ONE HUNDRED SEVENTH LEGISLATURE - FIRST SESSION - 2021
COMMITTEE STATEMENT
LB626

Hearing Date: Friday February 19, 2021
Committee On: Health and Human Services
Introducer: Vargas
One Liner: Change provisions of the Child and Maternal Death Review Act

Roll Call Vote - Final Committee Action:
Advanced to General File with amendment(s)

Vote Results:

Aye:	7	Senators Arch, Cavanaugh, M., Day, Hansen, B., Murman, Walz, Williams
Nay:		
Absent:		
Present Not Voting:		

Oral Testimony:

Proponents:	**Representing:**
Tony Vargas	Introducer
Teresa Berg	Self
Opponents:	**Representing:**
Neutral:	**Representing:**

Submitted Written Testimony:

Proponents:	**Representing:**
Spike Eickholt	ACLU of Nebraska
Opponents:	**Representing:**
Neutral:	**Representing:**

Summary of purpose and/or changes:
LB 626 would separate the State Child and Maternal Death Review Teams into [1] the State Child Death Review Team and [2] the State Maternal Death Review Team. The bill provides for the membership of each team, require DHHS to provide a team data abstractor for each team, and provides new duties for the State Maternal Death Review Team.

Core Members of Both Teams
Under LB 626, the core members would serve on both teams. The core members would be: [1] a physician employed by DHHS, [2] a forensic pathologist, [3] a law enforcement representative, [4] a mental health provider, and [5] an attorney.

Members of the State Child Death Review Team

Required members of the State Child Death Review Team would include [1] the Inspector General of Nebraska Child Welfare and [2] a senior staff member with child protective services of DHHS. The remaining members may include [1] a county attorney, [2] an FBI agent responsible for investigations on Native American reservations, [3] a social worker, and [4] members of organizations which represent hospitals or physicians. [Sec. 2, page 4, lines 4-12.]

Members of the State Maternal Death Review Team

The members appointed to the State Maternal Death Review Team may include [1] county attorneys, [2] representatives of tribal organizations, [3] social workers, [4] medical providers, and [5] community advocates. In appointing members to the State Maternal Death Review Team, the CEO of DHHS shall consider members working in and representing communities that are diverse with regard to race, ethnicity, immigration status, and English proficiency and include members from differing geographic regions in the state, including both rural and urban areas. [Sec. 2, page 4, lines 13-22.]

State Maternal Death Review Team Duties

LB 626 would require the State Maternal Death Review Team to review the maternal death case abstracts in accordance with evidence-based best practices in order to determine: [a] If the death is pregnancy-related; [b] the cause of death; [c] if the death was preventable; [d] the factors that contributed to the death; [e] recommendations and actions that address those contributing factors; and [f] the anticipated impact of those actions if implemented. [Sec. 5, page 9, lines 13-18.]

Team Data Abstractor

LB 626 would require DHHS to provide a team data abstractor for each team. [Sec. 2, page 4, lines 2-3.] The team data abstractor provided shall:

- Possess qualifying nursing experience, a demonstrated understanding of child and maternal outcomes, strong professional communication skills, data entry and relevant computer skills, experience in medical record review, flexibility and ability to accomplish tasks in short time frames, appreciation of the community, knowledge of confidentiality laws, the ability to serve as an objective unbiased storyteller, and a demonstrated understanding of social determinants of health;

- Request records for identified cases from medical, government, educational, law enforcement, and social service agency sources;

- Upon receipt of such records, review all pertinent records to complete fields in child and maternal death data bases;

- Summarize findings in a maternal death case summary; and

- Report all findings to the team coordinators.

[Sec. 4, page 7, lines 16-31.]

Explanation of amendments:

AM 642 clarifies certain ambiguities in LB 626 as introduced.

As introduced, LB 626 provided that a physician employed by DHHS would serve as the chairperson of the team, however, the separation of the Child Death Review Team and the Maternal Death Review Team created an ambiguity as to which team the DHHS physician would chair. The amendment clarifies this ambiguity by providing that each team shall annually elect a chairperson from among its members.

AM 642 clarifies that the Inspector General of Child Welfare and senior staff member with child protective services shall be permanent members of the Child Death Review Team and that the DHHS physician shall be a permanent member of the maternal death team. All other members shall serve four-year terms.

Additionally, AM 642 clarifies that each team shall submit an annual report to the Legislature.

Finally, based on the suggestion of the introducer, AM 642 strikes the fifteen-member maximum for each team and adds certain suggested occupations which may be considered for appointment to the Maternal Death Review Team, including obstetrics, maternal-fetal medicine, public health, community birth workers, community advocates, and anesthesiology.

John Arch, Chairperson