraska has one HIE, not multiple.

FELICIA QUINTANA-ZINN: Yes.

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ARCH: From what I understand, there are, there are advancements being made to integrate that into the electronic medical records so you don't have to go to two different systems to get that same information, so.

FELICIA QUINTANA-ZINN: Yep.

ARCH: Your, your, your focus on the practical aspects of, of clinical outcomes in the, in the office and in the, in the hospital, I, I really appreciate that. Anything else you'd like to share with the committee on, on your background or anything that you are, I guess, are excited about serving and wanting to see advanced?

FELICIA QUINTANA-ZINN: I am excited to see more use of our data and have defined places to use our PDMP data. It's, it's been difficult prior. And so having the HIT Board, I think, will be helpful to be able to utilize the data more.

ARCH: Good. Good. All right, thank you. Thanks very much.

FELICIA QUINTANA-ZINN: Thank you.

ARCH: Is there anyone that would like to speak in support or in opposition to this appointment? Seeing none, thank you very much. And we'll move to the next appointee, Director Bagley. I think I saw him, saw him walk in. Welcome.

KEVIN BAGLEY: Thank you. Good afternoon, Senator Arch. And I'll get started.

ARCH: Please.

KEVIN BAGLEY: Good afternoon, Chairman Arch and members of the Health and Human Services Committee. My name is Kevin Bagley, K-e-v-i-n B-a-g-l-e-y. I am the director for the Division of Medicaid and Long-Term Care in the Department of Health and Human Services. I'd like to thank Governor Ricketts for appointing me to serve on the Nebraska Health Information Technology Board as a representative for healthcare payers. The Health Information Technology Board presents a great opportunity to enhance Nebraska's healthcare system by creating guidelines and new ways health information can be shared among stakeholders. As a program that provides health coverage to over 300,000 Nebraskans, Medicaid is a key component of the state's healthcare system as the largest healthcare payer in the state. I began my current role with Nebraska's Medicaid program last November, as you recall. Since then, I've had the opportunity to work with many

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members of this committee. The Medicaid program appreciates this committee's ongoing support. In the ten months that have passed since beginning my role, our program has made great strides. As we move forward into the future, the Medicaid program is taking steps to better understand and manage the health of our members. As we work to ensure consistent access to quality healthcare services, we look forward to the opportunity to use the data provided through the statewide Health Information Exchange to measure our success. The Health Information Technology Board will be a mechanism through which stakeholders can access the array of health information available in the state and help these stakeholders put that information to good use. With the major role Medicaid plays in our state's healthcare system, I believe the perspective of the Medicaid program and its numerous providers is key to informing the Health Information Technology Board's work. I'd be happy to participate on the board and provide this perspective. I appreciate the committee's consideration of my inclusion on the Health Information Technology Board. Quality policy work from the Health Information Technology Board will help support the long-term goals of healthcare leaders across the state by improving patient and provider experiences. And I'm excited to be a part of it. Thank you for the opportunity to speak to you today and I'd be happy to answer any questions.

ARCH: Thank you. So you, you will technically serve as a-- as the payer appointee to the, to the board representing Medicaid as, as that payer. So I-- Medicaid and long-term care. Right?

KEVIN BAGLEY: Yes.

ARCH: So, so how do you see, how do you see the HIT-- HIE, how do you see that impacting long-term care as well as acute care within Medicaid?

KEVIN BAGLEY: Sure. So my colleague, Felicia, in, in her response to a similar question you just asked talked about kind of that patient experience. From a payer perspective, I think broadly, this gives us an opportunity to identify what policies and practices make the most sense, not just from a cost effectiveness, but from a health outcome perspective. When it comes to acute care and kind of the standard health services that are, are typical to a payer, your physical health, behavioral health, there are established outcome measures in the system. I think those merit opportunities for improvement and looking at. But the HIE gives an opportunity to make those standardized comparisons across payers. When it comes to long-term care, this is a space where I think there's a lot of opportunity. There are not the kind of standardized measures in terms of health

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outcomes and broader service outcomes that we might typically expect in the physical or behavioral health space. Having the data available to us and as more data becomes available on things like social determinants of health, there's an opportunity to really evaluate the impact of our long-term care programs in a meaningful way.

ARCH: So research-- an opportunity for research, I mean, that it's rich data--

KEVIN BAGLEY: Absolutely.

ARCH: --that's sitting there that is, is more than as you're, as you're describing it, it sounds like it's more than just the, the better care provider-to-provider relationship. But then it's this-- but do, you know, how can we care better for people with this particular health condition or, you know, what are those social determinants that we may be able to impact that will change the trajectory of, of health in the state of Nebraska? Do you-- within the, within the Division of Medicaid and Long-Term Care, do you have the capability of doing that kind of research right now?

KEVIN BAGLEY: So I would, I would say yes and no. We do a lot of analytics when it comes to evaluating the performance of our health plans that we contract with and looking at the population health of our members. Our members are a unique population in the state. That being said, I think the piece that, that this provides for us from a research perspective is the comparison. It's not an easy, indirect comparison between the Medicaid population and any other commercial payer, but there's an opportunity to look at best practices and identify opportunities to improve policies and practices across plans. And that is a place I see this being a, a very unique opportunity for us.

ARCH: That would be a unique opportunity. Very good. OK. Anything else you'd want to share with the, with the committee?

KEVIN BAGLEY: I don't think I have anything,--

ARCH: OK.

KEVIN BAGLEY: --but thank you.

ARCH: All right. Is there anybody that would like to speak in support or in opposition? Seeing none, thank you for coming today.

KEVIN BAGLEY: Thank you.

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ARCH: Next appointee, Dr. Anna Dalrymple. Welcome.

ANNA DALRYMPLE: Hi. OK. Hello, Chairman Arch and the Department of Health and Human Services Committee. Thank you very much for having me here today. So my name is Anna Dalrymple, A-n-n-a D-a-l-r-y-m-p-l-e. I am a family physician in Gothenburg, Nebraska. I practice what's considered full scale family medicine. I take care of obstetric patients and work in the emergency room. I take care of hospital patients as well as clinic. I've been working at Gothenburg Health, the hospital in Gothenburg, for this my fifth year just starting. I'm also a volunteer faculty member for the University Nebraska Medical Center and take third-year medical students for their family medicine rotation. And I'm a board member for the Nebraska Academy of Family Physicians and a fellow for the American Academy of Family Physicians. I received my medical degree from the University of Medical Center in Omaha and I grew up in Omaha, went to Millard North High School. Then I started traveling west and went to the Lincoln Family Medicine Program here in Lincoln for my residency training. And then I received my Bachelor of Arts in Anthropology from Creighton before all of those. So I am married to a farmer in Gothenburg. That's how I ended up there and for-- it's a town of about 3,500, it's 60 miles west of Kearney on I-80. I have two young sons and we're expecting our third in March since we're not busy enough, so. I would like to serve on this board for two reasons. First, to be a voice for patients and providers in a rural area. I believe we have some challenges that are different from the rest of the state. And I hope to bring a unique advantage being from Omaha and working in Omaha and Lincoln and now working in a rural area. And second, because health information is not historically rooted in technology, but sure, it is now. And I believe that has major advantages and, and potential. I think it also has opportunities for growth and improvement. And it has a-- I really-- I've heard this echoed from those previous, it's an incredibly powerful tool that I think we can tap into. I'm really excited to be a part of that, hopefully, and help make this work for our state in a positive way. So with that, I'd be happy to answer questions and go through anything, so.

ARCH: Well, your, your representation of the rural community and the, and the unique issues, that'll be very important. I know, I know from just anecdotally hearing health information technology isn't cheap and, and, and it can be, it can be a burden to a small practice in, in whatever, whether in a big city or in a rural community. Have you, have you seen the value of, of having the PDMP, the access to that information? Have you seen the practical value that, that would outweigh the costs associated with that?

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ANNA DALRYMPLE: Yeah, I think that the value, as others have spoken to, being able to see information that we would not have access to. So I'm, I'm pretty lucky. I work in a hospital that uses a, a pretty strong EHR [INAUDIBLE]. And even then, you know, if I have someone come into the emergency room from another city or another town, we always pull the PDMP and look at that and, and kind of see what medications because a lot of patients don't know what they're on.

ARCH: Sure.

ANNA DALRYMPLE: So sometimes that can be very helpful. And so I definitely think there is value there. And I think the, the more that we can use it and, and make it transparent and, and useful, I think will be really good.

ARCH: Good. The information that you're, that you're receiving now, is it reliable? Can you, can you count on that? I mean, if it says that they're on this medication, how, how do you, do you automatically assume that? Do you go back to the patient? How do you handle the information you pull off of the HIE?

ANNA DALRYMPLE: I will say most of the time. So I've had some situations, but I would say more often than not, it is accurate and reliable. We almost always go back and say, OK, this is what we have. Does this sound right? Is this what you're taking? Those kinds of questions. And so I would say most of the time it is reliable and there's usually a reason that's something maybe have been off or something like that.

ARCH: OK. You take third-year medical student-- medical school students? Are, are you seeing-- I mean, obviously, I was around earlier when we were all on paper and, and, and there was resistance to being, being in the electronic medical record, and then we had to do it and so it was done, but, but are you seeing, are you seeing students now coming out wanting more information?

ANNA DALRYMPLE: I think definitely so. There's a-- so when I-- the year I graduated from UNMC, it was right before they started Epic. So I, I still had paper charts. And then they started that. And so they-- they're very affluent with technology. They're very used to that. It's so different than seeing my preceptors who I think really had or have struggled with it. And I was kind of in that transition period where thankfully I think it's been OK to transition and I'm, I'm pretty used to it and expect it. But yes, they are very used to information and how to, how to pull that and look for it. They can navigate our EHRs better than, you know, we can sometimes, so.

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ARCH: Is there such a thing as too much information for a practicing physician?

ANNA DALRYMPLE: Yes, absolutely. I think more of that in-- I guess I should say more in what we're looking for, sometimes we can ask for too much information. Like if we're diagnosing a patient and ordering tests, I think it's important to know what you're ordering. I think in the sense of information from other facilities, probably not. A good clinician should be able to filter through that and, you know, say this is important to what I'm doing right now or maybe this is not. But if I ever had to air on one side, I'd rather have more than less.

ARCH: OK, very good. Very good. Well, thank you very much for being willing to serve and for volunteering to do this. It's going to be very important work that, that, that the board will be doing. Anything else you want to share with the committee?

ANNA DALRYMPLE: I don't think so.

ARCH: OK. All right.

ANNA DALRYMPLE: Thank you very much.

ARCH: Is there anybody who'd like to speak in support or anybody in opposition? Seeing no one, thank you for coming today.

ANNA DALRYMPLE: Thank you.

ARCH: Next appointee, Kimberley Haynes-Henson. Dr. Henson.

KIMBERLEY HAYNES-HENSON: Good afternoon.

ARCH: Welcome.

KIMBERLEY HAYNES-HENSON: Thank you for having me today and listening. My name is spelled K-i-m-b-e-r-l-e-y, and my last name's hyphenated because I couldn't make up my mind, H-a-y-n-e-s dash H-e-n-s-o-n. I am currently an associate professor of anesthesiology and pain medicine at the University of Nebraska Medical Center, where I am board certified in pain medicine. I'm also board certified in anesthesiology and recently in addiction medicine as well. As a pain physician, I'm also a medication assisted treatment provider for those patients of mine that need Suboxone. I've been with University of Nebraska for over 20 years and that makes me starting about age 12. Kidding. Prior to that, I was an accountant. I worked as an accountant for eight years for both U.S. Forest Service and the General Accounting Office, and I figured I had too much time off, so. At UNMC, along with being a

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care provider, I'm the program director of the Pain Fellowship Program, which required that I apply to the American College of Graduate Medical Education to set this up. I've been program director for eight years now, and I use this position to emphasize appropriate prescribing of opioids across all specialties and, of course, for our future generations of healthcare providers. I've been active in advocating for the PDMP for which I started working with Coalition Rx, which is a community organization. I was on the board at that, that organization. Excuse me. Prior to the adoption of the PDMP into law, I worked with this committee to set up a panel discussion between community members, a parent who had lost a child to opioid overdose, the state-- or the National Association of Boards of Pharmacy, as well as our state pharmacist that was broadcast here to the State Legislature in 2016. In that same year, I also worked with the chancellors and the Attorney General's opioid summit planning committee to put on the conference entitled "Charting the Road to Recovery: Nebraska's Response to Opioid Abuse," where I was an invited speaker. From this project, I continued to work on the opioid treatment subcommittee. At the beginning of the PDMP implementation, I was requested to give input into the ease of use of software. I currently work as an academic detailer with the Nebraska Medical Association and DHHS on a program known as SafePrescribe, where I'm a founding committee member who helped develop the curriculum, focusing on, number one, increasing naloxone prescribing for opioid users, which has been integrated into the one chart electronic record system that UNMC uses and numerous other private practices across the state. So when an opioid prescription is now written, it flags for do you want to write naloxone as well? Number two, we're also advocating for the use of PDMP by prescribers. We're still really low on the number of physicians that are using this great source of information. And our number three topic was prevention of co-prescribing of opioids and benzodiazepines due to the drastic increase in overdose risk. I continue to lecture about opioid and pain education, including interviews with KETV, the World-Herald, Clarkson College, and anyone else who will listen. I've been published on numerous pain topics and I'm currently awaiting the publication of a pain text for future medical learners, where I wrote a chapter on nonsteroidal anti-inflammatory drugs, which is a nonopioid treatment for pain. I've written chapters for other textbooks like for Radiofrequency Ablation, which is an interventional approach for pain management. I'm currently involved in research and continue my learning and sharing of knowledge on the topics of both pain and addiction. The reason for my being here today is doing-- due to my strong desire to serve on this board and to continue my work on providing education to care providers, while at the same time assisting with future integration electronic system that

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will assist us in preventing senseless deaths due to this opioid crisis. The key to fighting this crisis is in the methods of communication, both in the electronic reporting and continuing education. Since even before 2016, when I first became involved, I knew that comprehensive data was key to the resolution of the crisis, and that is why I'm here today. Thank you again for your time. And of course, any questions would be welcome.

ARCH: Thank you. Thank you. Great background.

KIMBERLEY HAYNES-HENSON: Thanks.

ARCH: You're obviously very versed in the PDMP. And the impact of the PDMP on the state of Nebraska, how would you describe how it has, how it has impacted Nebraska having that PDMP?

KIMBERLEY HAYNES-HENSON: For people in my job as a pain provider, it's been invaluable at really helping to intervene early with patients that are starting to have a problem, that are starting to request early refills, that are starting to look to multiple providers. It's not really a, a gotcha moment. It's more of a I'm really worried this medication may harm you and may damage you and I feel you may be losing control of it. And so I've, I've used it a lot to use it as a tool to talk to patients, to ask them if it's accurate and if it's not, I need to do investigations. I've called PDMP many times for technical assistance saying, hey, I'm not seeing this or I'm seeing this and I don't believe I should be. They've been very responsive in working with me as a provider and helping me either with the technology side of it or sometimes I'll reach even directly out to the pharmacies involved. But at least I have a starting point from where to start the investigation.

ARCH: Do you, do you, do use the PDMP or anything within the HIE to do, to do research on actual-- how would I say it, efficacy of pain management? Can you, can--

KIMBERLEY HAYNES-HENSON: I don't at this time, but I think with my provider background, sometimes the technology is beyond me and I think we could engage physicians better by making that technology more accessible and more easy to actually reach an approach because that would be amazing. I would love to do that.

ARCH: Right. Yeah, there's just-- as I look at, as I look at the HIE, and, and it was my interest in it as well, was, was there is just such rich data sitting there.

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KIMBERLEY HAYNES-HENSON: Yes.

ARCH: You have to, you have to know the questions and you have to know how to get it out. But, but there's, there's tremendous opportunity for research.

KIMBERLEY HAYNES-HENSON: Yes. And I actually am awaiting publication for a paper that I wrote comparing some of the legislation and its impact on opioid prescribing within the state.

ARCH: Oh, interesting.

KIMBERLEY HAYNES-HENSON: So, yeah, so I'm-- hopefully, we're trying to get it into a magazine.

ARCH: Yeah.

KIMBERLEY HAYNES-HENSON: --or periodical.

ARCH: Great, great. Well, that'll be very interesting.

KIMBERLEY HAYNES-HENSON: You know, that's always a, a shell game, so.

ARCH: Sure, sure. Keep, keep working. Well, thank you. And thank you for your willingness to serve.

KIMBERLEY HAYNES-HENSON: Well, thank you.

ARCH: It'll be-- that'll be great. Is there anybody would like to speak as a proponent or an opponent? Seeing none, thank you for coming down here--

KIMBERLEY HAYNES-HENSON: Thank you.

ARCH: --and doing this. Next appointee, Monalisa McGee. Welcome.

MONALISA MCGEE: Thank you, Chairman Arch, and thank you for having me here. I'm, I'm completely humbled to be a part of this.

ARCH: We're so pleased you're here.

MONALISA MCGEE: Well, and I also wanted to thank also Governor Ricketts and all the members of the committee for the ability to serve. I'm Monalisa, yes, McGee. That's M-o-n-a-l-i-s-a, McGee, M-c-G-e-e. I'm a lifelong Nebraskan from Omaha, went to Westside High School, have my undergraduate and my doctorate from the University of Nebraska-Lincoln. I have my master's degree from Creighton. I actually

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was awarded outstanding minority graduate professional student, and that included medical pharmacy counseling in law.

ARCH: Congratulations.

MONALISA MCGEE: So I kind of stuck out there. Currently I, I have a kind of an interesting history. I was with Boys Town. I, I served as the psychiatric hospital administrator for Telecare and they served individuals primarily transitioning out of the state regional center. And I saw the intense need for electronic health records system and coordinating with medical providers. And I found in my role as administrator what was missing when I started there was that missing link of biopsychosocial care and how we work collaboratively to identify what are the medical needs, what are the, the, the psychological needs as well as the social needs and how we can work in concert with the individuals' medical providers, their psychiatrist, their family members, and other key stakeholders so that they could transition into the community effectively. Today, I've been with the Salvation Army for five years and I serve as the divisional social services director over Nebraska, Iowa, and South Dakota. And I can say I am so proud, we are the only COA accredited program in all of the Salvation Army in the United States. We have down on 36th & Cuming a mental health respite program, which is a step down from psychiatric services. I'm hoping that will be more of a prevention of inpatient psychiatric services. We have senior services. We oversee the largest Early Head Start Program in all of the Salvation Army in the United States. Why I bring that to your attention is with COA accreditation, we required a way to communicate electronically and there wasn't any electronic health record keeping system with the Salvation Army. And so we developed, researched, and implemented over the last five years an EHR for our entire system in the Midwest. It's allowed us to really make data-driven decision-making with the clients from our mental health respite program. It's how we help prevent people and we're using that data. What are those key outcomes? What are those deliverables that prevent someone from having to go back into an inpatient program from what are those preventable measures in the first place so we can help create a continuum of care? Additionally, within my background, I'm a master addictions counselor through the National Board of Certified Counselors. I serve as a board director for them and I'm actually a full-time faculty member also in clinical mental health counseling with University of Phoenix. And I'm in charge of overseeing the redesign of our entire substance abuse curriculum so that we can train people in the field. I'm just so humbled to be a part of this. I see data is what's going to improve the healthcare outcomes for Nebraskans. And I appreciate being here today.

ARCH: Thank you.

MONALISA McGEE: Thank you, sir.

ARCH: I just have one comment, you're really busy.

MONALISA McGEE: Just a little bit.

ARCH: You're doing a lot of things.

MONALISA McGEE: It-- it's all important. It's for the people we serve in our community, so.

ARCH: Yeah, well, that's, that's great. So obviously addiction, do you have any, do you have any direct experience with the PDMP and the-- and, and--

MONALISA McGEE: Yes. Yes.

ARCH: Tell us a little bit about that.

MONALISA McGEE: Boy, sir, it's, it's, it's been really a blessing. It's been able to for us to be able to talk to, in a sense, electronically with the clients' medical providers that we serve. And where I see a dis-- a gap or a disjointedness in the continuum of care is when you have behavioral health practitioners not communicating with the medical providers. And so earlier you had asked really beautiful questions about medications and is there too much information. And, and I totally agreed with the esteemed physician's responses. I'd rather have too much information than not enough. And I think for us to collaborate with a, with a psychiatrist or with a medical provider means, well, you know what he, he feels like he's gaining weight and he, he isn't taking his psych meds, which then creates a whole myriad of problems from homelessness to, to attempts on one's own life. And so I've, I've witnessed firsthand at the power and the benefit of, of the EHR and how we communicate and collaborate with providers.

ARCH: Great, great. Another, another question. Social determinants. So I'm, I'm sure that you're-- you think about that often--

MONALISA McGEE: Oh, yes, everyday.

ARCH: --with the, with the people that-- people you work with. What-- you know, I, I, I know that, I know that CyncHealth as well has now begun the-- that whole understanding of social determinants of health.

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What do you see-- how, how do you see social determinants impacting health in particular of the people that you serve?

MONALISA McGEE: I look at healthcare from a, a three-legged stool and how we approach people from their medical needs, their social needs, and their psychological needs. When we review social determinants, just like Maslow's hierarchy, if someone is hungry and they live under the bridge and they are in the midst of a substance use issue or having a, a, a psychosis of some sort, they're social determinant system is broken. And I see how behavioral health can come in as help to kind of put back the pieces of the quilt together. And that's what I see this initiative as being, is how, as Nebraskans, we put those pieces of the quilt together to serve really the most marginalized citizens in our state.

ARCH: Well, thank you for your enthusiasm on serving on this board and the--

MONALISA McGEE: Thank you.

ARCH: --and the background that you obviously will bring.

MONALISA McGEE: Well, I'm, I'm very honored.

ARCH: Well, thank you.

MONALISA McGEE: Thank you, sir.

ARCH: Is there anyone that would like to speak in support? And anybody in opposition? Seeing no one, thank you for coming today and sharing--

MONALISA McGEE: Thank you, sir.

ARCH: --sharing your story and, and being willing to volunteer for this.

MONALISA McGEE: Absolutely. Have a wonderful day everybody.

ARCH: Thank you. Our next appointee is Lynn Elizabeth Modic Edwards.

LYNN EDWARDS: Well, thank you for inviting me and allowing me to participate with this esteemed group of people. It's amazing. And thank you, Chairman and HHS committee. So I'm just going to go into a little background.

ARCH: Please.

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LYNN EDWARDS: And if you don't mind, I, I did make some notes, so I just wanted to make sure that I include everything. Basically, I'm the director of health information at Gothenburg Hospital.

ARCH: And could you say and spell your name, please?

LYNN EDWARDS: Oh, sorry. Lynn Edwards, it's L-y-n-n E-d-w-a-r-d-s.

ARCH: Thank you.

LYNN EDWARDS: So I'm the current director of health information at Gothenburg Hospital and I feel very privileged to be there. I've traveled quite a bit and just recently moved there from Oregon and found my place to stay, I believe. In my role as health information director, I, I find myself wanting to advocate for my patients and I also have a background in privacy and security through the HIPAA of 1996. And, and I just find many times that maybe we, we, we write a line, maybe too much information, maybe too little. So I've had over 40 years experience and it included the HIPAA health information, nurse's aide, radiology technician. And it all dealt with paper at that time. And I know we've, we've all had that experience. Many of us have. And what I'm finding is that many times patients need to advocate for themselves. You know, you're always told, you know, you've got to be the guy to speak up. You've got to know and you've got to work for yourself, basically. And I think that's where I find myself. We work with coding patients' records. We work with releasing patients' records. We work with answering to patients and showing them how to use their portals and access to information. And oftentimes it's not enough for those patients. And so I find that wanting to protect their information is another aspect of it that many times we'll find that we may be releasing information that maybe that shouldn't be, or we just have to be very, very, very careful with releasing information. I found myself traveling many times before I ended up in Gothenburg. I worked in Oregon, Washington, many states as a traveler. I worked in Saudi Arabia. I worked in Kenya. And, and I think it just is very universal in trying to protect those patients and advocate for them. And that's where I am today.

ARCH: OK. Well, thank you. You mentioned, you mentioned patient portals. What-- how have you seen access, access to information by patients and, and desire to have access to their own information? How have you seen that change from when you were request for medical records and you have a person stand over at the copy machine and, and, and make those copies? How have you seen that change over the years?

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LYNN EDWARDS: Patients are more aware. They're much more aware. I mean, they'll throw terms at us that I never expected to hear. They're more educated, which is great. And they should be. And they know what their rights are, which is part of our responsibility at the hospital to, to-- well, at any provider. We should provide them with knowledge about what they can and cannot access. They oftentimes don't understand the, the computer part of it and, and maybe they don't have one and they don't have access to that. So I think that that can be frustrating. But if we provide that information to them that they can get to or even make it accessible to them by maybe in the, in the facility we say, come on in, we'll help you get to your portal. And they, they are interested in it. They might not understand everything. And they need to be able to ask questions. And then we need to listen and try to help them to get through that.

ARCH: Same question regarding providers. How have you seen attitudes of providers change over the years as it relates to physi-- as it relates to patients having access to their medical information?

LYNN EDWARDS: Well, I think we all kind of went kind of crazy at one time because at one time when I was first four years, the background was to protect those records. You would never, ever be allowed to provide those records. It was always owned by the hospital, it was-- or owned by that provider. And so we protected them. We thought we were. And now patients have access to that. So it's like, it's like a 360 or 180 or whatever, you know, where we're giving them the information that they need and they need it. They need to be able to take care of themselves and understand what's happening to them as far as care. And the more knowledge we can give them, I think that's very important. But I have seen it where it was, it was very restricted and now it's open to the patients, which is good. Yeah.

ARCH: Good. Good. Yeah, you've, you've seen the, the transition--

LYNN EDWARDS: Transitions, yeah.

ARCH: --director of medical records, which I would assume was your early titles and--

LYNN EDWARDS: Right.

ARCH: --now to all electronic and health information.

LYNN EDWARDS: Right. And the only, the only thing that I find is that-- I don't want to say we're giving them too much information, but maybe answering questions along that line and being careful timing it

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to where our providers have access to the information first and then because they're going to have to answer those questions. And you don't want the patient--

ARCH: Right.

LYNN EDWARDS: --I mean, I wouldn't want them to, to-- I don't know, not-- the word isn't blindside them, but to just say, hey, you know,--

ARCH: Or to misinterpret--

LYNN EDWARDS: --your provider needs to know.

ARCH: --misinterpret a test or,--

LYNN EDWARDS: Correct.

ARCH: --you know.

LYNN EDWARDS: Correct. And they could.

ARCH: Yeah, sure, sure. OK,--

LYNN EDWARDS: Yeah.

ARCH: --very good. What brought you to want to participate on, on the HIT board? Why, why would you be interested in that?

LYNN EDWARDS: I was looking at quality, the quality of the data and the access to the data. The quality, quality in, in that it all comes from one source saying, you know, at each facility or each provider and we're getting it from one area. There was a committee I sat on in San Bernardino, California, where they were developing the HR-- the exchange, and I knew nothing about what was going on, but I could see what was happening. We're all feeding into it, but maybe not from the same source or the way like a question might be asked. And there is one-- there is a question that we deal with. It's called, do you have an advanced directive? You know, it's meaningful use. It has to do with the feds wanting information. Well, we can tick that box and say patient says yes. It doesn't mean yes that it's in the record and that it's accessible to that provider. And so that's kind of like we're backing up, taking a look at maybe the way we ask that question is not correct or not the way we want to see that information. And I think that's where I come in that I want to be involved. I'd like to be involved. And I appreciate the opportunity to get it right. Let's get the data right. Who could access it is another one. And that comes with my HIPAA background and making sure that those people that

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should, get it. Those people that have no need for it and they don't have that need to know, don't-- do not have that. And I think protecting that and that makes the patient-- that assures that patient, that assures your customer, that assures the provider and anybody else using that data.

ARCH: Great. Very good. Well, thank you very much for volunteering to do this.

LYNN EDWARDS: Thank you.

ARCH: Thanks for coming down and, and sharing with us today. Is there anybody that would like to speak in support or in opposition to this appointment? Seeing none,--

LYNN EDWARDS: Thank you very much.

ARCH: --thank you. Thank you. That will conclude the HIT board appointments for today. We have two other appointments, and one is to the Child Abuse Prevention Fund Board, and it's Donald Blackbird. Welcome, Mr. Blackbird.

DONALD BLACKBIRD JR: Thank you.

ARCH: Thanks for being here.

DONALD BLACKBIRD JR: I appreciate the opportunity. Deacon Don Blackbird. Donald Blackbird, Jr., D-o-n-a-l-d, Blackbird, B-l-a-c-k-b-i-r-d, Jr., J-r. Again, it's a great opportunity and I appreciate it greatly. So a little bit of background about myself. I come to the board or I guess the Child Abuse Prevention Fund Board at the request of Mary Beth Hanus, who's a current board member and is leaving the board, and she came to me and asked if I'd be willing to serve in some capacity. So a little bit of background about myself. I am an elementary school principal at St. Augustine Indian Mission, Winnebago, Nebraska, and I've been working in the area of elementary education for 24 years, serving 13 of those years as an elementary school principal. And I'm also an ordained member of the Catholic Church. I serve as a deacon incarnated in the Archdiocese of Omaha. And through that position is where I came to know Mary Beth Hanus. I have a desire to serve the board because I believe I can bring opportunity to extend the reach of that board into what is historically an underserved and at-risk community, which is the Winnebago and the Omaha Tribal Reservations in northeast Nebraska. I myself am a member of the Omaha Tribe. And when Mary Beth Hanus approached me about joining this board, she expressed to me that the

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Child Abuse Prevention Fund Board, one of their tenets that they, they really strive for is reaching out to those at-risk communities. And having worked in education on the reservation for 20-plus years, I can attest that there is a need to address the issue of child abuse and child abuse prevention. And when they say prevention is worth, you know, an ounce of prevention is worth pound of, pound of cure. When it comes to child abuse, there's nothing that, you know, is too much to be done to prevent that damage from being done to a child. So it was an honor to be asked to take on that position, and it's something that I really hope I get the opportunity to do.

ARCH: Great. Great. As you look at, as you look at the area of, of child abuse and, and, and where you, where you serve as elementary school principal, any-- anything in particular that is that you believe to be unique to, to the children that you serve at general population in Nebraska and is, is there-- are there, are there specific needs for your population that maybe wouldn't be elsewhere or vice versa?

DONALD BLACKBIRD JR: I think with, with the population that I serve, we, we have a tendency to create a, a myopic worldview within our own communities. And we don't always necessarily seek out what's going on in other communities and look to them as models of things that can be effective within our own community. And with the Child Abuse Prevention Fund Board, I know that they've been working throughout rural Nebraska. And so each rural community obviously has its own unique set of challenges, but they've also found ways to tailor their approach to preventing child abuse. And I think we have some lessons we can learn from what is being done effectively in those communities. And it's my hope that I could bring, I guess, knowledge of what is being done in those other communities back to the Reservation to allow them to take advantage of the lessons that are learned there. But I also think that another challenge faced within our community is we have a tendency to not be aware of resources that might be available to us. And one of the reasons I was approached and asked to join the board was to help bring the resources that the board represents to those communities and help them access those, those resources so that they can access those dollars and those models that are out there and bring those into the Reservation communities. But on top of all of that, the region I would be serving would be the region one, which would also include like South Sioux City, Nebraska, and the Latino community up there. So we're going not just to the Reservation communities, but beyond that as well.

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ARCH: But you will definitely bring a different perspective, added perspective to the work that's being done so that's--

DONALD BLACKBIRD JR: That would be the hope.

ARCH: Yeah. Well, we thank you very much for being willing to, to step up and, and serve like this and the need, the need in the state of Nebraska for people such as you to volunteer and, and to do these things is, is never ending. And but we really appreciate people with your background being willing to do that.

DONALD BLACKBIRD JR: Again, I appreciate the opportunity to be here. And it just-- yeah, I want to thank you for that. And I want to thank the Governor and the board for asking me to do that, because it's about rolling up your sleeves and getting the work done. And I appreciate the work that you guys are doing here. And I know you have your hands full with the redistricting that's going to be happening. So Godspeed on all of that. Thank you, gentlemen.

ARCH: Thank you. Thank you very much. OK, anyone want to speak in, in support or in opposition to his appointment? Seeing none, thank you very much. And, and we will move these pretty quickly so we can get them voted on by the, by the general body.

DONALD BLACKBIRD JR: OK, thank you.

ARCH: Thank you. One more appointment, and that is Peggy Snurr. Thank you for being patient--

PEGGY SNURR: Yes.

ARCH: --and waiting.

PEGGY SNURR: I didn't know I could clear a room so quickly. Thank you for having me.

ARCH: Tell us a little bit about your background.

PEGGY SNURR: My name is Peggy Snurr, P-e-g-g-y S-n-u-r-r. I just began my 28th year of teaching special education here in Nebraska. And during that time, I've worked with a lot of kids in-- that have been in the state's care. And so I have had a desire to delve more into that than I do just as a teacher. And took that opportunity in 2016 and became a member of the Foster Care Review Board. And it was while being on that board that I found about, about the opportunity to be on the Foster Care Advisory Committee. And I have been a member of that committee since 2017. So I'm asking for to, to do another term.

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ARCH: OK.

PEGGY SNURR: While on the committee, I served as chair and I was chair during our recent change in executive directors.

ARCH: So what's the duties, the different duties between the Foster Care Review Board and the, and the, the Advisory Committee?

PEGGY SNURR: OK. So the Advisory Committee, we oversee the Foster Care Review Office. So we're in charge of the hiring, firing, and evaluating the executive director and then also taking part in deciding the strategic plan on what data we're trying to collect and what we can do with that to help kids in care or to keep kids out of care. And then an actual Foster Care Review Board, when you serve on a board, you meet monthly. You're given a set of cases that will soon be coming to court and we look through as unbiased parties. We can get information from parents, foster parents, CASAs, guardians ad litem, caseworkers, and anyone else who might work with the child. And then we go through all of that information and then make recommendations to the court on what we feel would be in the best interest of the child. So they're kind of two completely separate entities. I have also served on a probation board for the Foster Care Review Office reviewing cases of kids placed out of home that are on probation.

ARCH: Well, you've done a lot of things and I really appreciate you being willing to stand for another appointment for the, for the Advisory, Advisory Committee. You've been, you've been a special ed teacher for a number of years as well.

PEGGY SNURR: Yes. Yes.

ARCH: Lincoln Public Schools?

PEGGY SNURR: Some of it has been in Lincoln Public Schools. And I also taught in Beatrice at Beatrice Public Schools for a number of years. I was in Lincoln, moved to Beatrice, raised our children, moved back to Lincoln.

ARCH: OK. All right. OK. Well, I'm sure you're aware that our committee spends a great deal of time talking about child welfare--

PEGGY SNURR: Yes.

ARCH: --and, and the-- and our-- the kids, our kids in, in child welfare so we are always looking for ways to improve. We have--

PEGGY SNURR: Yes, and--

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ARCH: --we have, we have things to improve.

PEGGY SNURR: One of the reasons-- I'm sorry to interrupt, but one of the reasons that I finally took the jump and got involved with the Foster Care Review Office was I would be working with students who were placed out of home and then removed from placements into other placements. And I find that it's really hard to stay on track educationally when you're constantly moving not only placements, but whatever educational institution you're at and the struggle with, yes, it might be time for like to try our trial home visit. But especially for students in high school, those need to be timely in that if you're going to have to be moving out of a school district to make that placement change, waiting until the end of a semester is what's best because kids will lose out on credits that they've already halfway earned because it might not be the same where they're going. And it is-- the statistics show that the kids who have more placements are further behind on target to graduate.

ARCH: Yeah, no question.

PEGGY SNURR: So that is definitely something that I feel like is sometimes overlooked, whereas we, we need our kids to at least leave with a high school education. And when we're moving them throughout those four years, it makes it difficult to happen in that length of time.

ARCH: Yeah. OK, well, again, you, you know what the committee is and you, and you know what you're signing up for and--

PEGGY SNURR: Yes.

ARCH: --we just appreciate it very much that you're willing to do that.

PEGGY SNURR: Thank you.

ARCH: I don't see anybody that wants to speak in support or in opposition.

PEGGY SNURR: Yes, exactly.

ARCH: So with that, we will, we will end your, your interview here.

PEGGY SNURR: OK.

ARCH: And as I say, we'll move quickly to, to get this to the, to the full body for, for a vote.

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PEGGY SNURR: Thank you.

ARCH: And with that, we will end our gubernatorial appointment hearings for the day.