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DEPT. OF HEALTH AND HUMAN SERVICES

Division of Public Health

Nebraska Child Death Review Report

Prepared in Accordance with Nebraska Revised Statute 71- 3407

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Pete Ricketts, Governor

February 2, 2023

Clerk of the Legislature
Legislative Fiscal Office
P.O. Box 94604
Lincoln, NE 68509

Dear Clerk of the Legislature:

In accordance with Neb. Rev. Stat. 71-3407, the Division of Public Health submits this report for the Nebraska Child and Maternal Death Review Team.

This Child Death Review Team Report presents an in depth look at the manner and cause of infant and child deaths in the State of Nebraska, and key recommendations for prevention from the Child Death Review Team.

Sincerely,

Charity Menefee
Director of Public Health
Nebraska Department of Health and Human Services

Nebraska Child Death Review Report

Office of Maternal and Child Health
Epidemiology

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Contents

Background

The Nebraska Child and Maternal Death Review Team (CMDRT) was established by the Nebraska Legislature in 1993 and charged with undertaking a comprehensive, integrated review of existing records and other information regarding each child death. At that time, the Nebraska Commission for the Protection of Children found that about 300 children died each year in the state, but that there was no systematic process in place for consistent review of those deaths to determine contributing circumstances.

> *The Legislature finds and declares that it is in the best interests of the state, its citizens and especially the children of this state that the number and causes of death of children in this state be examined. There is a need for a comprehensive integrated review of all child deaths in Nebraska and a system for statewide retrospective review of existing records relating to each child death. §71-3404 Neb. Rev. Stat.*

The purpose of the CMDRT includes developing an understanding of the number and causes of child deaths, and advising the Governor, Legislature, other policymakers and the public on changes that might prevent them in the future. All child deaths are reviewed, not just "suspicious" or violent ones. The team uses information in written records and the expertise of its members to identify situations where, in retrospect, reasonable intervention might have prevented a death. Members of the original team determined that the specific goals of these reviews would be to:

- Identify patterns of preventable child deaths;
- Recommend changes in system responses to child deaths;
- Refer to law enforcement newly-suspected cases of abuse, malpractice, or homicide; and,
- Compile findings into reports designed to educate the public and state policymakers about child deaths.

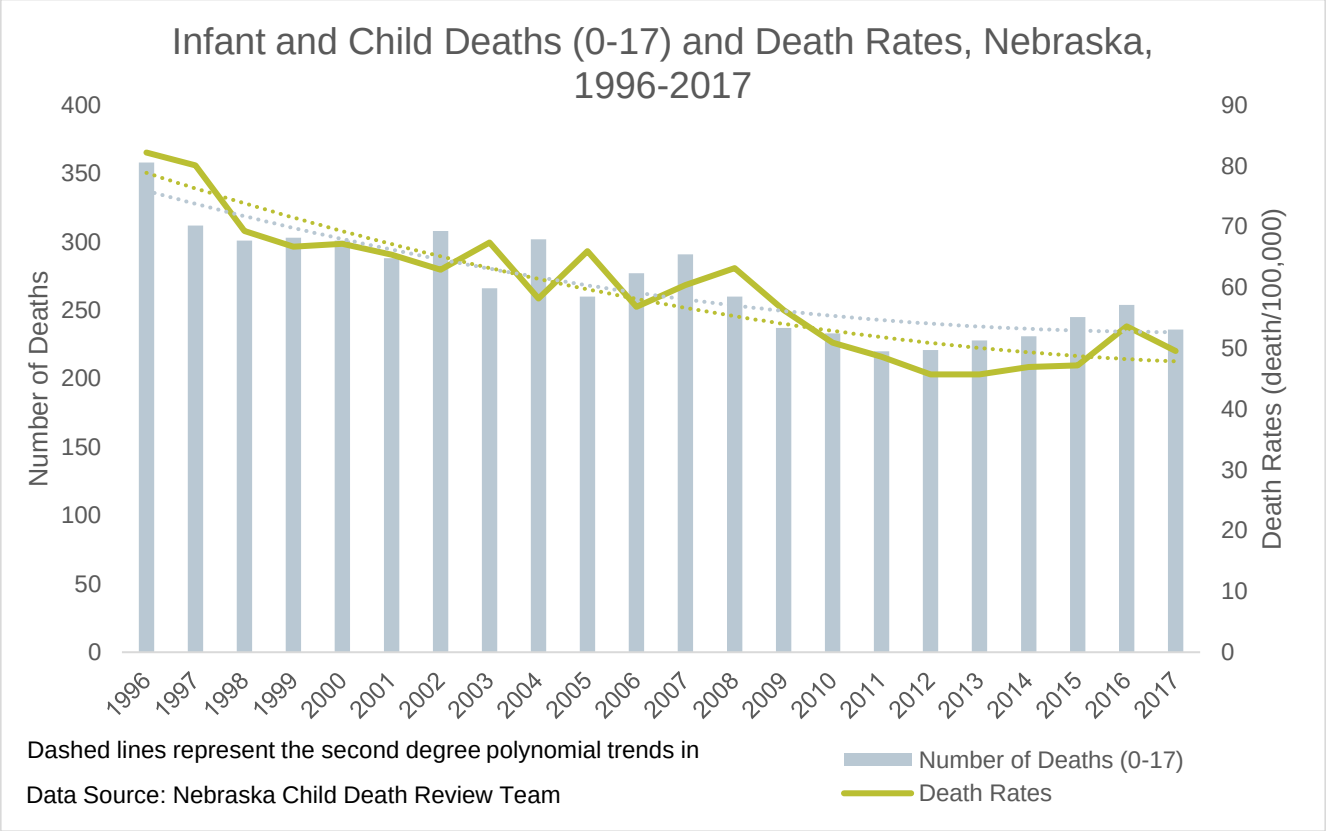
This report presents the findings and recommendations of the Nebraska Child Death Review Team (CDRT), a subset of the CMDRT, based on the review and tabulation of the deaths of Nebraska-resident children (newborns through age 17) known to have occurred during 2014 through 2017. The belief that "things will happen" ignores the reality that many of these deaths could have been prevented.

The CDRT timeline is four-step process and takes approximately 36 months to complete. CDRT staff receive finalized birth and death files approximately nine months after the end of a calendar year. When all cases are identified, records are requested and collected from medical providers, autopsy results, law enforcement agencies, motor vehicle crash records, schools, Child and Family Services records, and any other entities necessary. The record obtainment stage takes approximately nine additional months. When all records required to review a case have been obtained, cases are reviewed by expert, volunteer committee members. These individual case reviews can take anywhere from thirty minutes to eight hours per case to review in depth, and the overall process of reviewing one years' worth of child death cases takes approximately nine more months. The final step in the CDRT timeline is an approximately nine-month report generation phase, which encompasses committee member crafting of recommendations, data analysis, report writing, and report approval.

Child Death in Nebraska

A total 966 Nebraska children ages 0 to 17 died from 2014 through 2017 (Figure 1). Although the overall historical trend has been towards fewer deaths, the rate of death among infants and children combined has been slowly increasing since 2012. The infant mortality rate has remained fairly stable over the last ten years (Figure 2) while the child mortality rate has seen decreases during that time (Figure 3).

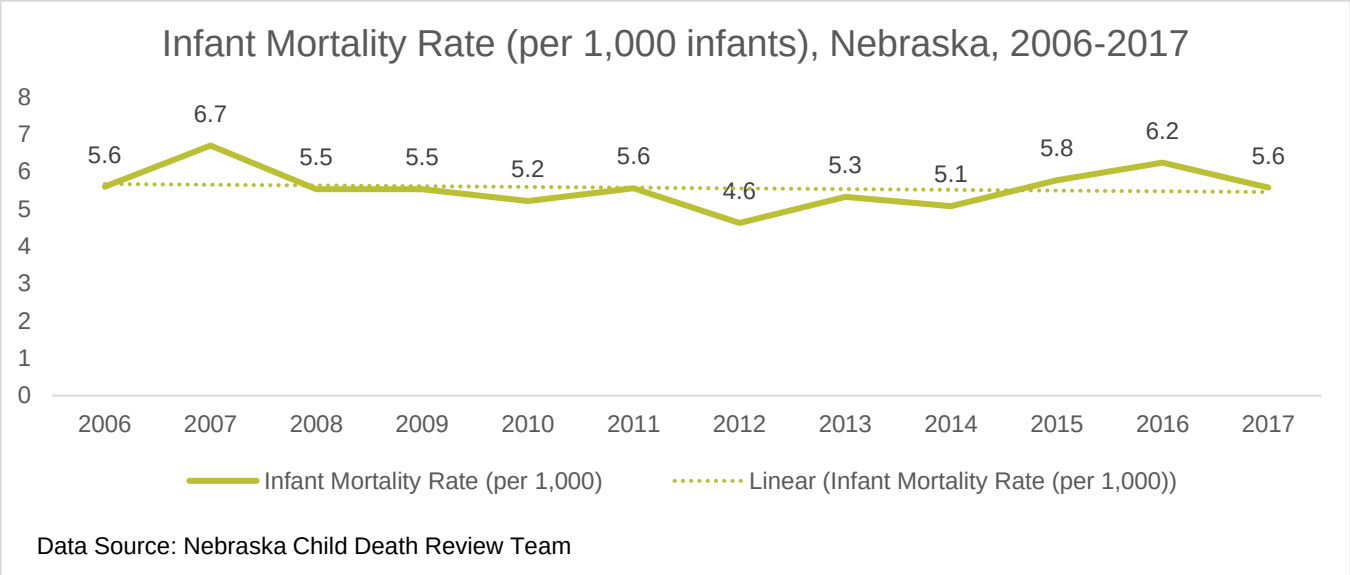
FIGURE 1



Dashed lines represent the second degree polynomial trends in

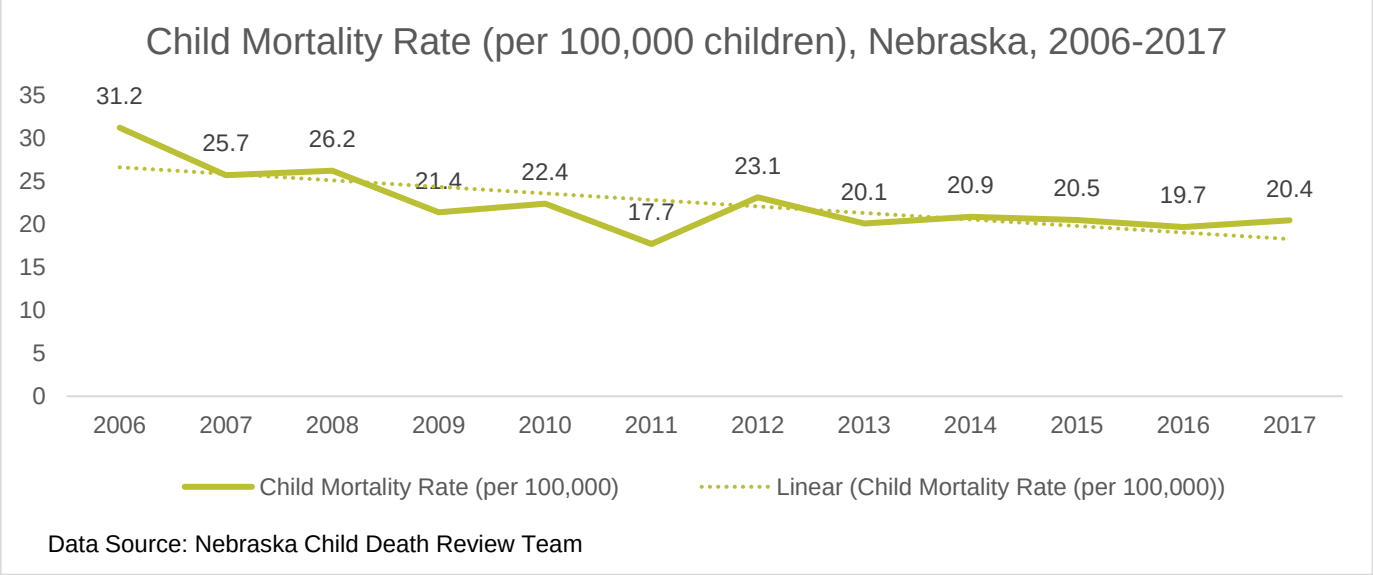
Data Source: Nebraska Child Death Review Team

FIGURE 2



Data Source: Nebraska Child Death Review Team

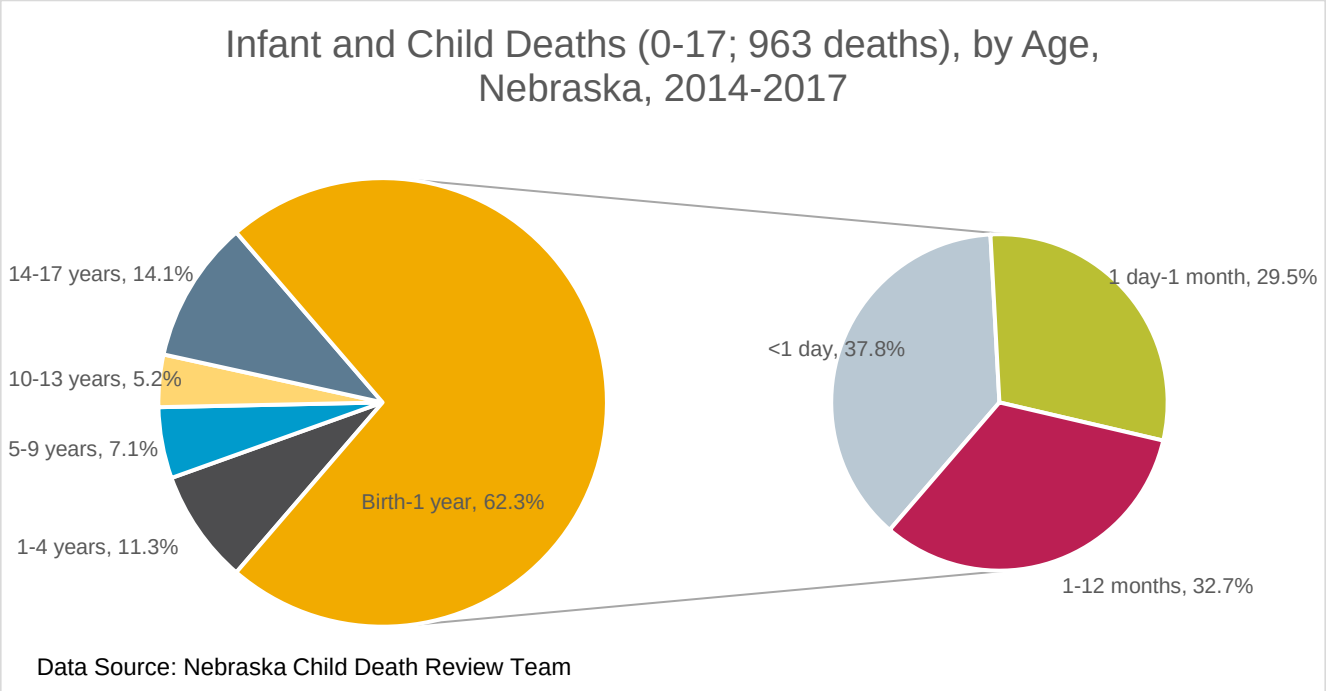
FIGURE 3



Data Source: Nebraska Child Death Review Team

Infants (less than 12 months old) accounted for 62% of all child deaths; 67% of those infant deaths occurred during the first month of life (Figure 4). Among children at least 1 year old, the largest proportion of the deaths was among ages 14–17.

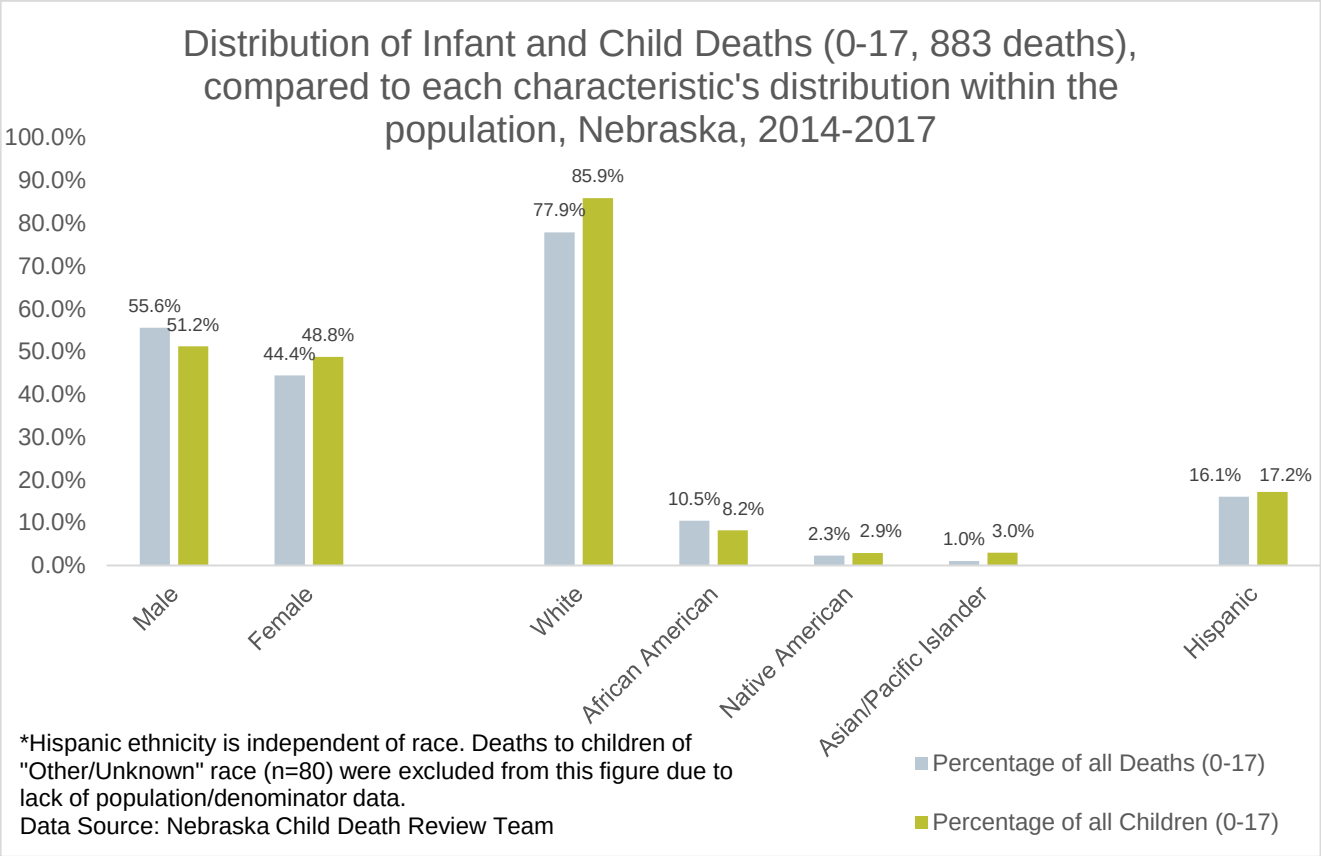
FIGURE 4



Data Source: Nebraska Child Death Review Team

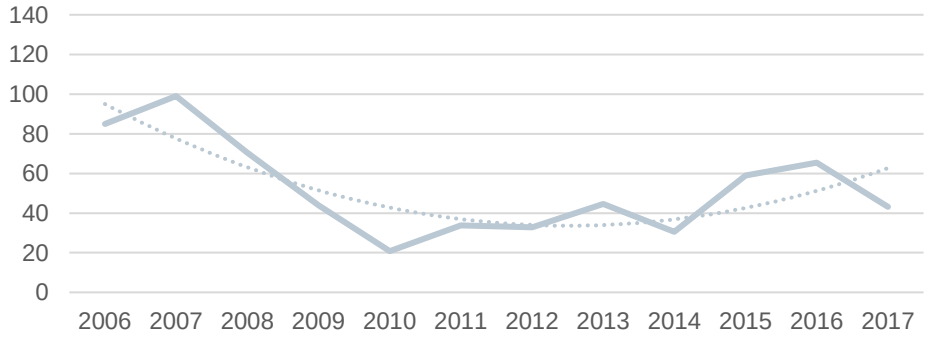
White children made up the vast majority (86%) of deaths from 2014-2017 (Figure 5). Figure five demonstrates the distribution of infant and child deaths in Nebraska compared to the percent of the child population represented in each characteristic. Mortality rates among American Indian and Asian/Pacific Islander children have been increasing in recent years, while rates among White and Hispanic children remain fairly stable and rates among African-American children have seen an overall reduction since 2006 that has recently slowed (Figure 6, Figure 7, Figure 8, Figure 9).

FIGURE 5



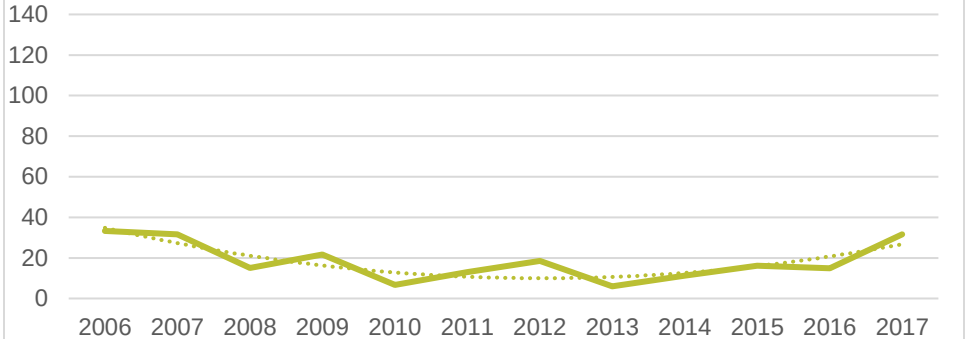
*Hispanic ethnicity is independent of race. Deaths to children of "Other/Unknown" race (n=80) were excluded from this figure due to lack of population/denominator data.
Data Source: Nebraska Child Death Review Team

FIGURE 6



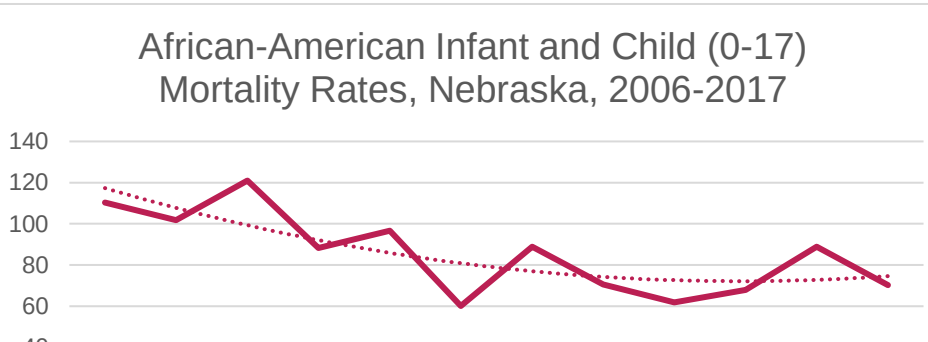
Data Source: Nebraska Child Death Review Team

FIGURE 8



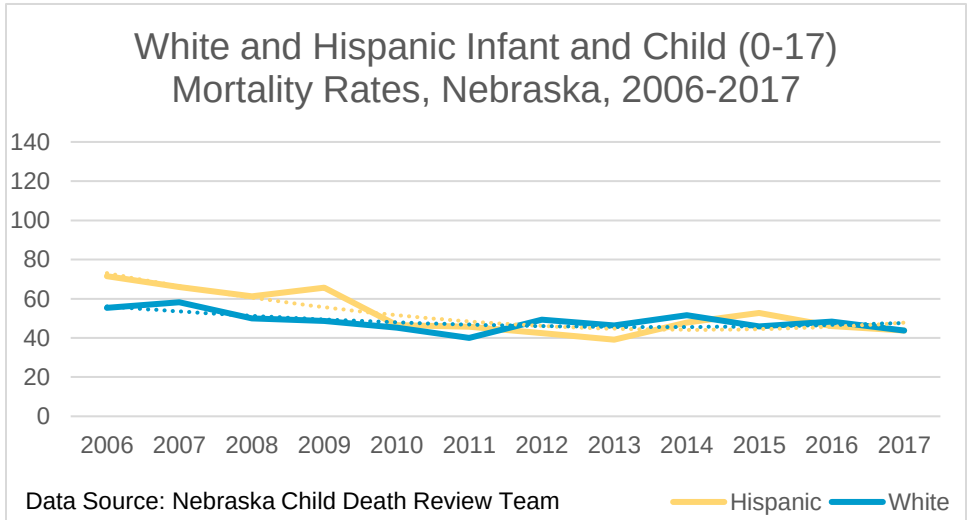
Data Source: Nebraska Child Death Review Team

FIGURE 7



Data Source: Nebraska Child Death Review Team

FIGURE 9



Data Source: Nebraska Child Death Review Team

Preventable child or maternal death means the death of any child or pregnant or postpartum woman which reasonable medical, social, legal, psychological, or educational intervention may have prevented. Preventable child or maternal death includes, but is not limited to, the death of a child or pregnant or postpartum woman from (a) intentional and unintentional injuries, (b) medical misadventures, including untoward results, malpractice, and foreseeable complications, (c) lack of access to medical care, (d) neglect and reckless conduct, including failure to supervise and failure to seek medical care for various reasons, and (e) preventable premature birth. §71-3405 Neb. Rev. Stat.

Preventability

Child death review committee members individually assessed whether each death was preventable on a five-point scale, from “strongly disagree” to “strongly agree.” For cases that occurred due to natural or medical causes, members assessed whether standard-of-care medical management would have changed the circumstances that led to death. For non-medical cases, such as unintentional and intentional injury deaths, members assessed whether an individual or community could reasonably have done something that would have changed the circumstances that led to death.

In 2014 - 2017, 299 (31.0%) child deaths were determined to be preventable through committee review. In rare cases, the committee may determine an underlying cause of death to be different from what was listed on the death certificate. The causes of death categories with highest percentages of preventable deaths included motor vehicle crashes (MVC), unintentional injuries, suicides, and Sudden Unexplained Infant Deaths (SUID) (Figure 10).

FIGURE 10

Deaths Among Nebraskan Children Ages 0-17, 2014-2017			
Underlying Cause of Death 2014-2017	**Deaths (n)**	**Preventable Deaths (n)**	**Preventable Deaths (%)**
Pregnancy Related	257	20	7.8%
Preterm Birth	142	10	7.0%
Maternal Complications	66	2	3.0%
Complications of Labor & Delivery	10	1	10.0%
Other Pregnancy & Neonatal-Related Conditions	39	7	17.9%
Birth Defects / Inherited & Chromosomal Disorders	216	2	0.9%
Sudden Unexpected Infant Death (SUID)	110	80	72.7%
Infectious, Chronic & Other Medical Conditions	127	22	17.3%
Motor Vehicle Crash (MVC)	69	68	98.6%
Suicide	51	39	76.5%
Cancer / Neoplasms	52	0	0.0%
Non-MVC Unintentional Injuries	36	29	80.6%
Child Abuse and Intentional Injury	31	17	54.8%
Undetermined	15	2	13.3%
Total (N)	**964**	**299**	**31.0%**
Underlying cause of death is derived from the Death Certificate. Preventability is determined through committee review, and therefore small numbers are not suppressed.			

Primary Causes of Child Death

Approximately 27% of all child deaths in 2014 through 2017 were attributed to perinatal conditions, a combination of maternal complications during pregnancy, complications of labor and delivery, preterm birth, and other conditions specific to pregnancy and the neonatal period (Figure 11). Some of these children survived into their teen years, yet the underlying problem originated during pregnancy or soon after birth. Deaths were attributed to preterm birth *only* if no specific cause or indication for preterm delivery could be identified.

Birth defects were the second most common underlying cause of death (22%). The lethal defects were detected anywhere from prenatally through the teen years. Third most common (11%) were sudden unexplained infant deaths (SUID). These deaths encompassed a variety of circumstances; however, all involved the infant being in an unsafe sleep environment.

FIGURE 11

Deaths Among Nebraskan Children Ages 0-17, 2014-2017										
Underlying Cause of Death	**2014**		**2015**		**2016**		**2017**		**2014 - 2017 TOTAL**	
	(n)	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**	**%**	**(n)**	**%**
Pregnancy Related	56	24.6%	70	28.6%	80	31%	51	22%	257	26.7%
Preterm Birth	31	55.4%	46	65.7%	38	48%	27	53%	142	55.3%
Maternal Complications	25	44.6%	15	21.4%	18	23%	8	16%	66	25.7%
Complications of Labor & Delivery	0	0.0%	-	-	-	-	0	0%	10	3.9%
Other Pregnancy & Neonatal-Related Conditions	0	0.0%	-	-	-	-	16	31%	39	15.2%
Birth Defects / Inherited & Chromosomal Disorders	62	27.2%	64	26.1%	48	19%	42	18%	216	22.4%
Sudden Unexpected Infant Death (SUID)	24	10.5%	27	11.0%	32	13%	27	11%	110	11.4%
Infectious, Chronic & Other Medical Conditions	27	11.8%	22	9.0%	24	9%	54	23%	127	13.2%
Motor Vehicle Crash (MVC)	16	7.0%	19	7.8%	13	5%	21	9%	69	7.2%
Suicide	16	7.0%	10	4.1%	14	6%	11	5%	51	5.3%
Cancer / Neoplasms	-	-	14	5.7%	-	-	18	8%	52	5.4%
Non-MVC Unintentional Injuries	8	3.5%	9	3.7%	12	5%	7	3%	36	3.7%
Child Abuse and Intentional Injury	10	4.4%	-	-	11	4%	-	-	31	3.2%
Undetermined	-	-	-	-	-	-	-	-	15	1.6%
Total (N)	**228**	**100.0%**	**245**	**100.0%**	**254**	**100%**	**237**	**100%**	**964**	**100.0%**
Deaths Related to Child Neglect (independent of underlying cause of death)	11	4.8%	10	4.1%	17	6.7%	31	13.1%	69	7.2%

-Numbers are not shown (suppressed) if there are between 1 and 5 deaths for that category.

Priority Recommendations

In late 2021 and early 2022, the Child Death Review Team convened to discuss recommendation development. Three teams were formed to focus on recommendations related to unintentional injury, intentional injury, and perinatal infant/early childhood health. Fifteen recommendations were put forth by the committee, which are outlined in this report.

Additionally, two systems-level needs were discussed by the team and should be considered when addressing the recommendations: health equity and data collection improvement. Programs focused on identified recommendations should discern the appropriate application of the systems-level needs as well.

- Health Equity, the assurance that everyone has the opportunity to be as healthy as possible, should be forefront when addressing any of the prioritized recommendations. Certain groups of people are at higher risk of negative health outcomes. It is possible to make progress toward health equity in public health practice by implementing equity-informed frameworks and strategies while addressing each recommendation. Ongoing monitoring and improvement of public health outreach materials and programs targeted to diverse audiences is required.
- Improved data collection is another key theme under any of the priority recommendations. Effective public health surveillance systems are accurate, complete, consistent, timely, valid, and unique, and can improve the health of populations. In particular, consistent documentation of the medical and non-medical circumstances and causes of child deaths is essential to develop and implement prevention programs. Data-driven decision-making will be most effective when forethought and resources are devoted to data collection, storage, analysis, and dissemination. No matter the data source, continuous improvements are possible to create greater public health impact.

Unintentional Injury

Motor Vehicle Crashes

Strengthen the Graduated Driver's License Provisions

Uniformly enforce enhanced sentencing for Driving Under the Influence with a child in the vehicle

Justification

The Traffic Injury Research Foundation (TIRF) established a Graduated Driver License (GDL) best practice framework that states are recommended to implement to reduce the elevated crash risk of teen drivers[1]. The TIRF report recommends GDL provisions be listed as primary enforcement rather than secondary enforcement, which Nebraska currently employs. Additionally, the Insurance Institute for Highway Safety (IIHS) crash reduction calculator estimates if Nebraska 1) increased the permit age, 2) increased number of practice driving hours, 3) increased the license age, and 4) tightened night time driving restrictions, the overall estimate of collision claims would be reduced by 26% and fatal crashes by 31%[2]. Nebraska loses at least half a million dollars in annual funding because of the existing underage licensing law provisions.

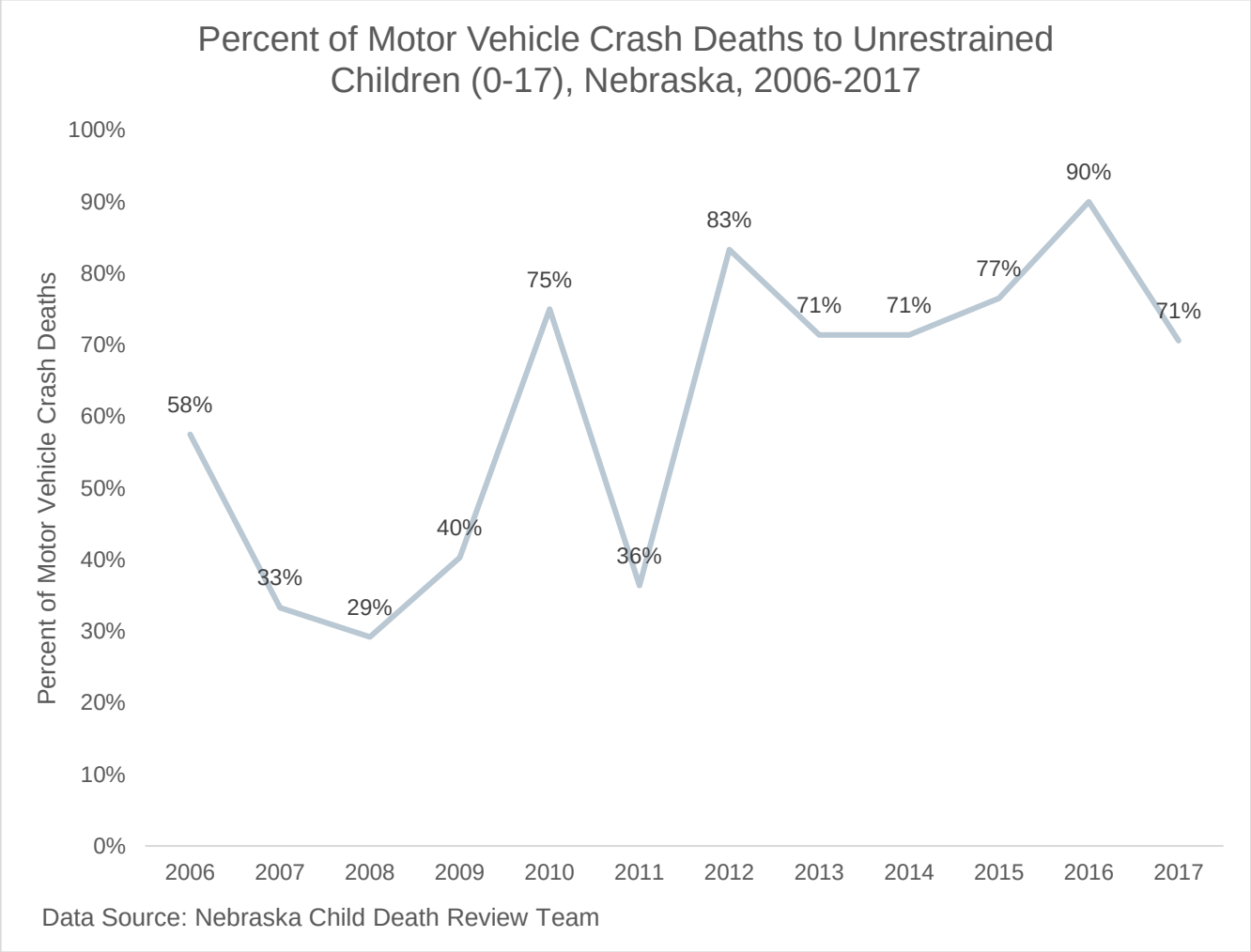
While these reports and frameworks provide evidence for best practice among new drivers with restricted licenses, the enforcement of laws specific to these drivers can be challenging in practice. It is difficult for enforcement agents to determine the age of a driver in order to know if they have a GDL. Some states require teens with intermediate licenses to display a decal on their vehicle to denote their status, however, if a driver utilizes several shared vehicles, this may be difficult to adhere to.

Therefore, to reduce the number of fatalities due to teen crashes, the Nebraska Legislature should support the upgrade of mobile use restriction among all drivers and safety belt use among all vehicle occupants should be upgraded from secondary to primary enforcement. Between 2014 and 2017, 70-90% of childhood motor vehicle crash deaths were unrestrained (Figure 12).

It is a felony for Nebraskans to drive under the influence of drugs or alcohol with a child in the car under a 2012 law that defines that act as DUI child endangerment, even when it is a first offense. Those convicted of Driving Under the Influence (DUI) with a child in the vehicle should uniformly have enhanced sentencing, however, these sanctions are not uniformly enforced. Mothers Against Drunk Driving (MADD) and other court monitors should advocate for enhanced sentencing for drivers convicted of DUI with a child in the vehicle.

[1] Traffic Injury Research Foundation; https://gdlframework.tirf.ca/
[2] Insurance Institute for Highway Safety; https://www.iihs.org/topics/teenagers/gdl-calculator

FIGURE 12



Data Source: Nebraska Child Death Review Team

Drowning and Fire

Strengthen and promote local ordinances on pool fencing and barriers

Develop and distribute family-oriented, multilingual drowning prevention materials during pool inspections

Distribute home smoke detectors to low-income residents

Justification

Barriers such as four-sided pool fencing helps prevent children from accessing a pool without a guardian's knowledge; use of such fencing reduces a child's risk of drowning by 83% compared to three-sided pool fencing[3]. The Child Death Review Team recommends Nebraska DHHS complete a study into which localities have pool ordinances requiring four-sided pool fencing. After a list is compiled, injury prevention experts across the state should strengthen and promote existing ordinances and address barriers in localities without strong policies.

Safe Kids Worldwide reports an overall reduction in childhood drowning deaths nationwide, due in part to increased parental education and community awareness, however drowning still remains a leading cause of unintentional childhood injury death[4]. Nebraska Safe Kids coalitions should continue to educate caregivers and communities through distribution of family-oriented, multilingual drowning prevention materials from Safe Kids Worldwide for baths, pools, and natural bodies of water.

The National Fire Protection Association reports that sixty percent of home fire deaths occur in homes with no working smoke alarms[5]. To decrease the number of Nebraskan homes without working smoke alarms, Nebraska DHHS and local health departments should promote culturally appropriate, multilingual smoke alarm outreach materials statewide such as those found on the United States Fire Administration outreach website.

Due to small numbers, no table or figure is presented with the justification for these recommendations. The team continues to prioritize efforts related to drowning and fire due to the high percentage of such deaths that are preventable with implementation of straightforward recommendations.

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[3] Centers for Disease Control and Prevention; https://www.cdc.gov/drowning/facts/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fhomeandrecreationalsafety%2Fwater-safety%2Fwaterinjuries-factsheet.html

[4] Safe Kids Worldwide; https://www.safekids.org/research-report/dangerous-waters-research-report

[5] National Fire Protection Association; https://www.nfpa.org/Public-Education/Teaching-tools/Community-tool-kits/Keeping-Your-Community-Safe-and-Sound

Safe Sleep

Update and expand family, community and provider-level promotion of infant safe sleep practices in all of the state's birthing hospitals safe sleep champions

Adopt and routinely complete Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) and Training

Justification

The number of infants dying of Sudden Unexpected Infant Deaths (SUID) has remained relatively stable over the past two decades. In years 2014-2017, 111 infants died of SUID (Figure 13). Three out of every four SUID deaths occurred in situations with identifiable risk factors: 62 of the deaths had bedding-related issues, 50 included an age-inappropriate bed surface, and 47 infants were found on their side or stomach (Figure 14). Mitigation of unsafe sleep practices can help prevent future avoidable infant deaths.

The American Academy of Pediatrics safe sleep recommendations updated in 2022 discuss 10 sets of risks and protective factors in creating a safe sleep environment and address ethnic and racial disparities in SUID rates particularly for African American infants[6]. Specific recommendations for safe sleep practices include infants sharing a bedroom with a parent—sleeping close to the parents' bed but on a separate surface designed specifically for infants. Nebraska's birthing hospitals can commit to becoming Safe Sleep Hospital Champions in order to reduce the disparities in SUID numbers across Nebraska's diverse populations[7].

In 2021, a Nebraska-specific Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF)[8] and corresponding training were developed for use by Law Enforcement, First Responders, Investigators, County Attorneys and their Designees, and Forensic Pathologists. The training is free, self-paced, and outlines the importance of documenting the SUID death as well as how to effectively complete the SUIDIRF[9]. The adoption and completion of this training and the SUIDIRF is imperative to understand fully the potential prevention efforts to reduce future SUID deaths.

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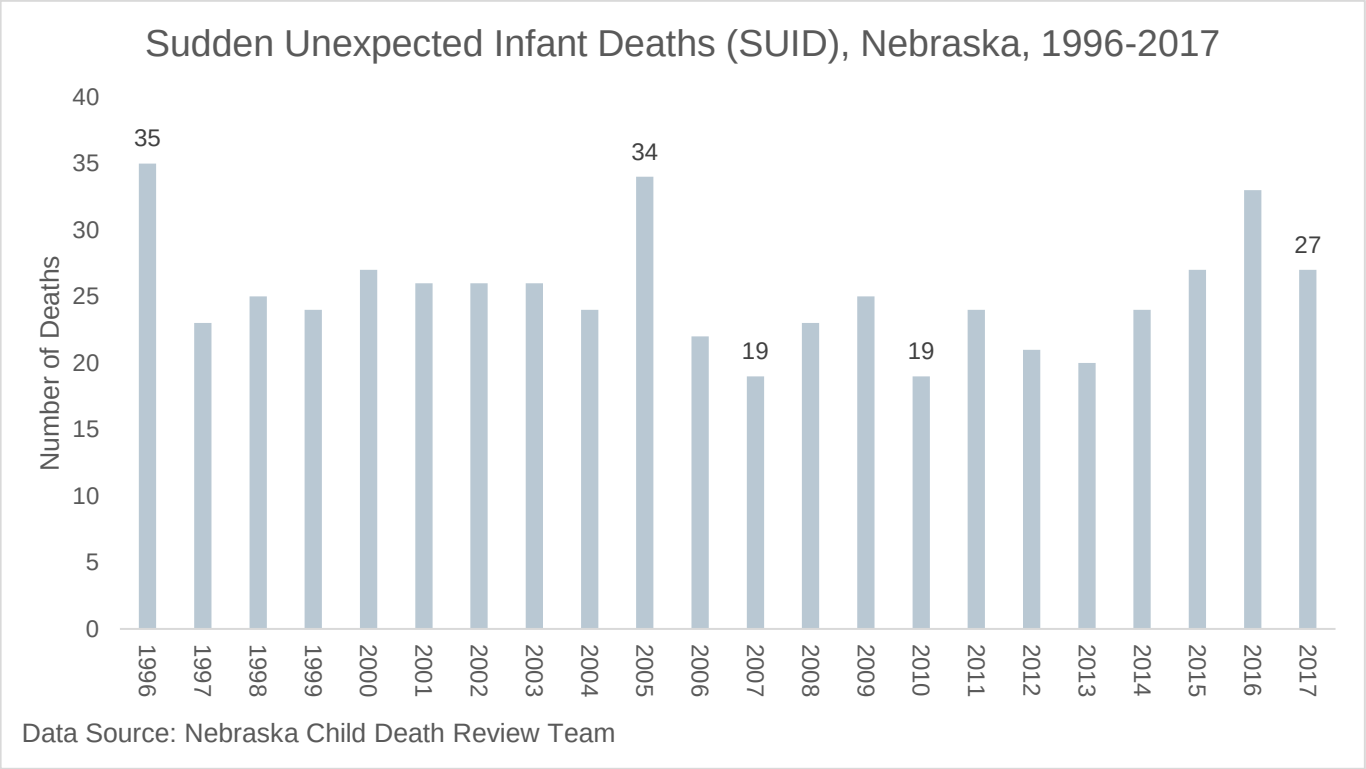
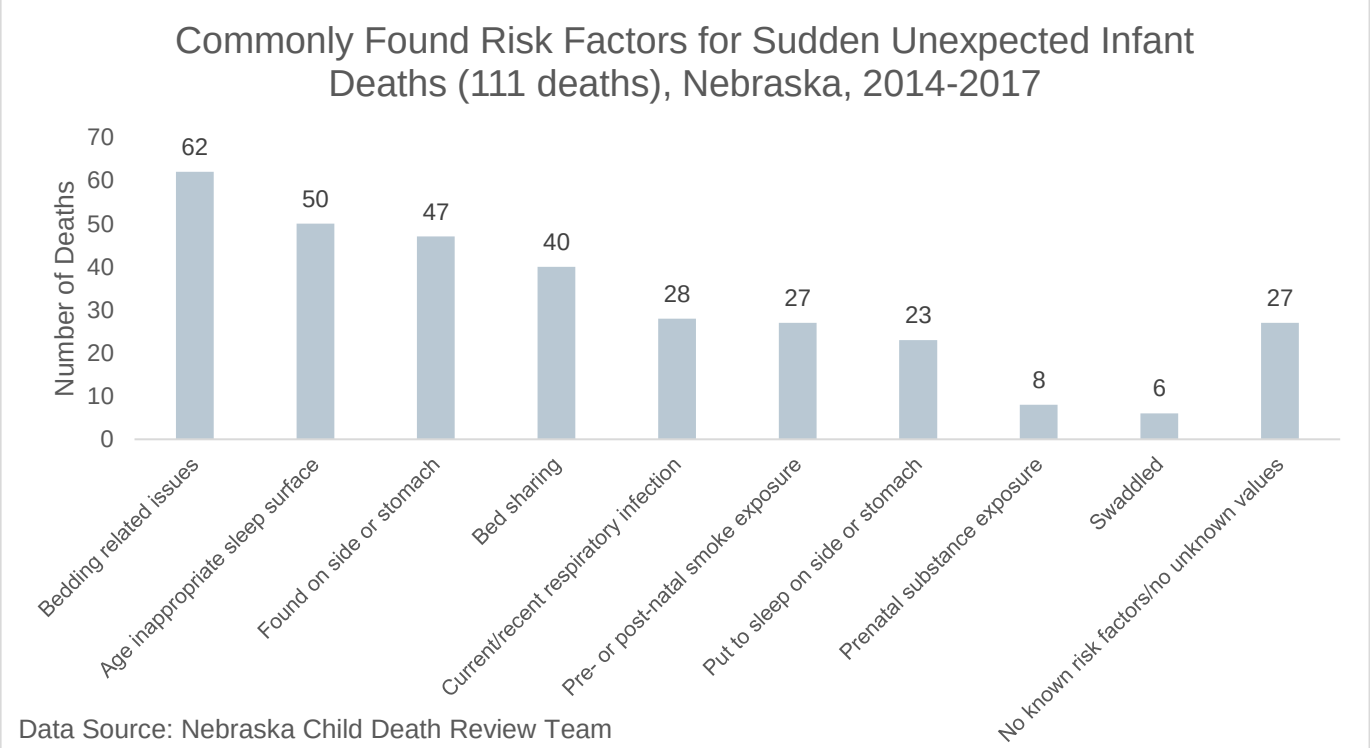
[6] American Academy of Pediatrics; https://www.aap.org/en/news-room/news-releases/aap/2022/american-academy-of-pediatrics-updates-safe-sleep-recommendations-back-is-best/
[7] Nebraska Department of Health and Human Services; https://dhhs.ne.gov/Pages/Safe-Sleep-Campaign.aspx
[8] Nebraska Department of Health and Human Services; https://dhhs.ne.gov/Documents/SUID%20form%20fillable%2011-2021.pdf
[9] Nebraska Department of Health and Human Services; https://dhhs.ne.gov/Pages/Child-Death-Review.aspx

FIGURE 13



Data Source: Nebraska Child Death Review Team

FIGURE 14



Data Source: Nebraska Child Death Review Team

Intentional Injury

Suicide

Ensure access to confidential, professional mental health services and crisis care for all young people across the state

Train all clinical and non-clinical staff to identify individuals at risk and to respond

Encourage medical mental health providers to develop a safety plan for children and parents if the child has expressed suicide ideation/thoughts

Reduce Access to Lethal Means

Justification

Suicide rates among youth in Nebraska have been increasing since 2010 (Figure 15Figure 16). Firearms and hangings continue to be the two most common methods of harm among all suicides (Figure 16). Although a large number of children and youth struggle with mental health issues, nationally only 1 in 5 receive specialized mental health care[10]. This lack of access to mental health care affects children in all geographic areas, but there is a particular problem for rural children, who make up a large proportion of Nebraska's population[10]. Ensuring access, including financial access, for all young people to confidential, professional mental health services and crisis care is a clear priority.

Nebraska should focus on increasing mental health providers and services across the state. Because access to care may be limited by individual factors, equitable investment may be best accomplished through public/private collaborations at the local and state level such as Bring Up Nebraska, NCFF.

The mental health challenges of the COVID-19 pandemic have strengthened the demand that schools do more to support students' social and emotional needs. Schools are good points to focus prevention and intervention efforts for suicide, however anyone who interacts with children including coaches, club sports, youth groups, extra-curricular activities, homeschool co-ops, and friends can be trained.

Nebraska's policy and decision makers can recognize the importance of providing mental health services to children, adolescents, and families directly in schools and communities by supporting evidence-based prevention and intervention efforts.

Supporting and expanding efforts such as Nebraska's Advancing Wellness and Resiliency in Education (AWARE) program implemented by the Nebraska Department of Education and Nebraska

[10] Robinson, et.al. https://www.cdc.gov/mmwr/volumes/66/ss/ss6608a1.htm

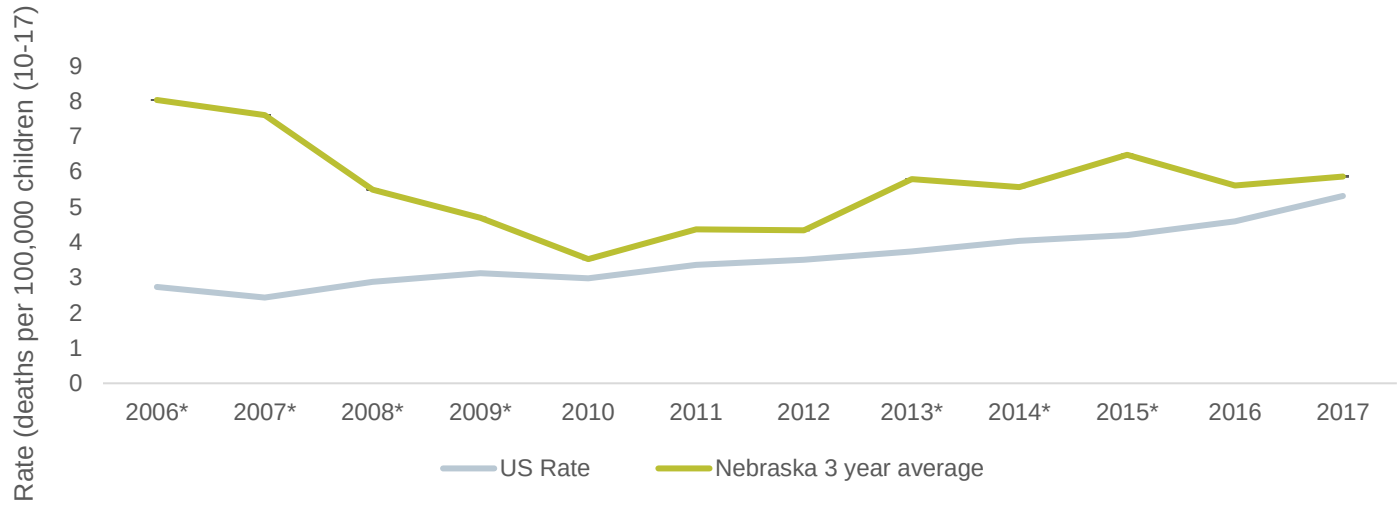
Department of Health and Human Services - Division of Behavioral Health in collaboration with six Local Education Agencies will improve school-based mental health services. The program addresses high level mental and behavioral health needs of school-aged children in rural schools, including depression, anxiety, suicidal ideation, and trauma.

The project's goals include:

- Prevention of mental health and behavioral disorders among students by providing positive, supportive, and trauma-informed learning environments
- Increasing student resilience and pro-social behaviors
- Increasing availability of school-based mental health services
- Increasing schools' capacity to identify and immediately respond to the mental health needs of students exhibiting behavioral or psychological signs requiring clinical intervention
- Increasing schools' capacity to identify and intervene in bullying and aggressive behaviors of students which may contribute to school violence.

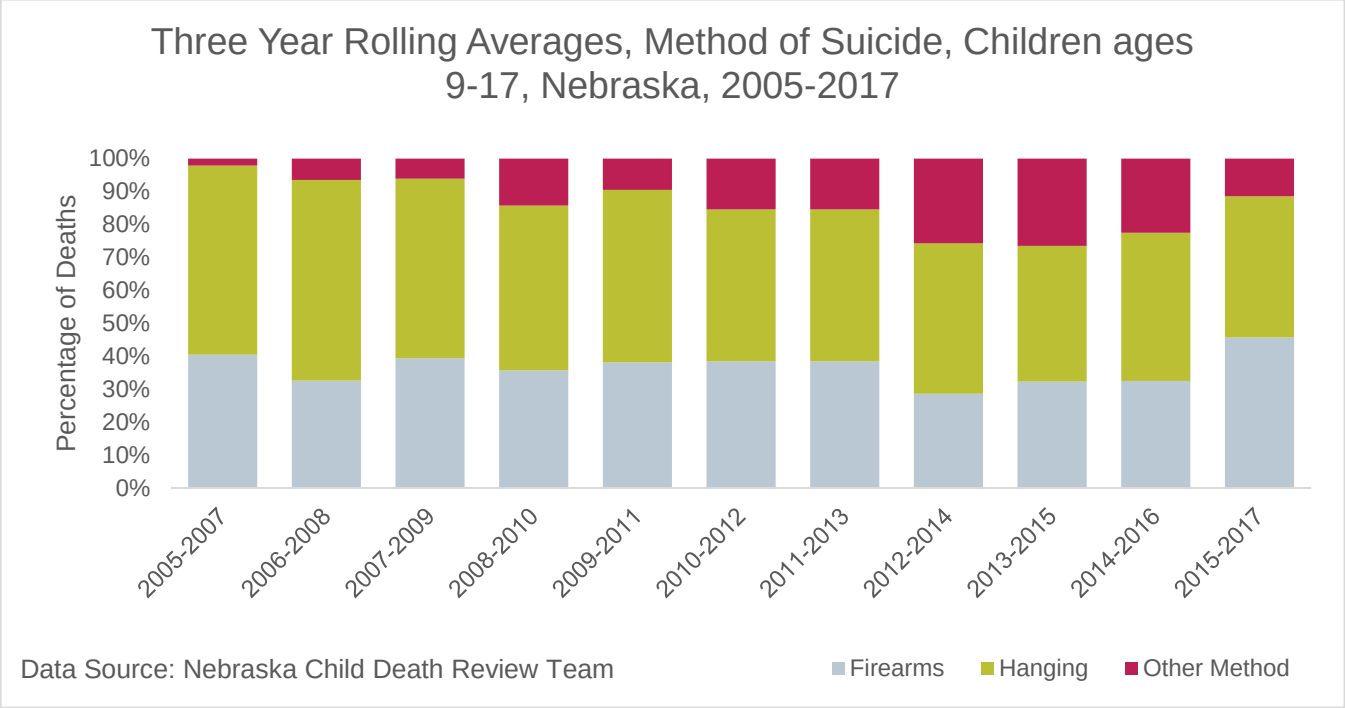
Nebraska Department of Education should expand suicide risk assessment protocols and school/trusted adults staff training to include assessment and documentation of depression and suicide ideation on social networking sites, and existing or needed mental health referrals and contacts

FIGURE 15



*Nebraska rates are three year averages; the 2017 value includes provisional numbers for 2018. Nebraska rates are significantly higher than U.S. rates for years denoted with an asterisk ($p<0.05$). Data Sources: U.S. data are from the Centers for Disease Control and Prevention. Nebraska data are from the Nebraska Child Death Review Team.

FIGURE 16


Three Year Rolling Averages, Method of Suicide, Children ages 9-17, Nebraska, 2005-2017
Percentage of Deaths
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2005-2007
2006-2008
2007-2009
2008-2010
2009-2011
2010-2012
2011-2013
2012-2014
2013-2015
2014-2016
2015-2017
Data Source: Nebraska Child Death Review Team
Firearms
Hanging
Other Method

Perinatal Infant and Early Childhood Health and Education

Prenatal and infant care

Increase access to affordable, quality prenatal education and care for vulnerable and at-risk women

Promote birth doulas

Extend postpartum Medicaid coverage

Increase public funding for evidence-based perinatal, infant, and early childhood home visiting services

Justification

Access to quality prenatal education and care reduces the risk of pregnancy complications, fetal and infant morbidity and mortality, and maternal morbidity and mortality[11]. This level of care should be universally available, with an emphasis on ensuring affordability for vulnerable and at-risk women.

According to the March of Dimes, prenatal education promotes the maintenance of healthy lifestyles during pregnancy, helping expectant mothers manage stress, support a healthy diet, avoid harmful chemicals and situations, recognize warning signs and symptoms that mean something may be wrong with their pregnancy, and prepare for labor and delivery. Many prenatal education programs take place in a supportive group setting. Many programs utilize curricula that can be adapted for women from specific cultural backgrounds, such as: Becoming a Mom/Comenzando bien, The Coming of the Blessing, and Stork's Nest[12]

Nebraska Department of Health and Human Services should improve awareness and accessibility to publicly available prenatal and infant/early childhood education including programs like text4baby, a prenatal and infant development program[13].

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[11] National Institutes of Health; https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care

[12] March of Dimes; https://www.marchofdimes.org/mission/prenatal-education-and-outreach.aspx

[13] Text 4 Baby; https://www.text4baby.org/

Doulas are non-clinical professionals who provide physical, emotional and informational support to mothers before, during, and after childbirth, including continuous labor support. Studies suggest that increased access to doula care, especially in under-resourced communities, can improve a range of health outcomes for mothers and babies, lower healthcare costs, reduce cesarean sections, decrease maternal anxiety and depression, and help improve communication between low-income, racially/ethnically diverse pregnant women and their health care providers.

Doula training is expensive and Doula support is not routinely covered by health insurance. Since one of the barriers to having doula support is cost, insurance coverage for doula support through Medicaid is needed. The Legislature should study the feasibility of increasing the availability of doulas in Nebraska including funding training and reimbursement of for services. NDHHS should consider creating and funding a statewide Doula program to fund recruitment and training of these community health workers.

Pregnant persons covered by Medicaid during pregnancy that have pre-existing medical conditions or experience conditions during pregnancy such as hypertension, diabetes, and mental health conditions, are only covered by Medicaid for a short time after pregnancy. After their coverage period ends, many persons are unable to receive the care they need to mitigate the effects of these medical conditions, which can lead to increases in morbidity and mortality. Additionally, this lapse in coverage leads to increased interpregnancy complications from medical conditions, with the woman entering any subsequent pregnancy with worsened medical status and can affect both maternal and infant outcomes.

Post-partum home visiting services have been associated with fewer emergency medical visits[14]. Increasing public funding for these services may reduce infant deaths in Nebraska. As part of the statewide Plan to Prevent Child Maltreatment Deaths, a home visiting affinity group was dedicated to expanding the reach of home visiting services. In particular, the group recommended that children under age one with prior Child Protective Services reports are prioritized for home visitation services. The group is also exploring Medicaid reimbursement for evidence-based infant home visiting services. This could result in the expansion of home visiting services to youth in foster care who are parenting, a particularly high-risk population.

These cross-cutting recommendations relate to overall infant and young child death prevention; therefore no additional data points, figures, or tables are provided in the justification for this section.

[14] Yonemoto et al; https://www.cochrane.org/CD009326/PREG_home-visits-early-period-after-birth-baby