PAUL HENDERSON: We are good.

HOWARD: OK, great. Good afternoon and welcome to the Health and Human Services Committee via Zoom. My name is Senator Sara Howard and I represent the 9th Legislative District in Omaha, and I serve as Chair of this committee. I'd like to invite the members of the committee to introduce themselves in alphabetical order, starting with Senator Arch.

ARCH: John Arch, District 14, Papillion, La Vista, in Sarpy County.

HOWARD: Senator Cavanaugh.

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

HOWARD: Senator Hansen, I saw you, yes. Senator Hansen.

B. HANSEN: Yep. Senator Ben Hansen, District 16, Washington, Burt, and Cuming Counties.

HOWARD: Senator Murman.

MURMAN: Senator Dave Murman, District 38, seven counties in south-central Nebraska.

HOWARD: Senator Walz.

WALZ: Senator Lynne Walz, District 15, which is all of Dodge County.

HOWARD: And Senator Williams.

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

HOWARD: Thank you. Also assisting the committee are our legal counsels, T.J. O'Neill and Paul Henderson, and Paul Henderson will be moderating the Zoom meeting, so he's managing our tech today. A few notes about our policies and procedures: These interim hearings are being recorded and they'll be posted on the Health and Human Services Committee's page through the Legislature's website. T.J., that's still correct? And then next week we'll-- we-- next week, we will have figured out how to stream them on NET, which is really exciting. Please keep yourself muted unless you're testifying. There's an icon at the bottom of your Zoom window that looks like a microphone, which

you can click to mute or unmute yourself. This afternoon, we're going to hear two interim studies and we'll be taking them in the order listed on the agenda on the legislative calendar. If you're planning to testify today, please ensure the introducer of the interim study has your updated contact information, including name, email, and phone number. This will help us keep an accurate record of the hearing. If you also have written testimony to submit, the Legislature's policy is that all letters for the record must be received by the committee by 5:00 p.m. the day prior to the hearing, and all of-- everything that we've received has been emailed out to the committee yesterday evening. Any handouts submitted by testifiers will also be included as part of the record, as exhibits. Please provide a copy of your handout to the introducer of the interim study and a copy to our committee clerk, Sherry Shaffer. Her email address will be posted in the chat. Each testifier will have five minutes to testify. When you begin, the timer will start, and then we'll-- you'll see a yellow card from T.J.-- T.J., can you wave? All right-- when you have one minute left-- we're very lo-fi here. And then when you're done, when your five minutes are up, you'll see a red card, like soccer. I think they use that for soccer. OK. When you testify, please begin your testimony by stating your name clearly and then please spell both your first and last name. The hearing on each interim will begin with the introducer's opening statement. After the opening statement, we'll hear invited testimony. The introducer of the bill will then be given the opportunity to make closing statements if they wish to do so. We do have a very strict no-prop policy in this committee. And with that, we will begin today's hearing with LR424, Senator Vargas' bill-- interim study to conduct a comprehensive view-- review of maternal and child mortality. Welcome, Senator Vargas.

VARGAS: Thank you very much. Thank you for clarifying the props. I put away all my props. Welcome, everybody. My name-- so good afternoon, Chairwoman Howard and members of the HHS Committee. For the record, my name is Senator Tony Vargas, T-o-n-y V-a-r-g-a-s. I have the honor of serving District 7 here in the Nebraska Legislature. As you know, LR424 focuses on diving deeper into maternal and infant mortality and the structures that are in place to address these important issues and what gaps continue to exist that can be addressed through smarter, more inclusive public policy. This issue, many of you know some of this about me, but for those-- everyone else in the public, the issue is personal to me. Almost two years ago now, my wife Lauren had to deliver our daughter Ava about five weeks early. Her labor was difficult and she required multiple blood transfusions. And so for--

for many weeks, I spent all my time in the hospital bouncing between her recovery room and the NICU, where my daughter Ava was. Thankfully, they're both OK now. And as you know, we are expecting our second child very, very soon here. It seems like it's going to be at the end-- coming into the end of this month, potentially. But our experience was a scary one and sharing it with others has only furthered my interest in doing all that I can to make sure that mothers and babies are safe and healthy and identifying what-- what barriers might exist to or are causing issues with their safe-- safety and health. So over the past year, my staff has worked with leaders in maternal and infant health, including the doctors you will hear from today, as well as other researchers, medical providers, and public health staff to learn more about what we can do to better understand what is currently happening, so that we can work together to reduce maternal and infant mortalities. Now, before we move on, I do want to extend a sincere thank-you to each of our testifiers and the many others who are not here to testify today but have taken time to talk with me and my staff about this interim study, including the women who are part of a roundtable organized yesterday by I Be Black Girl. This includes Ashlei Spivey, Caryn Vincent from DHHS, Jessica Ehule from CityMatCH at UNMC, Christian Minter from UNMC, and Ebonie Bailey, a doula, Serena Dacus, and Latasha Willis, who also shared their birth stories with us-- or Latasha, who shared her birth story with us. Our testifiers today are medical providers who are stretched so thin these days. And so I want to extend my sincere thank-you from our office and for myself for taking the time away from your patients to join us here today. With that, I'm really eager to start and hear from our invited testifiers and just thank everybody for taking the time and-- and for hearing why this is a personal issue with, you know, my-- my own wife going through pre-eclampsia and-- and-- and post-eclampsia and knowing and seeing what-- what-- how much I've learned about this issue. It's important for us to revisit it and do all we can. And also a shout out to Senator Cavanaugh. She's been working on this issue this last session, as well, and so I'm thankful for her leadership in that, as well, along with everything that Chairwoman Howard has done in the past for this. So thank you and happy to get started with our testifiers.

HOWARD: Thank you, Senator Vargas. Are there any questions for Senator Vargas from the senators? All right, seeing none, we'll invite our first testifier, Ann Anderson Berry, Nebraska Perinatal Quality Improvement Collaborative. It's nice to see you. Hello, Ann. Ann lives

around the corner from my mom. I already told everybody, so-- but I'm a big fan of yours, so I'm glad you're here.

ANN ANDERSON BERRY: Well, thank you very much for that. Good afternoon, Chair Howard and the members of the Health and Human Services Committee. I am Dr. Ann Anderson Berry, for the record, A-n-n A-n-d-e-r-s-o-n B-e-r-r-y. I'm a faculty member of UNMC and the medical director of the Nebraska Perinatal Quality Improvement Collaborative. However, I am not speaking as a representative of the university today. I am here speaking as an individual and on behalf of the Nebraska Perinatal Quality Improvement Collaborative, or NPQIC. I am here testifying with regards to LR424. As you are likely aware, maternal mortality is rising in the United States, more than doubling in 30 years from 7.2 deaths per 100,000 live births in 1987 to 17.3 deaths per 100,000 live births in 2017. Just last week, the Surgeon General released a call to action to improve maternal health, attachment A in my testimony. Included in this call to action are important steps that outline a roadmap for the U.S. to decrease maternal mortality by 50 percent in five years. In Nebraska, where our data is outdated and incomplete, our last published Vital Statistics report is for the year 2016. We must similarly define our current status and devote time and resources to improving maternal and neonatal outcomes with similar decreases. It is critical that we pay attention to not only maternal mortality but also maternal morbidities, infant mortality, and the disparities and outcomes that place Nebraska last among states when assessing infant mortality from a disparity standpoint. Despite our relative prosperity, our dedicated Midwestern work ethic, and nationally recognized healthcare systems and providers, we continue to have too many mothers and infants who suffer unacceptable maternal and neonatal complications. In fact, in the U.S., minorities remain at high risk of maternal mortality, with black and American Indian mothers enduring rates of mortality almost three to four times higher than their white peers. And risk among college-educated black women is still two times higher than white women without a high school education. As a state with a relatively small number of births, we face challenges understanding trends in rare events such as maternal deaths. One opportunity for our state is to track and assess major maternal morbidities. Understanding these can be very helpful in predicting and preventing Nebraska's associated risk of maternal mortality as they are much more frequent. Today, we have no standardized way to measure major maternal morbidities and to address their etiologies in order to work to minimize mortality. This is work that could be done by a well-funded and empowered MMRC with

current data. In my work as medical director for NPQIC over the last six years, I've focused on using limited resources to provide outcomes for Nebraska mothers and infants. In fact, the goal of the collaborative is to ensure that all Nebraska perinatal providers and birthing hospitals are equipped to provide evidence-based care that will reduce morbidity and mortality in mothers and babies. Our efforts have led to sustainable improvements in some specific hospital-based areas of risk. But in order to dramatically cut our rate of maternal mortality, reduce our maternal morbidities, and decrease our neonatal and infant mortality in minority populations, we must do significantly more as a state. We need better data. We need more resources allocated to both identifying and understanding the problem and disrupting the cycle we are in where mothers' and babies' outcomes are worse each decade. State collaborative groups across the country with state-supported funding have helped healthcare professionals adopt practices that import-- improve birth outcomes and reduce costs. NPQIC partners closely with DHHS, providers, private foundations, healthcare networks, and payers to achieve these outcomes, but the problem far exceeds our resources. We must work collaboratively with the state of Nebraska, following the goals and recommendations outlined in the Surgeon's-- Surgeon General's call to action, as well as those highlighted in my colleagues' testimonies today, to improve available data, including birth and death certificates, increase the scope of Maternal Mortality Review Committee to review major mor-- maternal morbidities, perform root cause analysis, and increase financial support from the state for continued maternal healthcare for the first year of life. In the long term, this investment will result in reduced state healthcare costs and decrease loss of precious life for our state. NPQIC works with all delivery hospitals in the state of Nebraska as NPQIC member hospitals. These member hospitals actively participate in quality improvement projects, and we have intentionally partnered closely with the excellent staff in the Maternal Child Adolescent Health Program within the Nebraska DHHS Division of Public Health in order to increase the impact of the resources across the state. Our plan is to continue to do this work and we would recommend that the state target specific resources towards these efforts, as is outlined in the Surgeon General's report for state healthcare provider and health system recommendations. These proposed initiatives will allow us to address perinatal issues that develop long before the hospital admission for delivery. The state is a necessary public health partner if we are to ensure safety for Nebraska families. In conclusion, Nebraska mothers and babies need the work of not only our perinatal collaborative, but of all stakeholders, including local,

state, and national governing bodies. With our statewide presence and our highly skilled volunteers, we have the potential to provide an even greater impact in close partnership with DHHS and the state of Nebraska. Working together, Nebraska's Perinatal Collaborative will continue to work so that Nebraska will be a state where great life starts with healthy moms and healthy babies. Thank you, Senator Howard.

HOWARD: Thank you. Are there questions from the senators? Senator Cavanaugh.

CAVANAUGH: Chairwoman Howard. Thank you, Dr. Anderson Berry, for being here. I wanted to ask you a question about the Perinatal Collaborative and-- and your current financial status. Did you experience a cut from federal funding this past year?

ANN ANDERSON BERRY: So we unfortunately have never had federal funding.

CAVANAUGH: Oh, OK.

ANN ANDERSON BERRY: We-- we were a month too late in our application when I worked with Senator Howard to establish the collaborative, and the federal program expired in December of the year before we achieved state funding for the collaborative. We were funded by the state at $100,000 per year in year one. In year two, we were cut to $70,000 per year and that's where we remained. We've worked to propose increasing funding to $200,000 per year, but when COVID disrupted the state economy, we were maintained at $70,000 per year.

CAVANAUGH: OK. And-- and what would you do if you were increased to the $200,000 that you were seeking this past year?

ANN ANDERSON BERRY: So much of our work needs to be in personnel, in education and implementation of public partnerships. And so much of what's called out in the Surgeon General's report is-- are items that could be accomplished by the state of Nebraska. It's just going to take people to do that. And so we would go through and prioritize our needs with the needs that are highlighted in the Surgeon General's report, and then we would activate our statewide network and all of our resources and contacts and collaborations that are current and double down on efforts, prioritizing those that were most applicable to the state of Nebraska. I think we have to highlight that our data is old, it's dated, and we have questions about its accuracy. And so

one of the very first things that needs to be done in this realm is to make sure that we've got our definitions right, make sure that our healthcare providers that are filling out birth and death certificates understand what information is critical so that we're reporting that right. The state can only do so much if it's getting inaccurate data, so education and communication is really key to starting to sort out this problem and decrease our rates.

CAVANAUGH: And do you get your data-- you get your data from DHHS directly?

ANN ANDERSON BERRY: We get our data through publicly reported, like the Vital Statistics, and then we work with members of the Maternal Mortality Review Committee, but they're under-resourced, underfunded, and backlogged. And-- and so data is-- is highly limited. I think Dr. Brown will be talking about data specifically in her testimony, and as our program administrator, she really delves into, you know, the usefulness, or lack thereof, of the state data.

CAVANAUGH: OK, I'll reserve my data questions then for Dr. Brown.

ANN ANDERSON BERRY: She'll-- she'll be a better expert, I'll be frank.

CAVANAUGH: Thank you so much.

ANN ANDERSON BERRY: You're welcome. Thank you.

HOWARD: Thank you. Other questions? All right. Seeing none, thank you for your testimony today.

ANN ANDERSON BERRY: Thank you.

HOWARD: The next person on the list is Todd Lovgren, but I don't see him in the room, with the Maternal Mortality Review Committee from the Child and Maternal Death Review Team. Well, we'll skip over him and then if he-- and then if he arrives, then we'll-- then we'll bring him up. OK, Chad Abresch, in his personal capacity as a member of the Perinatal Quality Improvement Collaborative.

CHAD ABRESCH: Yes, good afternoon, Chairperson Howard 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 a faculty member at UNMC. However, I'm not speaking as a representative of the university today. I also serve as executive director of CityMatCH, a national public health organization that works with 170 cities across the country to advance

equity and improve the health of women, children, and families. I'm speaking today in response to LR424 as an individual who has dedicated my career to advancing equity in maternal and child health. I would share today that the situation in Nebraska as it relates to equity and health outcomes is dire, and infant mortality outcomes are particularly bleak. Now I-- I realize that those are strong words, but they are warranted based on the data, which demonstrate that black babies in Nebraska are dying at an alarming rate and have been for years. In fact, Nebraska is among a handful of states at the bottom of the heap. To our shame, our state is one of the worst places in the country to be born black if the goal is to survive to your first birthday. Our most recent non-Hispanic black infant mortality rate is 11.98 per 1,000 live births. In other words, for every 1,000 black babies who are born alive, about 12 will not see their first birthday. It embarrasses me to share that this same data indicate our white rate is 3.84, which actually places Nebraska in the top half of all states for survival of white babies. More than three times as many black babies die in Nebraska compared to white babies. And I should also point out that black infant mortality rates for the best states are less than half our rate. In other words, the challenges that we face here in Nebraska are absolutely fixable. Now maternal mortality is also an issue, and unfortunately, I cannot provide you with similar state data by race for maternal mortality because those data are limited and not publicly available, a situation that I'll propose a solution to in just a moment. But first let me be abundantly clear about the source of these health inequities. Now science indicates the daily experience of structural racism causes stress, which results in people getting sick more frequently, at younger ages, and with more severe outcomes. And by structural racism, I mean systems that disadvantage communities of color in terms of housing, jobs, education and more. That's why, for example, black mothers who are healthy and do all of the right things, like early prenatal care and eating a healthy diet, are still-- they still have a greater chance of delivering preterm or experiencing a pregnancy complication. Now I have three recommendations to improve the situation in Nebraska. Number one, first and foremost, listen to and trust the voices of women and folks of color. During your review and formulation of recommendations, I ask that you assemble a panel of women, women of color, to guide your efforts and vet your policy recommendations. I also suggest that Nebraska expand existing maternal mortality reviews to include severe maternal morbidity reviews. This would create the opportunity to learn from women who experience significant events. And we also know that the causes of both are closely related, but maternal

morbidities are 100 times more frequent, giving us far more data to examine and learn from. Recommendation number two: Insist that postpartum Medicaid coverage be extended in Nebraska. HR4996, the Helping MOMS Act, has passed the House and it looks to garner Senate approval as well. This act would allow states to provide one year of postpartum coverage under Medicaid. It will also facilitate payment for doula services and group-based prenatal care, both of which have a demonstrated evidence for improving outcomes among women of color. Now we know that other states will extend coverage, and Nebraska simply cannot afford to fall farther behind. Third, and finally, I would encourage you to focus on the social determinants of health. And here are two actionable items to consider. First, incentivize public agencies to acknowledge the impacts of structural racism. Douglas County Health Department has declared racism a public health crisis. I would encourage you to find ways to have others follow suit and then create strategic plans for change. And second, I would encourage you to create a maternal data center that links community-level social indexes with state birth records and hospital data. Nebraska, we could be a leader in this regard with the result of better access to timely and actionable data. I know of only four other states who have done this. So in conclusion, Nebraska's women and infants deserve better. We have the resources, the expertise, and the answers to ensure that they do. We simply need the will.

HOWARD: I was muted. Thank you. Are there questions from the senators? Oh, Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you so much for your time today. As Senator Vargas said in his opening remarks, yesterday, I Be Black Girl, an organization here in Nebraska, organized a roundtable on maternal health. And one of the things that was discussed was structural racism as it re-- as it relates to maternal health issues. And so I appreciate hearing your views on that. One of the things that kind of stuck with me in that conversation yesterday, and you brought it up again today, is social determinants of health. And sort of the things that we think about around when we look at the disparities, the race disparities in health outcomes, is that women of color are-- are experiencing worse outcomes across socioeconomic status, as you said. And so what-- what can we do to elevate that conversation? Not that it's about people who are necessarily in poverty or lack education, but it is-- it is race based, not education or geography within, say, Omaha based.

CHAD ABRESCH: Yes. Thank you for that question. And I'll also say thank you for organizing the event, however it happened, with-- that took place yesterday. Jessica Ehule is our director of programs, and she called me immediately afterwards excited to have that opportunity. Exactly how you said, this is an issue of racism that stretches across socioeconomic status. And I would go back to that first recommendation that I made. I think it all begins there. It doesn't end there, but it all begins with actually listening to the voices of women of color. That's what you did yesterday. And we don't have that on the panel today, which is-- makes it even more important of why it happened yesterday and why I'd encourage you to really think about putting together that-- that panel as you go on and eventually make recommendations. I think it starts with listening. They'll have the best advice, better than I will, right? And also just the opportunity to-- to be heard, to tell their story and to be heard, I think, will-- will be valuable and begin to change indicators.

CAVANAUGH: And-- and Jessica, it was wonderful having her yesterday and hearing from her and all of the women that shared their points of view. I-- I-- I do wonder-- I-- moving forward, I mean, they did put together a list of recommendations which were really comprehensive and I would be happy to share with my committee members. But how do we as-- as a-- as a group here carry forward that message of listening to women of color, not just in the legislative field but in the medical field as well? Is there anything that we can do to help support that work?

CHAD ABRESCH: Yeah, absolutely. I-- I would go again back to the recommendation, and Dr. Anderson Berry did this as well, about extending reviews of maternal mortality to include maternal morbidity. I think it was two summers ago I got together with all of the states who are doing reviews at CDC. At that time, none of them were doing reviews of severe maternal morbidities, which means that you're not interviewing the woman. In many of-- this methodology is based on something called FIMR, which is the fetal and infant mortality review. And FIMR is like MMR reviews, but it includes as a core component an hour-long interview with the woman and some of the most rich information and actionable information come out of that interview. Now some of those states were considering key informant interviews, so interviewing the spouse. I could tell you, Senator Vargas could probably also tell you, that I would be a poor proxy for my wife, who also had a significant event during the birth of our fourth child. I-- I could tell her story, but I would be a poor proxy. She would be much better.

CAVANAUGH: Um-hum. Thank you.

HOWARD: Are there other questions from the committee? Senator Arch.

ARCH: Yes, thank you. You-- you referenced some research in your remarks that talked about, in spite of doing everything right during that pregnancy, women of color are still more likely to have outcomes, negative outcomes. If-- could you provide the source of that research? I'd be very interested in reading that-- in reading that research, if you could do that.

CHAD ABRESCH: Yes, absolutely, and I did include that on my written remarks, as well, the-- the source for that.

ARCH: The source?

CHAD ABRESCH: Yep.

ARCH: OK, very good.

CHAD ABRESCH: I bel-- I actually think there were a few of them, a few different sources, because I think that was probably an important one to have more than one reference.

ARCH: Very good. Thank you.

HOWARD: All right. Other questions? OK. Seeing none, thank you for your testi-- oh, Senator Hansen, was that a-- was that a hand for a question? Nope. OK, perfect. Seeing none, thank you for your testimony today. Our next testifier will be Todd Lovgren from the Maternal Mortality Review Committee from the Child and Maternal Death Review Team. Welcome, Todd.

TODD LOVGREN: Thank you. Can you hear me all right?

HOWARD: Yes, we can.

TODD LOVGREN: So I guess first, are there any direct questions for me that you would like me to answer to start with before I kind of have some comments?

HOWARD: You know, generally in legislative hearings, we invite you to open with comments and then we'll--

TODD LOVGREN: OK.

HOWARD: --close with questions.

TODD LOVGREN: So opening with my comments then, starting-- having worked with the MMRC for the last two years, and also having gone and done a trip to work with the CDC, with their MMRIA meeting and look at maternal mortality across the country and how it's being reviewed, Nebraska has a lot of room to improve on what we're doing. There was just some testimony about including patients, and one of the biggest things that some other mortal-- mortality review committees have looked at is including families in these processes and in these interviews, getting-- getting information directly from them. One of the biggest barriers we've had in performing our reviews is getting accurate and needed information to be able to-- to form a cohesive kind of conclusion when we're done with the case. The whole goal of our committee is to come up with recommendations that then get applied or get-- get pushed forward to Legislature and for legislative change in the state. And the biggest-- the biggest hurdle, like I said, we're facing is right now we're having a hard time getting the information we need to be able to draw accurate conclusions and conclusions that can-- we can then help guide policy and policy change going forward. This has been new for the state of Nebraska. We've now been working at it for close to 24 months in a more focused manner. We've been taking lots of cues from more experienced mortality review committees across the country, including Ohio, Colorado. They all have very well-formed committees and in some cases they have-- in-- in all case-- in both those cases, they have significantly more resources to work with, both financially and from a personnel standpoint, to be able to collect all the data they need to draw these conclusions and to be able to-- to move that information forward to making policy change and to improve-- improve healthcare for women in our state.

HOWARD: OK, thank you. Are there questions? Senator Cavanaugh.

CAVANAUGH: Thank you. Thank you so much. I-- it's actually-- it-- something you said caught my eye, about Ohio and they-- their maternal mortality. I'm aware of a program they have there with midwives and that they have actually really excellent outcomes for women who had C-sections and then are able to have a vaginal birth afterwards because of this group of midwives that they've been working-- that work with the women. Is that something that you're familiar with?

TODD LOVGREN: Yeah, and actually, I had experience with that in Colorado. Colorado has midwives who operate independently. In-- in my experience, when you have tiers of care-- and that's really what

midwives are a part of, they're a part of tiers of care-- you know, they're-- they're-- they're designed to take care of low-risk, low-intervention patients. And so understanding limitations in patient selection becomes very important in those situations. The programs in Colorado, Iowa, even here in Nebraska, in Omaha, we have a-- we have a very strong midwife, a couple midwife groups in-- groups in Omaha who are--

CAVANAUGH: Oh, I know.

TODD LOVGREN: --who [INAUDIBLE]

CAVANAUGH: I have two children delivered by midwives.

TODD LOVGREN: And-- and I've worked-- to be honest, I've worked with every midwife in Omaha over the course of my career, and-- and the strength of your midwife program and the strength of programs like you're talking about, which would be the trial of labor after C-section, those programs are really dependent on interaction between physicians and-- and midwives to work together to accomplish those successful outcomes, because those-- those types of deliveries are higher risk. And so you have to have very close sup-- physician supervision. And-- and those deliveries, from our governing body's opinion, is those are all deliveries that should be performed in hospitals, not performed at home, because of the potential need for an emergency C-section. And so, yeah, I-- there are-- there are very strong programs very similar to Ohio's all over the country, and really--

CAVANAUGH: The--

TODD LOVGREN: --what those programs are built on is collaboration.

CAVANAUGH: And we don't allow home births in Nebraska regardless.

TODD LOVGREN: Correct. They're-- they're not allowed with a licensed practitioner.

CAVANAUGH: Right, yes. Thank you.

TODD LOVGREN: Yeah.

HOWARD: Other questions? Since you serve on the Maternal-- the Child and Maternal Death Review Team, could you talk a little bit about the process for your reviews and sort of-- because often they take a

little bit longer for you to get those death certificates and sort of be able to put together your assessment. Can you talk about that process?

TODD LOVGREN: That process, I've only-- I've just recently got named to that committee, and so I've only worked through it once so far. The-- the difficulty with that committee, particularly reviewing some of the child deaths, is the majority of them are neonatal and a lot of them are related to prematurity. And so I've not really had to review one that was very challenging, in my opinion, quite yet. But in reviewing those cases, we get a large pile of records. And a lot of these kids, you know, some of them are hospitalized for upwards of six months or a year before they die. And so when you go to review that case, when, you know, you have an infant who has, you know, six providers potentially taking care of them on a daily basis and numerous nurse practitioners putting notes in the computer, you know, they-- they literally drop off banker's boxes of files for us to review just to get through 10 or 11 cases. And so it's-- it's-- it's something that we-- we obviously-- we need to keep doing and we need to review these cases for the-- for the few cases that definitely need to be reviewed for improvement in care. But a large number of the cases are fairly straightforward, but it's a matter of doing your due diligence and getting through all of the-- the paperwork.

HOWARD: Thank you. All right, any other questions? OK. Seeing none, thank you for your testimony today.

TODD LOVGREN: Thank you.

HOWARD: Now we'd like to hear from Peggy Brown from the NPQIC, the Perinatal Quality Improvement Collaborative.

PEGGY BROWN: Thank you. Chairman Howard 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, known as NPQIC. I'm a registered nurse with a doctorate degree and certification as a healthcare quality professional, and I'm testifying on LR424 in my role as a private citizen. The Nebraska Perinatal Quality Improvement Collaborative works to reduce maternal and neonatal morbidity and mortality through improvement science by collaborating with stakeholders throughout the state. These stakeholders include health systems, hospitals, healthcare professionals, health professionals, payors, and families. To improve mortality and morbidity in Nebraska,

accurate data specific to our state population is essential. According to the recent Surgeon General's call to action to improve maternal care, a key factor that may contribute to high maternal mortality and morbidity is data limitations which inhibit surveillance. If data are inaccurate, incomplete, or not available publicly in a timely fashion, stakeholders such as NPQIC, hospital systems providers, and other maternal child health professionals can't identify the key issues and provide interventions and track progress. Key data sources for work include the DHHS reports on Vital Statistics and maternal mortality, as well as hospital discharge data and some specific surveys contained-- performed by CDC that contain state data such as MPINC and PRAMS. The Vital Statistics report summarizes data that are collected on the birth and death certificates. Currently, the most recent Vital Statistics report available on the DHHS website is from 2016. In contrast, 2019 reports are available on Iowa, Kansas, and Colorado's websites. The Nebraska report needs to be timely to enable appropriate actions to improve maternal and neonatal morbidity and mortality. As evidenced by the Surgeon General's call to action, maternal mortality is a priority issue in the United States. Our statute calls for annual maternal death reports. However, the most recent report available is one that was issued almost two years ago containing information on maternal deaths in 2017. In contrast, 2019 results are available on South Dakota, Kansas, and Iowa's websites. In that most re-- recent Nebraska report, a chart shows Nebraska's pregnancy-related maternal death rate at 42 per 100,000 while the CDC shows the national rate to be 17.3 per 100,000. The Nebraska data is highly concerning no matter how it is interpreted. One possibility is that the data is true, meaning that Nebraska maternal mortality is more than twice the U.S. rate, or a second possibility is that the data we have in Nebraska is significantly flawed. While we wait for clarification and information from the Maternal Mortality Review Committee on these deaths, more mothers continue to die. The death of a mother is devastating for a family, and the CDC estimates that 60 percent of those deaths are preventable. We need timely, accurate data so those deaths can be prevented. Another key data source is hospital discharge data. This includes patient demographic data and medical diagnoses. In the future, for most Nebraska hospitals, this will include social determinants of health and race and ethnicity as the Nebraska Hospital Association is working with hospitals to include this in data submissions for 2021. This will help identify if we have health disparities based on various variables such as race and ethnicity. Both the Nebraska Hospital Association and Nebraska Health Information Initiative, NeHII, are sources of this type of data. It is important

that hospital personnel correctly classify the medical diagnoses by the appropriate code for this data to be valuable, and training on coding for personnel at the smaller Nebraska hospitals can be problematic. Other key sources are CDC surveys. The Pregnancy Risk Monitoring System, PRAMS, collects state-specific data on maternal attitudes and experiences before, during, and shortly after pregnancy. The Maternal Infants Nutrition and Care [SIC], MPINC, assesses breastfeeding support practices at hospitals and results are reported by states. I'd like to conclude by emphasizing that your support is needed to ensure that data specific to Nebraska are accurate and timely so that improvements can be made in respect to maternal and neonatal mortality and morbidity.

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

CAVANAUGH: Thank you. Thank you so much, Dr. Brown. Well, you said the magic word to me, "NeHII." I actually had a meeting with Jaime Bland yesterday to talk about some other data issues. And I-- that's what I was wondering is, what role does NeHII play in the data that's provided to the Maternal Mortality Review Board? But additionally, what-- what couldn't we do to help ensure that the review board is getting accurate, timely data?

PEGGY BROWN: So I don't know if the maternal mortality review group gets data from NeHII or not. I-- I do know that the coded data by diagnosis is very valuable in analyzing what our issues are and what factors are associated with that. Right now, Nebraska Hospital Association collects that discharge data from member hospitals. And we have one project where we're able to access severe maternal morbidity data from that, and we can track ours over time and compare it to other states that are participating in this national AIM program. As far as NeHII, we have just begun to work with them and it's basically on the same thing, the coded data. ICD-9, ICD-10, you may have heard it call-- called that. And in this other project, we're looking at those codes and the incidence of depression. So we are just beginning to explore how best to use that data. Of course, we need better access and all of the stakeholders working on this need better access to that data.

CAVANAUGH: And is the primary source of data that you need access to coming from DHHS, or is NeHII able to provide that data for you?

PEGGY BROWN: Most of what we've been using is from DHHS, the Vital Statistics report that is three, four years behind. We-- we try to

track fetal death rates and we have no idea if the interventions we've been doing in the recent years are making a difference or not, so it's been very frustrating to try to figure out if we're making any progress.

CAVANAUGH: I have an additional question, sorry. One of-- at the conversation I was having with Jaime yesterday was actually around health data and our-- our justice system, specifically our juvenile justice system. And I did not realize that our juvenile justice system, or Corrections at large, does not participate in NeHII. So are you aware if you are getting the health outcomes data about women who are in our-- are justice involved in Nebraska separately or how that's parsed out?

PEGGY BROWN: I am not familiar with the data from the justice system. I know that from the project we were-- we're also looking at doing substance use disorder research; and in exploring sources of data for that, I did contact the judicial system and they were unable to give me any information. And I don't know if they didn't have easy access to it or if something else prohibited them from sharing that, but that would have been one way to get some additional information.

CAVANAUGH: OK, thank you so much.

PEGGY BROWN: Um-hum.

HOWARD: Thank you. Are there other questions from the committee? All right, seeing none, thank you for your testimony today. That was our last invited testifier. Senator Vargas, you're welcome to close.

VARGAS: First of all, I want to thank all those that testified as part of the invited testimony. I want to thank the Health and Human Services Committee and Chairwoman Howard and the questions that have been asked thus far. And there's a couple of things I want to reiterate here. One, this is not the first time that Health and Human Services or the committee has taken up this issue. It's not the first time we've implemented some structures in place. The first really structures that put in place legislative-- in statute were 1993 and there have been many pushes since then to continue to hone the review board, to improve and set a structure in statute, to improve data. But I think what-- a couple of things that I think are really helpful to-- to acknowledge here that I hope some-- we can focus on recommendations and help inform this committee, is there are significant disparities that exist in regards to maternal and infant mortality. And so let

alone just maternal and infant mortalities, we continue to see disparities across lines of race, ethnicity, and then also if you-- you put overlay on top of that, income levels. And so we're seeing these disparity levels that continue to exist. We have structures in place that are meant to review these cases. But what we've heard and what I-- at least I've heard from testifiers and through some of the questions is that there continues to be issues of data access, data consistency, and consistency with existing legislative statutes on how often these reviews would happen. This is not saying that a sys-- what we're doing is broken, but it's clearly not being done to the effort that it's supposed to and there's an opportunity to do better. What we've also heard is there's a need to bring in more voices that are the ones affected by this within the system. We-- today was really about healthcare professionals sharing their-- sharing their perspectives here. But there is obviously a missing perspective of making sure we're seeing how these disparities are affecting communities of color because those disparities are real. And-- and I think what I've also heard is that beyond the data components, there is also a reason to look into the way that race and ethnicity in general, in terms of public healthwise and disparities that already exist within our systems because of social determinants of health, are also really important for us to look to recommendations. There are wraparound things that we clearly are help-- are either hurting or are detrimental to populations, specifically, you know, maternal and infant mortalities. The other recommendation that I heard that I think is-- is worthwhile consideration is that we look to morbidities because there's more plentiful data in terms of maybe obviously things that are not fatal, but that are affecting mothers, you know, post-- post-- you know, postpartum. And these are issues, these are opportunities for us to find some more data to look at beyond what we currently have. And so I-- I want to thank everybody because there-- there is-- there-- there is more that we need to do in regards to strengthening the existing structures we have in place, improving the data access, improving the data transparency, adherence to existing statutes and obligations we already have in coordination across the system, in addition to the social determinants of health and the wraparound we need to do to-- to-- to address these disparities that we're currently seeing, especially for those that are black and brown individuals in our communities. I want to thank the committee for asking these questions and also welcome any other questions that I might be able to-- to answer.

HOWARD: Thank you. Are there any questions for Senator Vargas? OK, seeing none, thank you for visiting with us, Senator Vargas. This will close the hearing for LR424. If you were a testifier for LR424, you are welcome to-- to leave the Zoom now, same with Senator Vargas. And this will open the hearing now for LR348, service animal fraud and emotional support animal fraud. Welcome, Senator Lindstrom. You're welcome to open.

LINDSTROM: Good afternoon, Chairwoman Howard and the Health and Human Services Committee. My name is Brett Lindstrom, B-r-e-t-t L-i-n-d-s-t-r-o-m, representing District 18 in northwest Omaha. Today, I would like to introduce LR348, an interim study to examine service animal fraud and emotional support animal fraud. I was brought this issue by a constituent who is confined to a wheelchair and utilizes a service dog that is trained to assist him in his everyday life. Guide dogs or service dogs are defined by the American-- Americans with Disabilities Act as, quote, a dog that has been individually trained to do work or perform tasks for an individual with a disability. The task or tasks performed by the dog must directly-- must be directly related to the person's disability. Emotional service animals are not directly defined by the ADA. However, according to the Disability Rights Nebraska, they are animals that provide emotional support or comfort by just being with the individual handler. They are not trained to perform specific tasks as a service-- as service dogs are. I have sent the committee clerk a document that compares the two groups with several points of comparison as to where the animal is allowed and what requirements are for both groups. Service dogs are trained to perform specific tasks or-- dis-- disabled people are protected under the ADA and as such, they are allowed into businesses, restaurants, airlines and protected from discrimination in housing. Emotional support animals are also, also allowed certain protections by law, but they differ. I have two documents provided by the Disability Rights Nebraska to outline what each of these provide by law-- provided by law. There have been a, there have been a recent trend of people attempting to pass untrained animals as service animals in order to bring their pets into public places where pets are normally prohibited, but service dogs are allowed. While there's no way to identify whether a dog is truly a service animal as they are not registered to any database and service dogs are not required to wear badges or vests to identify them as legitimate service animals, a business, an employer, or a potential landlord are able to ask questions to indicate whether or not an animal is a service animal or not. By law, a business owner, for example, may ask the individual if

the dog or service animal is required because of a disability and what work or task the dog has been trained to perform. A business owner is prohibited from asking for documentation. They cannot demand the dog demonstrate a task or inquire about the nature of the person's disability. So how do we deter people from trying to pass their dogs off as service animals in order to circumvent a no-pet policy? Criminalizing would be one option; 30 states have implemented statutes that make the use of fraudulent service dogs a misdemeanor, imposing a fine, community service, or even jail time if convicted of the offense. Current law in Nebraska makes posing as a blind person with either a white cane or a dog a Class III misdemeanor. No statutes in our state make a fraudulent claim of a service dog, of a service dog a crime. Second, education for the public, for businesses, employers, and property owners, as in the case with my constituent who has often felt frustrated and helpless when encountering what he considers a fraudulent animal in a business that is clearly not a legitimate service dog. On one particular experience, an untrained animal harassed his own dog. When he appealed to the manager to enforce the service animal-only zone, he was told that there was nothing, nothing that could be done because the person with the animal was a service animal. Confusion by these businesses, employers, and landlords by what they're legally-- by what they may legally ask are concerning. They are fearful of legal retribution should they ask the wrong question. Anyone who has ever owned a dog knows how important our pets are to us and our families. This is even more evident with people who depend on service dogs to improve the quality of their lives. I'm interested to find out what the committee finds appropriate for the people of the state of Nebraska. I appreciate being in front of the HHS Committee and for the accommodations made via Zoom and I'd be happy to answer any questions.

HOWARD: Thank you. Are there questions for Senator Lindstrom? OK, seeing none, thank you, Senator Lindstrom. We'll now invite Gene Eckel from the Goosmann Law Firm to provide us with his testimony. Welcome, Gene.

GENE ECKEL: Thank you, Senator. This-- I'm Gene Eckel, G-e-n-e E-c-k-e-l, and as Senator Howard said, I am an attorney in Omaha with Goosmann Law Firm and I'm also the legislative committee chair for the Apartment Association of Nebraska. We support LR348 because we think this is important for the industry and for landlords, particularly in Nebraska. Property owners have been a significant or have seen a significant increase in reasonable accommodation requests for emotional support animals in recent years. In cases where a property

owner may request documentation on the disability-related need for an emotional support animal, federal regulations allow for a broad range of individuals to provide verification. These individuals include a physician, psychiatrist, social worker, or other mental health professional. I think clarity [SIC] in the regulations opens the door for abuse and imposes an unfair burden on property owners, undermining the intent of the act to help truly-- those truly in need of an emotional support animal or an assistance animal. Among the concerns are the individual certifying the resident's need for an emotional support animal is not required to have an actual treatment relationship with the resident. In some cases, residents apply reasonable accommodation request documentation to property owners in the form of a letter purchased online for a fee. This documentation may be provided with little or no contact with a mental health professional other than the brief consultation. It is not the result of an actual treatment relationship. And while HUD, in January of this year, came out with guidelines called the HUD assistance animal request guidelines that gave some clarity to what a housing provider supposed to look at, it really still left open a loophole because what HUD indicated was that documentation from the Internet by itself is not sufficient. But a reliable form of documentation could be a note from a person's healthcare professional that conform-- that confirms that the person does suffer from a disability or has a need for an animal with regard to that provider's personal knowledge of the individual. So what has happened now is that these online providers will have now changed their letters to specifically state that they have a personal knowledge of that person's disability or that it's under their care. They can now get around the new guidelines by HUD and that still doesn't help a housing provider to determine whether or not that person actually suffers from a disability and if there is a disability-related need for that animal. I'd be happy to answer any questions that the committee may have.

HOWARD: Thank you. Are there questions from the committee? All right, seeing none, thank you for your testimony today.

GENE ECKEL: Thank you, Senator.

HOWARD: All right, now we'd like to invite Bradley Meurrens from Disability Rights Nebraska.

BRAD MEURRENS: Good afternoon, Senator Howard and members of the committee. For the record, my name is Brad, B-r-a-d, Meurrens, M-e-u-r-r-e-n-s, and I am the public policy director at Disability

Rights Nebraska. We are the designated protection and advocacy organization for persons with disabilities in Nebraska. We appreciate the opportunity to speak to you today and wish to thank Senator Lindstrom for bringing this study resolution, as clarity and more information regarding service and support animals is truly needed. Assistance animals are not pets. Federal law does define and outlines the rights and responsibilities of each. The Americans with Disabilities Act defines service animals. The support animal may provide companionship, but these animals, again, are not specially, specially trained to perform a task that assists a person with a disability. Thus, they are not considered service animals, but rather emotional support animals and they may nevertheless qualify as a reasonable accommodation under the Fair Housing Act. Both the Air Carrier Access Act and the Fair Housing Act have different standards for designating which animals are given access and require different documentation to secure access to housing and aircraft. With three different sets of definitions and standards in federal law, the issue can be confusing. A person who, for example, has a service animal for the purposes of the Air Carrier Access Act and the Fair Housing Act may not realize that a separate and more restrictive definition of service animal applies under the ADA, Americans with Disabilities Act. Thus, we would caution against framing this issue solely as a problem created by selfish people or unethical individuals. The use of unqualified animals as service animals may not be a deliberate act, but instead a problem created by misunderstood definitions, differences between the civil rights laws affecting service animals, and misinformation distributed by the medical community. Also, there are several unintended consequences that can arise when states attempt to legislate in this area, such as problems determining probable cause, which could ultimately violate the civil rights guaranteed under the ADA and can hit-- and this lack of determining the probable cause can also hinder prosecutions. Data indicates that almost half are dismissed or not pursued. When poorly constructed, these laws place an undue burden on people with disabilities and potentially even may prevent people who require a service animal from obtaining one. Additionally, involvement with the criminal justice system is also severe for the person and the service or support animal. Since there would be a question about the individual's disability, especially if not an obvious disability, they may not receive disability accommodations if arrested or thrown in jail. The animal may be sent to a shelter or the pound, which is often stressful for the animal and could be financially imposing upon the owner to get his or her animal back from custody. For the sake of brevity, we strongly suggest

reviewing the article by Tiffany Lee for a further list and discussion of other significant harms from criminalization laws. See in particular Section 5, pages 342 to 351. And I have access-- that footnote is footnote 1 in my testimony, which I emailed to all of your offices a little while ago. The US Department of Housing and Urban Development and the US Department of Justice have provided guidance documents in 2004 and again and most recently in 2018, which explain the rights and responsibilities that are existing under federal law for both individuals and landlords regarding service and support animals. Read together, these documents provide a clarity and offer best practices that can be used by both individuals using service animals, those requesting a reasonable accommodation for a support animal, and for landlords when faced with this issue. These guidance documents answer directly and give best-practice answers to many of the issues raised in previous legislative hearings on this issue. For example, how to handle documentation from the Internet, that's page 11, requests for unique types of support animals, page 13, and how to handle observable and nonobservable disabilities, page 9. The joint 2004 guidance provides a more theoretical overview of the parameters set out in the Fair Housing Act and the Americans with Disabilities Act. There are natural checks built into the federal laws involved in this issue. Along with HUD, we firmly believe education, clarifying the rights and responsibilities in the existing federal law, and following the guidance set forth by the DOJ and HUD is the optimal approach. Education serves as the most appropriate deterrent. And with that, I will be happy to answer any questions the committee may have.

HOWARD: Thank you. Are there questions from the committee? All right, not seeing any, thank you for your testimony today. Our next testifier is Roxann Hamilton, a guide dog handler. Welcome, Roxann.

ROXANN HAMILTON: Hello, my name is Roxann Hamilton, R-o-x-a-n-n H-a-m-i-l-t-o-n. I live in Bellevue, Nebraska, and I'm here to share my thoughts on this bill. I have used a service dog since 1998 for a multitude of disabilities that I have-- I began acquiring as I aged. I presently use two service dogs. They're not guide dogs, they are service. One is for hearing and mobility; the other is a medical response-- a trained medical response dog. I have actually trained service dogs since 1988 when I had a child with cerebral palsy that desperately wanted to run and play and scamper like other little boys and we trained our family dog, Brownie [PHONETIC], to accompany him and this was prior to the ADA on service dogs. So I'm quite experienced on a national level as well as a Nebraska level with giving advice, instruction to businesses, landlords, schools, and any

entity or person that needs information on exactly what a service dog is and what training they are expected to have. I would like to mention that the business-- businesses online that have developed providing certifications and registrations for service animals is completely bogus and it just-- that just doesn't exist. The federal government requires no certification and no registration of service animals. The only registration bringing a service animal to the attention of a local government would be during the animal licensing-- dog-licensing situation where most states allow no fee for a dog license if you have a service dog. And with that request, it is common, just like living in an apartment complex, that you have a statement of need, a statement of disability provided by your treating physician. And that verifies, basically, that, yes, that is a service dog that mitigates a per-- my, my personal or your personal disabilities. The other thing that needs to be mentioned is, again, I did research all 50 states and I found well over half of them have service dog fraud laws that clearly define a service dog function and when-- what is not a verification of disability or need. And it has been determined that the online purchases of certification and registration are actually bogus and they're illegal because people will buy them if they are not informed. Also, businesses, landlords, churches, other places of business or of public access, they also believe those because they look very official. They are quite expensive, usually around $350 to $600 to get a slip of paper that is bogus and meaningless. What has happened to me as a service dog handler repetitively is that dogs that live in public housing, private housing, private landlord housing, large complex housing, dogs are sometimes passed as a service dog when they actually are not. And I can, I can attest that my service dogs have been attacked and harassed a minimum of 1,200 to 1,500 times within the last six years. Two of those times resulted in me falling down a hill. Each time resulted in an ambulance to the emergency room, hospitalization, treat-- emergency treatment, and physical and occupational therapy that I'm still going through for a, a torn rotator cuff, different sprains, and a head injury. And I would like to see a halt for-- in Nebraska for accepting these certifications that state on pretty paper and a beautiful certificate that the dog is a bona fide trained service animal. Let's see-- so what--

HOWARD: Roxann, I'm going to invite you to wrap up your final thoughts.

ROXANN HAMILTON: OK, just-- I, I would like the landlords also to be better trained, as Brad mentioned, in the differences between ESAs and SSDs or SAs and keep up with the FHAA and ADA rulings on, on law.

HOWARD: Wonderful, thank you.

ROXANN HAMILTON: [INAUDIBLE]

HOWARD: Are there any questions from the committee? Senator Walz.

WALZ: Thank you. Thanks for coming, everybody. I, I kind of want to go back to the time that you go and you get your dog tagged and licensed.

ROXANN HAMILTON: Um-hum.

WALZ: So is there a definition or a designation at that time when you go to get your dog licensed; and if there is, where do they get that definition from, do you know?

ROXANN HAMILTON: Federal law. Federal law-- ADA states that there cannot be any taxation or fee posed upon a service dog handler to have a service dog work for them, accompany them in public places or in housing and that actually was not followed in Nebraska. And in 2009, I worked-- I proposed a bill with Senator Wallman and he proposed that-- to, to have that discussed in committee. And it was passed that service dogs do not have to pay any fee or-- I mean, the owner of a service dog does not have to pay a fee or taxation to have it. But what I do, because that's what I have learned to do, is I submit my reasonable accommodation letter from my current treating physicians or specialists that, you know, determine whether or not I would require a service dog to live independently and I present that to the humane society. Since I live in Sarpy County, I go into Douglas County to the humane society. And when I lived in Lincoln, I also just got my license and I presented my letter of documentation of disability and need. And then my dog licenses, service dog licenses are authorized without a fee.

WALZ: OK, thank you.

ROXANN HAMILTON: OK.

HOWARD: All right, other questions? OK, seeing-- oh, Senator Williams, did you have a question? No. OK. It's hard to tell when people raise their hands up. All right, seeing none, thank you so much for visiting with us today. We really appreciate you taking the time. And Roxann

was our last testifier for today. Senator Lindstrom, you are welcome to close.

LINDSTROM: All right, just in the nick of time, I got about ten minutes before it gets a little chaotic around here with the kids coming home from school. I crossed my fingers that we could get it done, so that's good. No, I appreciate everybody testifying today. What-- an interesting thing that has transpired over the last week is Senator Clements also has a constituent who has had some issues regarding service animals and, and looking at getting some laws changed that way. In light of COVID and, and because of our process with having a hearing, I, I think what we'll probably do and I've talked to Senator Clements about this, is that we'll work together on one bill that addresses these issues so that we don't have competing bills. So as we move into session, I think Senator Clements has, has stated to me that he would look at carrying the bill, then I would help and cosponsor and sign on. So that's where it stands right now and then any feedback that we can get from the committee and any changes or what, what you're looking at, we'd be more than happy to make those changes. So thank you for having me today, always good to be in front of HHS.

HOWARD: Thank you. Are there any final questions for Senator Lindstrom? All right, seeing none, thank-- oh, Senator Murman--

MURMAN: Sorry.

HOWARD: --in at the last minute.

MURMAN: I've got to apologize. I've been having a few medical issues. It's non-- not COVID related, so don't worry about that, nothing serious either, but I had-- so I missed part of it, I apologize. I was just wondering is this something that needs to be-- there should be laws at the federal, federal level rather than the state level? And maybe that was discussed during the hearing. It just seems like, you know, it'd be good to have it more uniform all around the country.

LINDSTROM: Yeah and we, we will-- I assume that question is for me. Yeah, we will look at that. I know in my testimony, I mentioned about 30 states have something that, that details that, but we'll work with the different groups in Nebraska. I know they often take the policies and the structure from the federal side, so we'll try to keep it as uniform as possible. But like any state law, we'll, we'll try to

tailor it the best for Nebraskans if, if that is something, is something that we need to do.

MURMAN: Thank you.

HOWARD: Perfect. All right, any final questions for Senator Lindstrom? All right, seeing none, this will close the hearing for LR348. And then just a reminder, I will-- we will see each other back on Zoom on Tuesday, December 15, at 10 a.m. for Senator Stinner's interim study about prescribing psychologists, should be a wild one. Have a great weekend, everybody, and I'll see you next week.