[LB406 LB457 LB481 CONFIRMATION]

The Committee on Health and Human Services met at 1:30 p.m. on Thursday, March 5, 2009, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB406, LB457, LB481 and gubernatorial appointments. Senators present: Tim Gay, Chairperson; Dave Pankonin, Vice Chairperson; Kathy Campbell; Mike Gloor; Gwen Howard; Arnie Stuthman; and Norman Wallman. Senators absent: None. [CONFIRMATION]

SENATOR GAY: Hey, Rebecca, sorry I'm late. I had a constituent catch me and I didn't look at my watch, so I appreciate you calling in. We've got several senators here, and what we'd like is just to tell us a little bit about yourself, and we have your resume in front of us. The senators here...and you're on a speakerphone, and we do have some audience members who will be...who are also listening, about 20 or 30 public members here; maybe not so much for your appointment but on other issues. But we have Senator Kathy Campbell is with us; Senator Dave Pankonin; myself, Senator Tim Gay; Senator Arnie Stuthman; and Senator Norm Wallman are all here. And what we wanted to do, of course, is just...we appreciate you're willing to serve on the Stem Cell Research Advisory Committee, but if you could just tell us a little bit about yourself and maybe your interest in this...serving on this position that would be helpful. [CONFIRMATION]

REBECCA MORRIS: Okay, should I begin now? [CONFIRMATION]

SENATOR GAY: You bet. [CONFIRMATION]

REBECCA MORRIS: Okay. I received my Bachelor of Science in Biology from Muhlenberg College in Allentown, Pennsylvania in 1976, and I received my Ph.D. in Biology from Syracuse University in 1981, where I had the uncommon good fortune to be able to do my dissertation research at the Pathology Department at the state medical college. I began a postdoctoral fellowship from Tom Slaga to Sue Fischer at Oak Ridge National Laboratory, and moved very actively with a very short time with Dr. Slaga and Sue Fischer to the University of Texas with the M.D. Anderson Cancer Center in Science Park in Smithville, Texas, and that's where I truly began my research career. I was in (inaudible) in the Anderson Science Park for 11 years and began as a research associate and began my career up the ladder as assistant biologist. And then in 1992, I moved to the Lankenau Institute for Medical Research in Wynnewood, Pennsylvania, (inaudible) Thomas Jefferson University in Philadelphia, and I was an associate investigator and a senior investigator there. And I had two (inaudible) so I was there until 1999...or 2001 when I moved to Columbia University in the Departments of Dermatology and Pathology where I was an associate professor; and then I just moved recently, last, late last fall, to the Hormel Institute in the University of Minnesota in Austin, Minnesota. So that's my career. I had a (inaudible) I had a wonderful opportunity

to be visiting fellow with Christopher Potten and at the Christie Hospital and Holt Radium Institute in Manchester, England; I was there for six months. I also had a wonderful opportunity to work with a colleague of (inaudible) . I was visiting investigator at the Hanson Center for Cancer Research in Adelaide, Australia. In terms of professional responsibility, I've had the opportunity to be funded from NIH since my first grant; and in 1997 I received the Junior Faculty Award from the American Cancer Society that helps me with my salary. I've been on a number of...I'm ad hoc member on a number of NIH (inaudible) Study Section for postdoctoral fellows, and they give what are...they give RO1 Research Grants. And I was also a member for four years on the American Cancer Society Study Section on Carcinogenesis, Nutrition, and the Environment. I have a number of papers in journals such as Cancer Research and Investigative Dermatology and have a couple of patents. So that's my academic career. And in terms of my research interest, I've been interested...ever since I was in graduate school I've been interested in stem cells and the skin. I didn't study stem cells as a graduate student. It wasn't popular to talk about stem cells, the skin having stem cells, but I....the experiment that I did for my dissertation looking at cellular kinetics following wound healing and tumor promotion in the skin led me to the hypothesis that those results could be explained if the skin...if the epidermis had a population of stem cells. So my...in terms of my research, I've been interested in the stem cells in the epidermis of hair follicles, and our approach to this problem was, initially, was to take characteristics of stems cells in the bone marrow which was the where the stem cells were known to be present; to take those characteristics like (inaudible) and (inaudible) and (inaudible) and clonogenic under certain conditions and ask whether cells in the epidermis had those characteristics. And we found over the years, yes, indeed they did. And in terms of research that we're doing now, we published a paper a couple of years ago with the first selectable determined hair follicle stem cells. We found that hair follicle...a population of hair follicle stem cells expressed speed (inaudible) or the blood stem cell markers (inaudible) we're pursuing now, trying to understand what it is about these cells that make them express a blood stem cell marker. But we showed that cells...the hair follicle cells that have this marker have characteristics of stem cells like poly (inaudible) and high potential for growth and an ability to reconstitute the tissue graft. So our second project we have going on in the lab now is an approach to lineage tracing, to fate determination of those hair follicle stem cells during the development of skin cancer. And we found, very clearly, that hair follicle stem cells are, indeed...do indeed participate in the formation of skin tumors, for papillomas and malignant skin cell carcinomas in mice. And then a third research focus in the lab right now is to determine the...to try to identify the genes that are responsible for regulating the number of keratinocyte stem cells with an eye to determining how they behave in skin diseases, including cancer. And this should provide the basis for determining what these genes...to determine their role in epidermal growth, and hair growth, and particularly in skin cancer development. And we have a relatively new project that, actually, one of my students is working on--he's still at Columbia--but that is the role of bone marrow-derived cells in skin cancer development. So we hope that this information will

enhance effort toward the design of new treatment for skin diseases, including cancer. [CONFIRMATION]

SENATOR GAY: All right, thank you. [CONFIRMATION]

REBECCA MORRIS: That's it; that's a nutshell. [CONFIRMATION]

SENATOR GAY: Yeah, that's a nutshell, isn't it? Thank you, Doctor. That's a...appreciate that. We're going to see if there's any questions for you. Senator Mike Gloor also joined us, just so you know, but I think Senator Arnie Stuthman has a question for you. [CONFIRMATION]

REBECCA MORRIS: Okay. [CONFIRMATION]

SENATOR STUTHMAN: Thank you, Senator Gay. And Dr. Morris, thank you for your willingness to serve on this committee. Do you feel that there is a lot more to learn about stem cells in your research in skin? [CONFIRMATION]

REBECCA MORRIS: As you know, that this...we're just really beginning to understand, you know, just as late as 2003, we found the first selectable marker for these cells so that we could actually begin to isolate them and study their properties in humans and mice and in cell culture systems, so I think we're really at a very exciting time right now because we're actually...you know, we have the basic assays for these cells, and now we're beginning to be able to home in on the particular populations. Because before this we didn't...we had cell kinetic data that suggested that the epidermis had stem cells and that the hair follicles had stem cells, but we didn't have any way, just up until very recently, to enrich for these cells or to isolate them. So, yeah, I think it's just...every day is a really exciting opportunity just right now. [CONFIRMATION]

SENATOR STUTHMAN: Yes, Dr. Morris, I truly agree with you. I think there is so much more to learn from this and we've just actually broken the skin on this, so I think, you know, I really appreciate the fact that you're willing to serve on this committee. Thank you. [CONFIRMATION]

REBECCA MORRIS: All right, thank you. [CONFIRMATION]

SENATOR GAY: All right, let's see if there's any other questions. Any other questions from the panel? I don't see any other, Doctor; we appreciate it. It sounds like you're more than qualified, and thank you again on behalf of all of us for your willingness to serve. What we will do is look this over and then we'll meet, and most likely vote out of committee, and then go to the floor of the Legislature and vote, and then it would be confirmed, I guess, so. But we sure appreciate you calling in and your willingness to serve on behalf of all of us, so. [CONFIRMATION]

REBECCA MORRIS: All right; well, thank you for this opportunity. [CONFIRMATION]

SENATOR GAY: All right, thank you. [CONFIRMATION]

SENATOR STUTHMAN: Thank you. [CONFIRMATION]

REBECCA MORRIS: Okay; bye. [CONFIRMATION]

SENATOR GAY: Bye-bye. All right, we're waiting; Dr. Roop is calling at 1:15 so we've got a few minutes until he calls in. But I guess Senator Stuthman gets away with that. But if you would silence all cell phones, we'd certainly appreciate it. If you're going to testify, and I know many of you are here to testify and we appreciate you coming, there's testifier sheets over there. If you print your name out and then hand that to our clerk, Erin, over here in that box--she's transcribing all this. So you also need to spell your name out, because many times, you know, it's not a common name and it certainly helps to spell it out when she's transcribing it later, which could be, you know, a couple of weeks from now at least. So if you could do that, we'd appreciate it. We got three bills today to hear: LB406, LB457, LB481--all dealing with, obviously, the same subject matter. The idea...sometimes we combine all those bills into one bill. I don't want to do that today, and the reason I don't want to do that, I think they deal with specifics. Now, we need your help on that as well, to not be repetitive. But if you could speak to that portion of the bill...let's say it's Senator Fulton's bill dealing with clinical privileges in hospitals, it would be better. Because I know some of you will come up more than once, but sometimes...we have a timer here and it's five minutes, so sometimes if everyone keeps talking and talking, five minutes turns into about 7:00 at night, and I'm sure, with the kids here and all that, that's maybe not the best for any of us. But we'll hear you out. Sometimes there will be questions asked of you. Stay around; if there's any questions from the senators, we will direct those at you; the light is off and take as much time as you need to answer that question. So those are kind of the rules of what goes on, and we'll get immediately started; hopefully the doctor will call in here in a minute, and we'll listen to what he has to say and then we'll proceed on. We'll do a quick introduction. You heard me talking to the doctor, but we'll start over here on my right with our legal counsel. [CONFIRMATION]

JEFF SANTEMA: My name is Jeff Santema, and I serve as legal counsel to the committee. [CONFIRMATION]

SENATOR GLOOR: I'm Senator Mike Gloor from District 35, which is Grand Island. [CONFIRMATION]

SENATOR CAMPBELL: I'm Senator Kathy Campbell from District 25, which is east Lincoln. [CONFIRMATION]

SENATOR PANKONIN: I am Senator Dave Pankonin from District 2, which is Cass County, and Nebraska City, and the south part of Sarpy County. [CONFIRMATION]

SENATOR GAY: I'm Senator Tim Gay from the Papillion-La Vista area. [CONFIRMATION]

SENATOR STUTHMAN: Senator Arnie Stuthman, District 22 from the around the Columbus area. [CONFIRMATION]

SENATOR WALLMAN: Senator Norm Wallman, District 30, which is Beatrice in there also. [CONFIRMATION]

ERIN MACK: I'm Erin Mack, the committee clerk. [CONFIRMATION]

SENATOR GAY: And Senator Gwen Howard is also a member of the committee from Omaha. Our pages, Justin and Blair are here, and if you have handouts they will get those for you and distribute all those. If you want to hand out your testimony or you have handouts for us, they will take care of that and assist you in any way, so. We appreciate their help as well, so. We'll just sit tight here for a little bit and hopefully we get a call, and if we don't here in a few minutes, we'll get started. [CONFIRMATION]

DENNIS ROOP: Yes, this is Dennis Roop. [CONFIRMATION]

SENATOR GAY: Oh, hey, Doctor, how are you? [CONFIRMATION]

DENNIS ROOP: Fine. [CONFIRMATION]

SENATOR GAY: Good. Senator Gay; we have with us Senator Mike Gloor, Senator Kathy Campbell, Senator Dave Pankonin, Senator Arnie Stuthman, Senator Gwen Howard, and Senator Norm Wallman are here. And we just wanted to...we've got, like I say, we've got your resume...very good there. If you could tell us a little bit about yourself and what you look forward to on the committee or on the research advisory committee, how you'd help out with that. [CONFIRMATION]

DENNIS ROOP: Okay, I mean...if you have the resume you know that I'm currently director of a new Regenerative Medicine and Stem Cell Biology Program here at the University of Colorado Denver. I've been here since January 2007; prior to that I was at Baylor College of Medicine in Houston for 19 years. So the research that we do here is primarily using adult stem cells. We're also...you may be familiar with the topic of reprogramming adult cells into embryonic-like stem cells, but primarily we've always focused our research efforts on adult stem cells, and I think in the very near future the use of embryonic stem cells will become a moot point, because there will be better ways

to approach therapy using stem cells; using the reprogramming method since this, actually, is really personalized medicine. It allows you to take a biopsy of the skin from the patient that you want to treat; reprogram those cells into a cell that looks like an embryonic stem cell, correct them, and return them to the same patient. So you really don't have to, then, worry about an immune response rejecting the tissue that you've made in the patient. [CONFIRMATION]

SENATOR GAY: Okay. All right, thank you. We do have...your resume is very extensive; your writings and honors and awards, so we do have that in front of us. I'm just going to see real quick if there's any questions from our committee members. We've had your resume for several days, but is there any questions from committee members right now for Dr. Roop? I don't see any. I don't see any right now, Doctor. The one thing what we do, we'll...as a committee we vote this out to floor of the Legislature then they would approve or disapprove; usually...you should be approved, I would guess. And then, you know, your service on that, we certainly appreciate it. Speaking on behalf of all of us, this is a new venture for us--the Research Advisory Commission--and we certainly are honored to have such good participants such as yourself being willing to serve, so I would say that. But that's the case. I don't know exactly...Monday we meet and we'll deal with this in a committee, but I don't know exactly when on the floor of the Legislature it would be scheduled for the agenda; probably, it could be a week or two, probably, so. But somebody, obviously, will get back with you and then you'll proceed, hopefully, as an important member of the Advisory Commission. So with that I appreciate you calling in, and like I say, I didn't see any questions for you. I appreciate you calling in, and we will keep in touch when we can tell you some more. [CONFIRMATION]

DENNIS ROOP: Okay, very good. [CONFIRMATION]

SENATOR GAY: All right, thank you very much. [CONFIRMATION]

DENNIS ROOP: Certainly; goodbye. [CONFIRMATION]

SENATOR GAY: Bye-bye. [CONFIRMATION]

SENATOR STUTHMAN: Goodbye; thank you. [CONFIRMATION]

SENATOR GAY: Okay. With that just for, also, we do open these appointments up for any public comment. Would anyone like to comment on either Dr. Rebecca Morris or Dr. Dennis Roop? Dr. Shaefer, do you want to say a few things? [CONFIRMATION]

JOANN SCHAEFER: I'll just comment that I've met all of these physicians that have been out the last two days...or the scientists...through the process. They're all very highly qualified. These two today came from Creighton; the two yesterday came from

UNMC. I'm ready to work with them on the Stem Cell Advisory Committee, so as soon as they are approved we have work for them to do, so. [CONFIRMATION]

SENATOR GAY: You do, okay. [CONFIRMATION]

JOANN SCHAEFER: Plenty. [CONFIRMATION]

SENATOR GAY: Dr. Schaefer, while you're here then, that's important to know because when we do go to the full Legislature, if there are questions I would hope that you and I can visit, or anyone else that's interested, so we could visit and answer any questions that may come. All these people are very, very well qualified, but quite honestly, some of the things they're discussing are beyond our pay scale, so. (Laughter) [CONFIRMATION]

JOANN SCHAEFER: Quite frankly, they're beyond mine. (Laugh) [CONFIRMATION]

SENATOR GAY: So thank you, Dr. Schaefer. [CONFIRMATION]

JOANN SCHAEFER: You're very welcome. [CONFIRMATION]

SENATOR GAY: All right, is...what have we got, Senator Fulton here? Is he going to...should we...are you going to do it for him? [LB406]

JOSH SHASSERRE: (Inaudible) [LB406]

SENATOR GAY: Oh, I don't...you're here, do you want to do it? [LB406]

JOSH SHASSERRE: Sure. [LB406]

SENATOR GAY: Let's do that. All right. We'll start with LB406. Is he at Judiciary? [LB406]

JOSH SHASSERRE: Yeah. [LB406]

SENATOR GAY: Oh, okay. So we have a conflict: Senator Fulton has been scheduled for two bills at the same time, one in Judiciary and one here at Health. His legislative aide will go ahead and introduce this bill and then if he can join us later, he will. But go ahead, and we'll have an introduction on LB406. [LB406]

JOSH SHASSERRE: Thank you, Senator Gay, members of the committee. My name is Josh Shasserre, S-h-a-s-s-e-r-r-e. I'm Senator Tony Fulton's legislative aide, and I apologize in advance for his inability to bilocate. Senator Fulton is pleased to introduce LB406 on behalf of the Nebraska Friends of Midwives. This bill adds certified nurse

midwives to the list of providers that cannot be denied privileges solely based on the type of professional credential that is held. The section that's operative in this bill was originally enacted to allow podiatrists to maintain hospital privileges at the University of Nebraska Medical Center in 1989. It was subsequently amended to add licensed psychologists to those who cannot be denied hospital privileges in 1998, so there is precedent for amending this particular section. Hospital privileges are necessary for a provider who cares for patients in a hospital; and within Section 38-611, certified nurse midwives are authorized, among other things, to attend cases of normal childbirth and provide care for the newborn immediately following birth. So if a certified nurse-midwife is incapable of obtaining hospital privileges, then it presents a conflict to the care that they are statutorily authorized to perform. LB406 alleviates this potential conflict and enables families seeking the quality care performed by a certified nurse-midwife to be certain that such care can be provided should they be in a hospital setting. With that I will close, and hopefully Senator Fulton can come back for closing if need be. [LB406]

SENATOR GAY: Okay. And Josh, we'll save you; we won't ask you any questions then, we'll go from there. (Laughter) And then did you fill out a testifier sheet to give to...? [LB406]

JOSH SHASSERRE: Yes, I did. [LB406]

SENATOR GAY: Okay, just for spelling of your name. [LB406]

JOSH SHASSERRE: Thanks. [LB406]

SENATOR GAY: All right, we will hear from proponents; those of you who would like to speak on LB406 come on forward. How many people will be actually speaking on this bill, either for or against or neutral? Okay, so we've got about seven or eight people, it looks like. All right, thank you. And we'll hear from proponents first. [LB406]

MANDY GILMORE: (Exhibit 1) Hi; good afternoon, Chairman Gay and committee members. Thank you for the time that you've given us to bring this concern that personally affects many Nebraska women. My name is Mandy Gilmore, G-i-l-m-o-r-e, and I am a resident of Norfolk, Nebraska. My husband and I have four darling little people in our home, and three of which were delivered by a certified nurse-midwife; one of them by a physician. The care and personal attention that I received from Gail Consoli, our Norfolk CNM, was extraordinary. In my experience, CNMs have taken the necessary time to be actively involved in my life and the life of my children. Gail has provided me with comfort and patient guidance throughout my pregnancies. With the knowledge, experience, and skills coupled with their personal consideration and time, CNMs are truly set apart; it's not just a phrase, they truly are. For example, during my last pregnancy I had several complications, one of which included a kidney stone. I'm able to call Gail in the middle of the night; she meets me there immediately. When we

went through labor and delivery with our last child it started at 2:30 in the morning, ended at 6:30--she stayed the whole time with me; even an hour post-delivery, just with our family. Having Gail as a CNM alleviated many fears that I had related to childbirth. By taking the time to answer my questions, by guaranteeing her attendance at delivery, and by taking extra time to ensure my well-being. I'm concerned with our hospital's policy now. They have closed the category of midwives, and should we choose to have any more children, we greatly value the option that we have of midwifery care. Once Gail retires, that's no longer a possibility for us and for all the other women in our area. She is in such high demand now, as the only CNM allowed to practice, that she carries a load more appropriate for two and is still having to turn away women that would like her services. For many women, including myself, the loss of this option would be devastating. Please vote in favor of this bill to help improve our access to the care provider of our choice. I appreciate the time. This isn't in my testimony, but it is amazing to me to be part of this country and to be allowed to even come to a table and voice a concern, so thank you for that today. [LB406]

SENATOR GAY: We appreciate you coming. [LB406]

MANDY GILMORE: Um-hum. [LB406]

SENATOR GAY: Hold on, we got a question for you. Senator Wallman. [LB406]

MANDY GILMORE: Sure. [LB406]

SENATOR WALLMAN: Thank you, Chairman Gay. Thank you; this is your house, you know. The hospital policy...was that challenged at all or was it just... [LB406]

MANDY GILMORE: You know, I am not clear about the specifics of that. I asked a few questions and realized very quickly that there were a whole lot of politics involved with that in our small Norfolk area. And the ladies that will speak after me are very well versed in statistics and demographics, and they can probably help you better, I imagine, with the hospital policies. I am a simple mama from Nebraska that loves my midwife. (Laughter) [LB406]

SENATOR WALLMAN: Thank you. [LB406]

SENATOR GAY: All right; thank you. Any other questions? I don't see any, thank you. [LB406]

MANDY GILMORE: Okay, thank you. [LB406]

ALICE MAY: (Exhibit 2) Senator Gay and Health and Human Services Committee members, good afternoon. My name is Alice May. I've lived northeast Nebraska for

approximately... [LB406]

SENATOR GAY: What is it again? Alice what? [LB406]

ALICE MAY: May. [LB406]

SENATOR GAY: M-a-y? [LB406]

ALICE MAY: M-a-y. [LB406]

SENATOR GAY: Okay, thanks. [LB406]

ALICE MAY: We rhyme. (Laughter) [LB406]

SENATOR GAY: That won't get you any further though now (Laughter). Okay, go ahead. [LB406]

ALICE MAY: I have lived in northeast Nebraska for approximately 25 years. I have worked as an RN for 15; 14 of which have been in labor and delivery, postpartum, and newborn nursery. In October 2008, I graduated as a certified nurse-midwife, and in November I passed the national board exam. I'm ready to start working as a CNM. Unfortunately, there is currently a restriction on midwifery at Faith Regional Health Services, the only hospital in Norfolk, Nebraska. Gail Consoli, the only practicing certified nurse-midwife in northeast Nebraska, has practiced in Norfolk for approximately 12 years. In 2002, another CNM moved to Norfolk to join Gail's practice, but left after about a year because she was unable to obtain hospital privileges. In 2003, Faith Regional Health Services closed the category of nurse-midwife, and has declined to accept any further applications for hospital privileges from nurse-midwives. Although there are five obstetricians and one family practice physician who provide obstetrical services in Norfolk, there is a strong demand for midwifery services in our community. Gail's practice is bursting at the seams and needs another midwife to accommodate all the women who are seeking midwifery care. This high level of interest in midwifery stems from the unique services that we provide. Midwives do more than provide obstetrical care to pregnant and postpartum women. We spend a considerable amount of time with our clients focusing on education and the assessment of the multiple social and economic factors that can impact a woman during the childbearing year. The essence of midwifery is described in the ACNMs Hallmarks of Midwifery, which I have attached to your copy of my testimony. In addition to my concern about women in our community not being able to access the care they desire, I am also concerned about the health status of women and children in northeast Nebraska. Several maternal/child health indicators in Madison County remain below the Healthy People 2010 goals, including rates of infant mortality, low birth weight, premature births, teenage pregnancy, and cigarette use during pregnancy. I have provided you with a chart

comparing these statistics for Madison County, Nebraska, and the nation, as well as the Healthy People 2010 goal. Historically, nurse midwives have made a significant contribution toward improving all of these maternal/child indicators. In 1987, the Institute of Medicine recommended an increased use of CNMs and called for state laws and physicians to support hospital privileges for CNMs. In 1993, the March of Dimes published the report entitled Toward Improving the Outcome of Pregnancy: The '90s and Beyond which addressed the problems caused by the denial and delay of hospital privileges for CNMs. The Pew Health Professions Commission's 1999 executive summary recommended that midwifery should be embraced by and incorporated into the healthcare system and made available to all women. That report is included in your packet. Just five months ago, The Cochrane Library published its systematic review of midwifery care, finding that midwife-led care confers benefits for pregnant women and their babies and is recommended. That report is also included. This Cochrane review concluded with the recommendation that all women be offered midwife-led models of care. Improving maternal/child health is an important objective for the state of Nebraska. I am eager to contribute to improving the maternal/child indicators in our state. I have been raised in Nebraska and have lived here for nearly all my adult life. My children and my grandchild also reside here. I do not want to have to leave northeast Nebraska in order to practice as a nurse-midwife. Even more important is the fact that when Gail retires, the women of northeast Nebraska will not have access to hospital-based midwifery care. Faith Regional Health Services in Norfolk recently welcomed a new CEO, and I have heard excellent comments about him and his administration. I have an appointment to meet with him next week regarding this issue, and I sincerely hope that the policy can be changed to not only allow the growth of midwifery, but to also actively promote it as an excellent evidence-based service for the women of our community. Even if that happens, however, I still believe that LB406 should be passed. This bill will ensure that all Nebraska communities have the basic structure in place to allow women and families to have access to the care they so ardently desire. I urge you to lend your support to ensuring that all Nebraska women can readily access nurse-midwifery care. [LB406]

SENATOR GAY: All right, let's see if there's any questions. Senator Wallman. [LB406]

SENATOR WALLMAN: Thank you, Chairman Gay. Thank you, Alice, for coming. One thing that jumped out at me is infant mortality rate. Are these people seeing nobody, then, do you think? [LB406]

ALICE MAY: No, no; if you look at the list that has the percent that receive inadequate care and first trimester care... [LB406]

SENATOR WALLMAN: Sure, I see that. [LB406]

ALICE MAY: ...I don't know that we can pinpoint exactly why our infant mortality rate is

higher, but historically nurse midwives have helped reduce it. [LB406]

SENATOR WALLMAN: Do you think it pertains to immigrants, or...we sponsored some immigrants, our church, and one of them women had the baby at home with nobody; called a nurse in our congregation and, I mean, she had the baby by herself. [LB406]

ALICE MAY: Um-hum. There's no way for me to know. [LB406]

SENATOR WALLMAN: Thank you. [LB406]

ALICE MAY: Um-hum. [LB406]

SENATOR GAY: Any other questions? I've got one for you. [LB406]

ALICE MAY: Um-hum. [LB406]

SENATOR GAY: Now, you listed some of the benefits, I think, of midwifery. How do you...how is it promoted? Like word of mouth, or...because I really, quite honestly, this is kind of a new thing to us. [LB406]

ALICE MAY: It depends on what area you are in. [LB406]

SENATOR GAY: Up in your area. [LB406]

ALICE MAY: In our area it's word of mouth. Gail's practiced for 12 years and I know initially had a smaller practice, but it started growing rapidly because women are so satisfied with the care. [LB406]

SENATOR GAY: So it's more...I assume personal care is what you're offering here to your women. And then, I guess we're involved...that are concerned about their wife. Is...costwise what is the differences between...is it a services cost, what else is... [LB406]

ALICE MAY: The cost for care provided in the clinic is the same as if you go to a physician. Gail practices with a physician; they bill the same rate. The hospital may generate a little bit less revenue because there's less interventions: lower C-section rate, lower use of equipment. I don't think that's a significant amount, other than avoiding C-sections. [LB406]

SENATOR GAY: But it's comparable then, is what you're saying. [LB406]

ALICE MAY: Right, right. [LB406]

SENATOR GAY: Okay, okay. Any other questions? I don't see any, thank you. [LB406]

HEATHER RAMSEY: Hi, my name is Heather Ramsey, R-a-m-s-e-y. I'm a certified nurse-midwife in Omaha, Nebraska. I've been practicing there for approximately 13 years. I'm one of the older practicing midwives in the state since it became legal in 1991. I've been practicing in Omaha since 1996. I came to support LB406 for a couple of reasons. This does not directly affect myself or my practice, but I strongly believe in access to care for all women. And this is a legal practice in this state, and nurse-midwives, if some of you don't know, we are RNs, or Registered Nurses. Many of us have several years of experience in labor and delivery and delivering...on helping physicians to deliver babies, and we've gone back to school--usually about two years--to get our certificate or our master's degree in nurse-midwifery. So we're somewhat equivalent to a nurse-anesthetist or a nurse-practitioner. So that's pretty much what nurse-midwives are. Alice's and our other lovely lady have discussed about what hands-on approaches that we use for delivering babies, and a lot of women who deliver with us seek us out; and again, it's word of mouth, as you suggested how do women know? Some of us do advertise, but not very much. Our practices are booming as it is; we don't have enough midwives in the state now. As far as interventions, I'm our statistics keeper at the Nebraska Medical Center where I practice, and we deliver approximately 25 percent of all of the babies at the hospital at Nebraska Medical Center. And I have our statistics from 2008: we have an 88 percent vaginal birthrate, which is a 12 percent Cesarean rate. This equates to a physician average of about 30 percent. We also have a very successful VBAC rate; VBAC stands for Vaginal Birth After Cesarean rate. Many hospitals in this state are currently no longer offering VBAC as a method of childbirth, so by performing VBACs we substantially reduce costs. We also substantially reduced the costs in general for the woman. A woman, to have a normal vaginal delivery and stay approximately 24 hours in our institution, costs approximately $3,000-$5,000. If a woman were to have a Cesarean section in our institution after a labor, we're looking at somewhere between the neighborhood of $10,000-$15,000. Approximately 60 percent of our patients are government-paid or Medicaid-relied-on patients. So you can see right there that's a substantial reduction in cost based on our lower Cesarean rates, and based on the number of women that come to us that receive Medicaid. In our institution, in this area, in our economic climate, I don't see that it's not fiscally responsible to allow this bill to pass; to allow more women access to care which is as equal, if not better, outcomes compared to our physician counterparts with a cheaper cost for both insurance companies and for both the government itself. I'm open to questions. [LB406]

SENATOR GAY: All right. Senator Gloor. [LB406]

SENATOR GLOOR: Thank you, Chairman Gay. And thank you for providing testimony, Ms. Ramsey. Do you work with an established physician group? [LB406]

HEATHER RAMSEY: I work with an established physician group, yes, I do. [LB406]

SENATOR GLOOR: Okay. Do you decide your patients or is that something that's collaboratively decided upon in terms of who takes what patients? [LB406]

HEATHER RAMSEY: We have mutually agreed upon, between the physicians and our group of midwives, things that we feel are inside our scope of our practice to take care of and things that are outside of our scope of practice to take care of. And we see those women initially for their first OB visit. If we feel, at that time, that they are outside of our scope of practice, we will refer them to a physician that's within our group. If it's a moderately high-risk pregnancy, we sometimes will co-manage that care of the pregnancy. [LB406]

SENATOR GLOOR: The difficulty I have with the statistics is that it seems to me that it might be an apples-to-oranges comparison. [LB406]

HEATHER RAMSEY: Yes. [LB406]

SENATOR GLOOR: That some of those patients that the physicians keep are going to be the higher-risk patients that would be more challenged and less likely to be a candidate... [LB406]

HEATHER RAMSEY: Yes. [LB406]

SENATOR GLOOR: ...for VBAC and whatnot, so... [LB406]

HEATHER RAMSEY: Yes, that's correct. [LB406]

SENATOR GLOOR: Okay. [LB406]

HEATHER RAMSEY: Thank you for bringing that up. These were statistics from our hospital in Omaha. But let me talk to you about national statistics. There's a 33 percent lower risk of neonatal mortality and a 5 percent decrease rate of Cesarean section--national statistics--when you compare low-risk to low-risk patients; low-risk CNM patients to low-risk physician patients. [LB406]

SENATOR GLOOR: Which, as far as you're concerned, takes that factor out...the pre-selection factor out. [LB406]

HEATHER RAMSEY: Correct. [LB406]

SENATOR GLOOR: Okay. Do you have credentials or privileges at just one institution? [LB406]

HEATHER RAMSEY: Yes, and we're grandfathered into the Clarkson side as well, but yes. [LB406]

SENATOR GLOOR: Okay, thank you. [LB406]

SENATOR GAY: Any other questions? Senator Campbell. [LB406]

SENATOR CAMPBELL: Thank you, Senator Gay. Ms. Ramsey, do you have a statistic and know how many...out of how many hospitals in Nebraska you are, midwives are, credentialled? And even a rough estimate from your knowledge of the state. [LB406]

HEATHER RAMSEY: How many hospitals? I would guess roughly eight to ten. [LB406]

SENATOR CAMPBELL: Okay. [LB406]

SENATOR GAY: Senator Wallman. [LB406]

SENATOR WALLMAN: Thank you, Chairman Gay. Yes, thanks for coming. In your reimbursement, do you get the same...you don't get the same reimbursement as the doctor, do you? [LB406]

HEATHER RAMSEY: Yes, right now we do. [LB406]

SENATOR WALLMAN: Do you? [LB406]

HEATHER RAMSEY: Depending on the insurance company as well. [LB406]

SENATOR WALLMAN: And the Medicare involvement. [LB406]

HEATHER RAMSEY: Yeah, Medicaid. [LB406]

SENATOR WALLMAN: Medicaid, yes. [LB406]

SENATOR GAY: Any other questions? I don't see any. Thank you. Other proponents who would like to talk? [LB406]

GAIL CONSOLI: (Exhibit 3) Senator Gay and Health and Human Services Committee members, I'm Gail Consoli. I'm a CNM in Norfolk, Nebraska. I began practicing in 1997, graduated in 1996, but at that time the hospital had no category for CNMs to apply to and had to be convinced to create one. I was here in front of this legislative body in 1996 or 1997 when Senator Wesley kindly tried to help me get privileges. He proposed home birth as an option for me to practice, and the physician's feathers flew. I believe

there was also a Dr. Massey at the time and he was here, I believe, to represent the Nebraska Medical Association. He told me that it might take time to get privileges at the hospital but to be patient. The hospital did eventually allow me to practice as a CNM, after I had 60 supervised births or one year, whichever was longer. This was the hospital's requirement. This excessive requirement was unheard of among all that I've shared this with, including the American College of Nurse-Midwives. The hospital, though, made it very difficult to practice midwifery. I struggled to get my privileges more in line with what is evidence-based and supported by research. One example would be ruptured membranes, or the bag of water breaks; it's been more than 12 hours without active labor. Or another one was a previous history of a stillbirth. When I first began practicing at the hospital, those two examples required physician consultation. In 2002, I requested my privileges to be less rigid and that ruptured membranes, for instance, perhaps the best management, and absolutely the best management, is allowing a little bit more time. Within a couple of months, a new list appeared and these and several other conditions required me now to transfer to the physician. This meant that I was no longer able to care for the woman at all, but transfer her care to the physician. My point is that every time I addressed trying to get privileges improved and consistent with midwifery standards of practice and how I was educated, I lose ground. In 2000, some of my patients started a letter-writing campaign to protest some of the times that they were told they would not be able to be cared for by me. The CEO told me he had grave concerns about open discussions with my patients that I seemed to be having. He said it violated the confidentiality of the peer review process when I discuss these things with my patient. I then reminded him that I'm not privileged to attend peer review. He said he'd received several letters, he put them in file, and felt he needed to put me on notice that when patients are told about peer review issues, this is discoverable and creates legal problems for all concerned. I told him my clients needed to be aware that if these certain conditions are present in labor, I would be unable to care for them. And this is an ethical necessity and an honesty that all my clients expect and deserve. When I repeated this put me on notice phrase, he just said heads up, and if he kept getting letters, that disciplinary action would be required--what that was I have no idea. My attorney at the time wrote a letter to the chief of staff that stated: honesty with the clients resulted in chastisement from the CEO and an allegation that she has somehow violated the confidentiality of the peer review process. Such chastisement, at best, is harassment and at worst, is one more step in what increasingly appears to become an effort to drive Mrs. Consoli out of business, legally known as restraint of trade. I have had four attorneys over the past 13 years, and prior to becoming a CNM I never had the cause to secure the services of an attorney. About a year ago, I solicited many physicians in Norfolk to see if there was any interest in collaborating with me in starting my birth center. This birth center that I built was built to serve the needs of my increasing client load and for midwives to be able to practice midwifery. I ate crow and even went to the vice president of medical affairs. He told me if the hospital had any idea that I would be so popular--his word--I never would have gotten privileges in the first place. He stated that the medical executive committee thought that I might have a

certain appeal to hippie-type women. Well, now what I've done is made matters worse. I had 173 births last year, which is 18.4 percent of the births. My other stats are amazing: 4 percent were Cesareans. These are really good stats, and I work way too many hours. My friend, Alice, is ready to start caring for these women and helping me, but the hospital won't open the category. I dearly love what I do, but it's not healthy to be tied to your beeper 24/7. I don't get out of town. I pray that the hospital will see a way to open this category and allow women a right to midwifery birth if that is...and that is the safest way to have a baby, if you have to be in the hospital to have your baby in the first place. Women decide many things in our society, shouldn't they be allowed to have midwifery services without someone whose only vested interest in their birth is the dollars produced? So here we are, 13 years after the Nebraska Medical Association told me to be patient, rehashing the same information. We know that midwifery care is safe for low- to moderate-risk women; it is cost effective for payers and clients. This information hasn't changed. The only thing that has changed is that now different women are fighting for what should be their God-given right. Thank you. [LB406]

SENATOR GAY: Thank you. Were there any questions? Senator Stuthman. [LB406]

SENATOR STUTHMAN: Thank you, Senator Gay. Thank you for your testimony. The question that I have is why do you...why are we seeing so many Cesarean births now as we had in the past? Is this because of convenience? [LB406]

GAIL CONSOLI: Well, I'm sure that's part of it. I'm sure there's other people that are going to hear this testimony or see it, so there are truly many reasons. One is that VBACs, as Rachel mentioned, are not being done in a large number of hospitals around Nebraska and around the United States, and so if you had a C-section once, the next time you have one. That certainly increases the rate. Another is that certain deliveries that were done such as breech deliveries that were done, years ago, vaginally are now being delivered by C-section. And primarily, the majority of the C-sections probably have a whole lot to do with liability. [LB406]

SENATOR STUTHMAN: Okay, thank you. [LB406]

GAIL CONSOLI: Um-hum. [LB406]

SENATOR GAY: Senator Gloor. [LB406]

SENATOR GLOOR: Thank you, Chairman Gay. Ms. Consoli, you have a new CEO now. [LB406]

GAIL CONSOLI: Yes. [LB406]

SENATOR GLOOR: And so have you had discussions with that new CEO and birthing

centers and some of those discussions...or is any of this dialogue any different? [LB406]

GAIL CONSOLI: We haven't had the opportunity...I think we applied to visit with him about, possibly two months ago, and Alice and I have an appointment next week. [LB406]

SENATOR GLOOR: Alice? [LB406]

GAIL CONSOLI: Alice May, who testified two back. But even if he is kind enough to open the category, we just want to see this bill passed so it doesn't happen again to another hospital, and you don't have to keep seeing us every 12 years. (Laughter) [LB406]

SENATOR GLOOR: Thank you. [LB406]

SENATOR GAY: Senator Pankonin. [LB406]

SENATOR PANKONIN: Thank you, Chairman Gay. Appreciate your testimony, and you brought up, in a previous answer, the word liability. And I'm just curious...because you have a lower percentage of C-sections and you do have...currently do some births that maybe doctors won't because of the liability situation, what kind of insurance do you carry, and what's the situation with midwifery on liability? [LB406]

GAIL CONSOLI: Did I...I wouldn't do a birth that some physicians wouldn't do. I'm not sure if I understood the question. [LB406]

SENATOR PANKONIN: Well, you've indicated that your percentage is a higher percentage without C-sections. Is that correct? [LB406]

GAIL CONSOLI: Correct. Absolutely. [LB406]

SENATOR PANKONIN: And you also stated that some doctors won't take a chance and will do a C-section because of the circumstances of the birth. Is that... [LB406]

GAIL CONSOLI: No. [LB406]

SENATOR PANKONIN: Okay. [LB406]

GAIL CONSOLI: That wouldn't be any different at all. If the physician saw some reason for...an actual, legitimate reason for a C-section, a nurse-midwife would readily recommend the same exact thing. The primary goal is a safe mom and a safe baby, always. There is a lot of evidence...and Heather, who comes next, has a lot of information, but there is a lot to be said for another woman being present when the

woman is in labor; and midwives do things to help labor progress, where physicians would rely on the nursing staff. [LB406]

SENATOR PANKONIN: Okay, but liability insurance--you have... [LB406]

GAIL CONSOLI: Oh, yeah. [LB406]

SENATOR PANKONIN: Yeah, and it's...has it gone up... [LB406]

GAIL CONSOLI: Oh, yeah. [LB406]

SENATOR PANKONIN: ...just over the years...okay. [LB406]

GAIL CONSOLI: Yes. I think when I first graduated it was $5,000, and that's if you were doing births, and now it's over twenty. [LB406]

SENATOR PANKONIN: Twenty-thousand a year? [LB406]

GAIL PANKONIN: Um-hum. [LB406]

SENATOR PANKONIN: Thank you. [LB406]

SENATOR GAY: Any other questions? I don't see any, thank you. [LB406]

GAIL CONSOLI: Thank you. [LB406]

SENATOR GAY: Other proponents. Just while she's coming up, I did want to...I usually mention, a lot of times senators have to go to introduce other bills so they're going to be coming and going throughout the day; and I know several senators today have introductions, so if you see somebody leave, it's not that they're not interested, they're usually having a bill introduction in another committee--as we learned, first of all, Senator Fulton can't be in two places at once, so. But don't take any offense to that; that's what is going on, so. Go ahead. [LB406]

HEATHER SWANSON: (Exhibit 4) Hello, Senator Gay and committee members. My name is Heather Swanson, S-w-a-n-s-o-n. I'm a certified nurse-midwife from Wilcox. As well, I'm nationally certified as a lactation consultant and a family nurse-practioner, though I'm not licensed in Nebraska as an FNP, and I'm eager to see LB230 pass out of committee. I completed my undergrad nursing education here in Lincoln with UNMC College of Nursing in 1999; and in 2002 I obtained a master's in nursing with a speciality in nurse-midwifery from the University of New Mexico; and in 2006 finished a post-master's certificate as a family nurse-practitioner through UNMC Scottsbluff. I've worked for a private physician-owned practice as well as in a Critical Access Hospital

and for the U.S. Department of Health and Human Services Indian Health Service in Pine Ridge, South Dakota. I am now teaching in Kearney awaiting statute change. I am very grateful for, and since 2002 been involved with, Nebraska Friends of Midwives and other consumers who support midwifery care. I have recently been elected to serve on the national board of directors for the American College of Nurse-Midwives as the Region V representative, which covers 15 states. I'm here today to speak in support of LB406 as an interested consumer and as a nurse-midwife. This bill does not...there's a couple of things I'm going to skip over because they were already mentioned previously, but I do want to point out that this bill doesn't mandate that hospitals extend privileges to nurse-midwives. They can do anything they want to after somebody applies. This just gets the nurse-midwife in the door and ensures that they have to go through due process to review his or her application. I think it's quite unfortunate this bill has become a necessity for the livelihood of the health profession, and regardless if hospitals lift existing restrictions on nurse-midwives applying for privileges, I feel strongly that this bill's essential in preventing further unmerited discrimination of my profession. Back in 2002 I left New Mexico where, in 2006, 38.2 percent of the vaginal births in the state were attended by nurse-midwives; turned down the opportunity to work for a large physician-owned home birth practice in Chicago and moved to Norfolk. This is my home state and this is where I want to live. Unfortunately, I'm familiar with the testimony that Gail and Alice gave. In the fall of 2002, I applied for privileges at Faith Regional Hospital. In January 2003 the category was closed, but since my application was received before that date they had to consider it. I was denied privileges and went through the appeal process. The committee then heard my appeal, recommended that I be given privileges and found no reason why I should have been denied them. The hospital board of directors decided to not take that recommendation and upheld their decision to restrict me from practicing there. The reasons they gave me were ones that were insulting, not only to my credentials as a nurse-midwife, but even more so to my experience as a labor and delivery nurse. I provided support for my education and experience regarding their listed reasons, and in the end I didn't feel that anyone there really cared and that they caused unjust harm to my career and livelihood. I moved later that year. I was told that shortly after I moved to town, a committee was formed by the hospital to review the number of maternal health providers in town. They weren't concerned about the number of family practice or obstetric physicians in town, they only reviewed the number of nurse-midwives and the growing number of births that one midwife, my practice partner at the time, was attending. This was supposedly the committee that recommended the closure of the nurse-midwifery category. The reason was reported was to allow enough births for family practice residents that would be coming to Norfolk for rotations. I do think these physicians need a residency that includes maternal healthcare, but not at my professional expense. Keep in mind that hospitals do get paid to participate in a resident training. As well I was told by a family practice doctor, who held a prominent position at the hospital, that the more births the current CNM attended, the fewer the other practices did in town. This sounds like a consumer demand issue to me, which leads me to question a letter from Faith Regional

to Gail Consoli in 2004. The hospital reported in 2003 when they closed the category that they'd reconsider the category a year later, so Gail inquired about it. The reply, which you have a copy of, said that a needs assessment was done and there was no compelling need to reopen the category. If a busy nurse-midwife doing the work of, I would say, three nurse-midwives not compelling enough, I question what the assessment really was. Hospital's refusal to allow nurse-midwives to practice in their facilities is not unique. Closing the category, like what happened in Norfolk, or not opening it to start with has been documented as a means to control the number of practicing nurse-midwives and to ensure patient numbers for other types of providers. There are cases across the U.S. like mine and of nurse-midwives showing up for work and being told they've been let go; there was a case in Iowa where this happened several years ago. A 2007 article documented many of these stories. I'm going to read a brief one, part of one, here. This is a nurse-midwife, a conversation with the OB she had: I remember a conversation I had with an obstetrician with whom I had a good relationship. He said, I don't have any problems with you personally, but the fact is my practice is not full, and until it is there is not going to be another nurse-midwife that will get privileges at this hospital. We were told that a decision was made that no more midwives will added to the medical staff because the midwives were getting too busy and that there are people who don't want this to turn into midwifery hospital. When I read this article I thought, that sounds like things I heard up in Norfolk, and so this isn't just unique to one hospital here in our state. This bill is needed. The 1999 Pew Health reports that you were given by Alice, The Future of Midwifery , you have a copy of supports it and calls on legislators to ensure that nurse-midwives are not denied the ability to practice in hospitals. You have letters of support for this bill from the American College of Nurse-Midwives among other prominent people and consumers who desire nurse-midwifery care. I do hope you'll support this bill and support a model of care and a profession that had documented high quality of care outcomes and cost-effectiveness. Thank you. [LB406]

SENATOR GAY: Thank you. Any questions? Senator Stuthman. [LB406]

SENATOR STUTHMAN: Thank you, Senator Gay. Ms. Swanson... [LB406]

HEATHER SWANSON: Um-hum. [LB406]

SENATOR STUTHMAN: ...what do other states around us have, our bordering states, as far as midwifery? [LB406]

HEATHER SWANSON: Well, do you want to know in specific to this bill, to this provision? This provision is not..I did some searches online for it and in different...contacted the American College of Nurse-Midwives about it. This isn't a common thing that's done, typically, unless there's problems. So I can't tell you exactly what the stats are; I could try to call around and ask further about that with different

states. But from time to time it does come up because of situations like this. [LB406]

SENATOR STUTHMAN: Okay, thank you. [LB406]

HEATHER SWANSON: Um-hum. [LB406]

SENATOR GAY: Any other questions? I don't see any; thank you. Other proponents who would like to speak? I don't see any on this bill. Opponents? [LB406]

DAVID BUNTAIN: Senator Gay, members of the committee, my name is David Buntain, B-u-n-t-a-i-n. I'm a licensed...or registered lobbyist for the Nebraska Medical Association, and our legislative commission has taken a position in opposition to LB406. The problem that we have with this bill is that I don't really think it does anything. The issue has been kind of misrepresented to some extent. This does not require any hospital to license nurse-midwives, and I think your last witness testified and acknowledged that. Basically what this says is that a hospital cannot refuse to credential a professional based on the mere fact that he or she holds that credential. That's what the statute says. We went through this issue about 12-15 years ago with the psychologists who wanted to be included in it. It does not require the credentialling of any health professionals, and it allows hospitals to set the standards for the credentialling. It also does not prevent the closing of categories of licensure for, in this case, nurse-midwives or anyone else. So even if this bill were in place, it wouldn't solve the issue that is giving rise to the bill which is apparently...well, it does arise out of the Norfolk situation. The issue of credentialling is really a local issue for the hospitals, and they set the standards, and there are hospitals across the state...we don't have...I think the number I saw is that we currently have 21 certified nurse-midwives in the state, many of whom do have hospital privileges presently. And it's still going to come down to the hospital having standards and the person having to meet those standards. And like I say, there's nothing to prevent Norfolk hospital from closing the category of physicians or dentists or psychologists or nurse-midwives, so. To some extent, I think it's a solution for which there's no problem. [LB406]

SENATOR GAY: Thank you. Any questions? I don't see any, thank you. [LB406]

DAVID BUNTAIN: Thank you. [LB406]

SENATOR GAY: Other opponents? Any other opponents who would like to speak? Anyone neutral who would like to speak on this? [LB406]

_____: (Exhibit 5) I have a letter from the Hospital Association. [LB406]

SENATOR GAY: Okay, we'll just take that. [LB406]

_____: Thank you. [LB406]

SENATOR GAY: (Exhibit 6) All right. Anyone neutral would like to speak? I don't see any. And then Senator Fulton is still not here I see, so what we're going to do, we'll waive his closing. We know where to find him, so. And I think...Senator Friend...did he go back? He's on his way, so we'll wait here. I saw him over there...here he comes. While Senator Friend's getting situated, we do...we did receive several letters on all these bills and they will be put into the record. I'm not going to read through every one of them, but we do have a lot of support letters that we did receive, so I just want to let people know that we did receive those letters. They're in the record and in our files as well, because there were several letters to all these bills, so...of support. So we'll go from there. Senator Friend, earlier we had talked about instead of combining all these bills together, we're hearing them each separately, and then proponents and opponents are addressing just the specifics in the bill, so. We kind of said that earlier today how we're going to run it, so. [LB406]

SENATOR FRIEND: Okay. [LB457]

SENATOR GAY: Go ahead. [LB457]

SENATOR FRIEND: (Exhibit 1) Fair enough. Thank you, Chairman Gay and members of the Health and Human Services Committee. For the record, my name is Mike Friend; last name is spelled F-r-i-e-n-d, and I represent the 10th Legislative District in northwest Omaha. I'm here to introduce LB457 on behalf of the Nebraska Friends of Midwives. And in LB457, the key here is that it removes a requirement that certified nurse-midwives, or CNMs--I'll use the acronym from here on in, I believe, for most of the rest of the testimony--that they first procure a signed, written practice agreement with the supervising physician in order to practice midwifery. Removing this barrier to licensure and practice would increase opportunities for CNMs to practice in a variety of settings and locations across the state. I believe the committee has already received a copy of...and Senator Gay may have alluded to this too...a March 3 letter by a Joanna King with the American College of Nurse-Midwives. I'd like to highlight some of the comments that she made, for the record. Ms. King writes, and I quote, CNMs are primary care providers. This is a very good letter--CNMs are primary care providers who are trained to work independently and, as needed, consultatively with OB-GYNs and other physicians. When interdependence is needed, it takes place along a well-defined spectrum of interactions so that midwives are able to freely consult with physicians on matters that are beyond their scope of practice, and to co-manage or transfer care if appropriate. There is no justification to require CNMs to be supervised by or have any signed, written agreement with physicians in order to practice midwifery. Physicians do not need to execute signed, written agreements with specialists to whom they refer clients. Current Nebraska law is profoundly--in Joanna's eyes, and I tend to agree with that, that's a side note--profoundly misguided as it places liability on the supervising

physician for the midwife's actions or omissions, a primary reason physicians are understandably reluctant to sign collaborative agreements. The American College of Nurse-Midwives believes strongly that midwives and physicians should work within their scope of practice and be held independently accountable. Nebraska's laws are in need of being modernized to align with current standards of CNM practice. Highly skilled providers of primary care services for women and their families, CNMs have completed extensive education, training, credentialling, and certification. CNMs not only take care of women through pregnancy and childbirth, but also provide primary care, annual exams, cancer screening to women of all ages. Midwives have historically cared for those populations most at risk for health disparities. Current Nebraska restrictions on practice are severe, and they translate to a near complete de facto ban on CNM practice, a result which surely cannot comport with legislative intent. Nebraska legislators, we can play an important role in improving health outcomes, quality care, and resource utilization by addressing barriers to evidence-based maternity and womens healthcare. Approval of these bills that we're talking about here today is vitally important to our certified nurse-midwife members to be able to practice in Nebraska, and for other newly-minted graduates, as well as established practitioners in other states to be drawn to relocate to the state. In this day and age where there are growing shortages of healthcare practitioners who can provide primary care services to women and their families, particularly in rural areas, Nebraska can ill afford to continue to allow outmoded, patently unnecessary restrictions to impede the practice of highly qualified licensed certified nurse-midwives. That's the end of her quote, or at least the ones we chose to use. Also, for the record, I wanted to...I'd like to draw the committee's attention to a letter of support authored by Dr. Marsden Wagner--he's a physician, perinatologist, epidemiological scientist, and for 15 years the Director of the Women's and Children's Health and World Health Organization. I was trying to talk too fast. I hope you'll take time to read those comments. I also wanted to thank...we have a lobby behind us that seems to be between the ages of two months to 24 months (laughter) and that's pretty refreshing at this point in the session, so I wanted to thank everybody for coming out here. My discussions with a constituent that I had earlier this year, actually it was before the first of the year, indicate to me that there are some issues. If we can go somewhere to try to resolve some of that I think it would be beneficial. So I'd be happy to answer any questions, but I know some folks probably want to speak to these specifics, too. [LB457]

SENATOR GAY: Okay, then Senator Friend can I...like I say, we had three bills, so if we limited discussion...we heard about the benefits of the midwifery...if we...so this is the practice agreement that'd be... [LB457]

SENATOR FRIEND: The specific is here, let me repeat it. [LB457]

SENATOR GAY: ...that we could discuss... [LB457]

SENATOR FRIEND: Current Nebraska laws...wait a minute. All right, LB457 removes the requirement that a certified nurse-midwife first procure a signed, written practice agreement with a supervising physician in order to practice midwifery. [LB457]

SENATOR GAY: Right. So the question I'm going to ask you, it's your bill: my intent was to limit, now, more discussion, because I think several people are going to be testifying on all these bills but I would like to hear on the practice of agreement; the pros and the cons of a practice agreement. If we limited our discussion to that, I think it would be better for everyone, and that's...is that okay with you? That's kind of where I think we're going. Of course they can come up and talk whatever they want, but for any (inaudible) benefit, that's kind of the gist of the bill. [LB457]

SENATOR FRIEND: That's satisfactory, sure. [LB457]

SENATOR GAY: Okay, thank you. Are there any questions for Senator Friend? Senator Stuthman. [LB457]

SENATOR STUTHMAN: Thank you, Senator Gay. Senator Friend, also in your bill here it has, you know, that except that a certified nurse-midwife shall not attend home delivery. Is that correct, that's in the...page five? [LB457]

SENATOR FRIEND: Yeah, Senator Stuthman, what page would that be? [LB457]

SENATOR STUTHMAN: Page five, in the new...in the first two sentences, one and two. That's the new language in the bill, so. [LB457]

SENATOR FRIEND: Right. In any other setting approved by the board except that a certified nurse-midwife shall not attend a home delivery. Within an organized public health agency, or...I think...I can't speak to why that particular...I mean, that's an interesting question. I can't speak to why that particular piece is in there, except that to say that I think bill drafting felt that that would be... [LB457]

SENATOR STUTHMAN: And Senator Friend, I think this is an issue that we can address, but I just...you know, I have a very...I have an interest in home delivery is what I do. And so that's what I just...further and maybe even address Senator Gloor. [LB457]

SENATOR GAY: Or...and Jeff Santema, our legal counsel, can also get you information, Senator Stuthman, on that. Senator Gloor. [LB457]

SENATOR GLOOR: Thank you, Chairman Gay. You know, I'll throw you a line, Senator Friend. [LB457]

SENATOR FRIEND: Thank you. [LB457]

SENATOR GLOOR: I think your intent isn't that they can't do home deliveries, it's just a representation of the bill drafters that that's in current law. [LB457]

SENATOR FRIEND: Absolutely. And when I read that...it didn't...I didn't read it the same way that...I mean it didn't raise the concern that it raised with Senator Stuthman. But that doesn't mean that there's not a concern here. [LB457]

SENATOR GAY: Thank you, Senator Gloor, for helping with that. Any other questions for Senator Friend? [LB457]

SENATOR FRIEND: But can I only add one more thing? [LB457]

SENATOR GAY: Absolutely. [LB457]

SENATOR FRIEND: Being a Revenue Committee member, you notice that there's no fiscal note on this? (Laughter) You're welcome. [LB457]

SENATOR GAY: We'll take that into account. All right, thank you, Senator Friend. And then are you... [LB457]

SENATOR FRIEND: I do have to get back to Revenue because it's crazy over there... [LB457]

SENATOR GAY: You bet. [LB457]

SENATOR FRIEND: ...so I'll probably waive. [LB457]

SENATOR GAY: Okay, thank you. All right, we'll hear from proponents on LB457. How many will be testifying on this bill? Okay, so quite a few. Go ahead. [LB457]

SHAHAB ABDESSALAM: Hi. I'm Shahab Abdessalam. I'm a physician and a pediatric surgeon in Omaha, and I want to thank you guys for the opportunity to speak. [LB457]

SENATOR GAY: Can you spell your name? [LB457]

SHAHAB ABDESSALAM: The whole name? Shahab is S-h-a-h-a-b; Abdessalam is A-b-d-e-s-s-a-l-a-m. [LB457]

SENATOR GAY: Thank you. [LB457]

SHAHAB ABDESSALAM: And basically I just want to make one comment, and I would kind of equate limiting the practice of the CPNs (sic) under the guidance of a physician

to equate to all of the pediatricians having to sign an agreement with me, being the specialist and getting a lot of their referrals. Obviously, the pediatrician can handle 90-95 percent of what comes through their door, but when they run in to a problem or see something that is out of their scope of practice, then they are free to send the patient to me in consultation. So I would equate the independent practice as being like an independent pediatrician or a primary care physician that once it gets outside of their scope of practice they refer them on to somebody that's more qualified or can deal with more specialized care. [LB457]

SENATOR GAY: Okay. Thank you. Any questions? I don't see any, thank you. [LB457]

AUTUMN COOK : (Exhibit 2) Hello, good afternoon. [LB457]

SENATOR GAY: Hello. [LB457]

AUTUMN COOK: My name is Autumn Cook, which is A-u-t-u-m-n C-o-o-k. Just real quick, Senator Stuthman's question: the reason that that clause is still in there is because this bill doesn't deal with the home birth provision; we decided to split those up in the hopes that maybe, you know, it'd be clearer what we were working on with each bill. Does that make sense? [LB457]

SENATOR STUTHMAN: Yeah, thank you, thank you. [LB457]

AUTUMN COOK : So we're dealing with that issue with LB481, okay. Chairman Gay, members of the Health and Human Services Committee, I am chairwoman of Nebraska Friends of Midwives, and we are a consumer-based organization dedicated to supporting and advocating for the practice of midwifery in the state of Nebraska. I feel the need to begin by begging your pardon for having the baby with me. Ordinarily I'd make other arrangements for my children, as I have with my older ones, but this one's just two weeks old today, and I didn't dare hand her off to someone else during cold season. And I wasn't going to miss this. I and my organization strongly support LB457. It is sound policy that will help move Nebraska forward in its healthcare goals. The current statute requiring certified nurse-midwives, or sorry...regarding certified nurse-midwives does not reflect current practice standards, as Heather Swanson will discuss in depth. LB457 will bring Nebraska up to date by removing harmful restrictions on CNMs practice. This will increase the availability of certified nurse-midwives in the state and allow them to practice more consistently with their training. In reference to that statement, for example, more that one member of our group has been told by their midwife: if it were just me I'd handle it this way, but my backup doctor would have my hide so I have to do it this way. We women go to CNMs for a certain type of care, and we would like to be able to access that more freely. There are three points I'd like to discuss. First, the high demand in Nebraska for CNMs. Second, cost and freestanding birth centers; and third, the challenges that midwives face. The demand for CNMs is

increasing across the state. In Lincoln, one of the two practices with CNMs has just added a third midwife, and at the other, women must schedule their appointments weeks in advance because they fill up so quickly. At UNMC, the midwives are handling only obstetric patients--is that right, Heather?--only obstetric patients; no well-woman care because the demand for their services is so high. At Methodist in Omaha, the demand is such that women can't get in with the midwives after 18 or 20 weeks of pregnancy--that's halfway through. An obstetric practice in Beatrice will soon be adding a new CNM to their team. In addition to this, there are many women throughout the state who are members of our group or who contact our group looking for midwives in their area. Unfortunately, outside of Lincoln and Omaha where, as I've mentioned, the demand is high enough that even there women can't get in with the midwives if they're late to the game, the midwives are few and far enough between that many women who want one can't find one close enough. So the demand is high and growing, and we believe this legislation will enable more CNMs to practice in Nebraska. We don't think they'll swamp the state as soon as it passes, but it will allow them to set a practice over time and access the service with growing demand that women want. Second, cost and birth centers. I'll touch on quality of care in relation to this. CNMs provide excellent care outcomes, you've heard about that, along with high patient satisfaction and lower costs. The lower costs are due mainly to lower rates of interventions which someone else will discuss, or maybe have discussed; no one has to do that--make us be quiet. However, another very promising way to lower healthcare costs associated with childbirth is through the availability of freestanding birth centers. You'll hear from Gail Consoli in a few minutes, and she'll explain to you how the current situation has prevented her from opening a beautiful birth center in Norfolk. I've had personal experience with a free standing birth center in Utah, where I gave birth to my second child. The experience was exceptional, and Nebraska women would benefit greatly from the cost savings and consumer satisfaction that birth centers offer. Third, I wish to anticipate a possible objection to this legislation which affects midwives and consumers alike. At the 407 review in 2006, members of the Board of Health expressed concern that the current system of care may be reluctant to support CNMs as autonomous care providers. As I and other members of my organization have spoken with CNMs about their work on this bill, it has become apparent that a main factor preventing their explicit support of these bills is the difficulties they would face in building working relationships with physicians. They're concerned about the medical culture in Nebraska in which physicians avoid collaborating with non-physician providers to whom they have no legal obligation. These midwives explained to me that the medical culture in Nebraska is such that removal of the practice agreement requirement would create a rocky situation for some time as physicians get used to working with CNMs as autonomous care providers. I recognize the challenge here and it does concern me. More than one midwife has told me that she's been in a situation where she had to make not one quick phone call, but multiple calls in the middle of the night, to find a physician that would agree to perform a Cesarean section. Another told me of a physician who agreed to help, but then said the midwife had to leave and couldn't be there to provide support to her patient, and I found

these stories outrageous. But these are situations we may face as we deal with the transition period. I just want to let you guys know we recognize this, and we are willing to be the group of women who will deal with these difficulties during a hopefully short transition period, if it means our little sisters and daughters will have better access to midwives. So as a consumer of healthcare, I'm deeply disturbed to know that there are doctors in this state who would rather engage in turf war in the middle of the night than render the services for which they're trained. But I also know there are many good physicians who would never treat another healthcare provider or patient with such condescension. In the meantime, this legislation is the bridge that must be crossed before...and attitudes can begin to change. And I've got the rest here and I don't want to go further with the red light on so I'll let you read it. (Laugh) [LB457]

SENATOR GAY: No, that's all right; that's all right, you did a great job. Thank you. Any questions? Senator Gloor. [LB457]

SENATOR GLOOR: Thank you, Chairman Gay. And thank you for your testimony, and thank you to the little one who's very well behaved; better behaved than most of the senators are. (Laughter) [LB457]

AUTUMN COOK: She's doing pretty good. [LB457]

SENATOR GLOOR: There's a sentence in here that says: more than one midwife has told me she's been in a situation where she's not been able to get physicians to respond for an emergency C-section. I'm assuming it was emergency C-section...or a routine C-section? [LB457]

AUTUMN COOK : It would have been an emergency; in the middle of the night and they needed one. I believe, as the story was told to me, the collaborating physician was not available one way or another, so. [LB457]

SENATOR GLOOR: So it was the collaborating physician who was not available to do the C-section. [LB457]

AUTUMN COOK: No, it wasn't that she called the collaborating physician and the collaborating physician wouldn't come. I believe, as the story was told to me, that he was away, so I...it was just...what struck me was the idea that there would be doctors who'd say no, sorry, I don't want to come in and do a C-section for you, even though we know when a C-section is actually needed it's needed. That's what struck me and disturbed me, and I realize that that may be something that we have to deal with as women, you know, seeking the care of a CNM before physicians get used to working with CNMs that way. And I bring this point up to let you know we recognize that; I think it would be a short transition period, but I think there are plenty of physicians who would step in and be willing to help and, anyway...I hope that makes sense. [LB457]

SENATOR GLOOR: But it wasn't the collaborating physician? [LB457]

AUTUMN COOK : It was not, no. He's very supportive and he would have been there, but...yeah. [LB457]

SENATOR GAY: Any other questions? I think we'd all agree Mary Elizabeth is the youngest to be here. (Laughter) [LB457]

AUTUMN COOK: Yeah, two weeks. [LB457]

SENATOR GAY: That's pretty good. I don't see any other questions, thank you. [LB457]

AUTUMN COOK: Thank you. [LB457]

SENATOR GAY: Other proponents. [LB457]

RACHEL GILLIGAN HOWELL: (Exhibit 3) Hi, senators, my name is Rachel Gilligan Howell, it's R-a-c-h-e-l; Gilligan is G-i-l-l-i-g-a-n; and Howell is H-o-w-e-l-l. I am a voter in District 1, and I support the passage of LB457 and ask that you will too. This bill will lift the current requirement of written practice agreements between CNMs and obstetricians, allowing CNMs to own their own practices. As one who is currently in pursuit of the CNM profession this is personally important to me. Due to raised insurance rates, it can be difficult or next to impossible for a CNM to obtain a practice agreement with an obstetrician. An additional disincentive for physicians to enter such agreements is that they have, to a degree, competing practices with CNMs. Also, even if a physician is willing to sign such an agreement, the hospital with which the physician has privileges may be less than supportive as fees for the midwifery model of care generate much less revenue. Because of this, it is possible that an institution may unduly influence a physician's ability to enter such an agreement. Although one might think that maternity costs would be only a small portion of a hospital's income, the truth is is that it costs our nation more than any other health condition. Child birth is the number one reason for hospital admittance in this country. This bill prevents this obstacle of conflicted interest and supports fair trade. The passage of this bill would also facilitate the possibility of freestanding birth centers, my first choice of practice location. Birth centers have existed in this country for 30 years and have proven to have maternal and fetal morbidity and mortality comparable to that of hospitals while using substantially fewer medical resources and procedures. Many women with whom I have spoken express that while home birth is not a good option for them, they are also not thrilled with what hospitals offer, and bemoan the fact that we have no freestanding birth centers here in Nebraska. Without legislation friendlier to CNMs, it is possible that my family and I will be forced to relocate to another state in the future when we would rather stay here in Nebraska. Please vote to send this bill to the floor. Thank you. [LB457]

SENATOR GAY: Thank you. Any questions? Senator Pankonin. [LB457]

SENATOR PANKONIN: Thank you, Senator Gay. I just have one question. I represent District 2 and you've got an Omaha address but you say you vote in District 1, so where are you from? [LB457]

RACHEL GILLIGAN HOWELL: Well, I am in Omaha. [LB457]

SENATOR PANKONIN: Well, I think you're in... [LB457]

RACHEL GILLIGAN HOWELL: I was thinking I had Senator Tom White as my senator. [LB457]

SENATOR HOWARD: Eight; that's eight. [LB457]

SENATOR PANKONIN: Oh, okay. [LB457]

RACHEL GILLIGAN HOWELL: Oh, that's eight? I'm so...(Laughter) [LB457]

SENATOR PANKONIN: Yeah, District 1 is southeast Nebraska, so I just was trying to figure out... [LB457]

RACHEL GILLIGAN HOWELL: Oh, well, would you just mind making an eight right on top of that one? (Laughter) [LB457]

SENATOR PANKONIN: All right, okay. [LB457]

RACHEL GILLIGAN HOWELL: Thank you for that correction. Anything else? [LB457]

SENATOR GAY: I wouldn't have known either. [LB457]

RACHEL GILLIGAN HOWELL: I'll do better next time. (Laugh) [LB457]

SENATOR GAY: You did fine. [LB457]

SENATOR CAMPBELL: Just vote; that's all that counts. (Laughter) [LB457]

SENATOR GAY: Other proponents. [LB457]

GAIL CONSOLI: (Exhibit 4) Good afternoon, again. And I am still Gail Consoli, and I'm the nurse-midwife in Norfolk. I'm here in support of LB457 to remove the mandated requirement, as has been stated many times over. And also that the ACNM supports

that nurse-midwives are primary care providers; you've heard that already. Also, that we're required to work within our scope; I think you've heard that. So in 2007 the hospital sent me a requirement for a second backup physician. This was a new requirement that the hospital had just come up with and I don't have one. I couldn't find one and I've looked. There is an OB/GYN in town who I have consulted with recently; he is very willing to help me out if...one example was I had a lady--it was her fifth baby and she absolutely did not want a C-section, and I could not make the baby turn and it was breech. He's very comfortable doing breech deliveries; my particular collaborating physician is no longer comfortable doing that. So he was very gracious and attended the birth along with myself. So there are physicians that would agree to assist, but he's...it's doubtable that he would ever sign an agreement for me to get that second backup like the hospital wants, because he works in a practice...he's employed in a practice which is very much not friendly towards me. I have no doubt that if they wanted to pursue the requirement for a second physician I could lose privileges altogether. Requiring a practice agreement creates many problems and no solutions. It very successfully, however, reduces access to nurse-midwifery care, especially for those wanting to have a CNM attended out-of-hospital birth. I built a birth center which I believe was the solution for many of my clients to have a safe and personalized birth in an environment conducive to midwifery philosophy and practice. Also to serve the needs of my increasing client load and for more midwives to be able to practice midwifery. I originally had the backing of my collaborative physician at the time, and for reasons related to malpractice insurance and other issues, he changed his mind in his support after the project was well underway. At one time I had enough money in my husband and my retirement to search for a physician, outfit the birth center with all the needed equipment and furnishings and staff, and to take care of the costs for the first six months. Now, because of needing a practice agreement, which was reneged on, paying for the building which has been for sale for over a year and a half, I'm broke. My husband and I may need to file Chapter 13. I have helped Alice by precepting her and always expected we would work together in the birth center. I believe women have the right to a midwifery birth in that setting if that is their desire. So here we are, 13 years after the Nebraska Medical Association told me to be patient, rehashing the same information. But one difference now is that there's a birth center in Norfolk which could have been admitting women for over a year and a half. But the requirement of a practice agreement and now, being out of money, time, and women are once again limited in their healthy choices. So it's kind of the same song but a different tune. Thank you. [LB457]

SENATOR GAY: Thank you. Any questions? Senator Gloor. [LB457]

SENATOR GLOOR: Thank you, Chairman Gay. These are serious questions, trust me. I'm going to ask you to give me the benefit of some of your years of experience. If I wanted to become a midwife, could I become a male midwife? [LB457]

GAIL CONSOLI: Absolutely. There are male midwives in the United States. [LB457]

SENATOR GLOOR: Okay. Are there male midwives? [LB457]

GAIL CONSOLI: Uh-huh. I actually had one of them as my mentor when I was in Fargo... [LB457]

SENATOR GLOOR: Okay. [LB457]

GAIL CONSOLI: ...two women, one man. [LB457]

SENATOR GLOOR: And this has to do more with I think your opinion and experience and that is female OB/GYNs become very popular very quickly, and that's always made sense to me. As a male, I prefer going to a male physician for issues that are related to me and my physiology. [LB457]

GAIL CONSOLI: Exactly. [LB457]

SENATOR GLOOR: I can see why women would want to go to women for healthcare for issues that are strictly women's issues. [LB457]

GAIL CONSOLI: Right. [LB457]

SENATOR GLOOR: To what extent do you think that plays into the popularity of midwives? [LB457]

GAIL CONSOLI: Well, I think it certainly plays into the popularity, but women...you know, probably truthfully half of my population comes to me because I'm a woman. And I think truly the other half is looking for midwifery care. A lot of my patients will come in having no idea what midwifery care is, just knowing that they wanted a woman. And that is sometimes because of their history or sometimes just as a desire. But unfortunately, there is in all communities--I just need to make this broad scope--in all communities usually of any size there are female OB/GYNs, and they don't always turn out to have the best following. [LB457]

SENATOR GLOOR: I'm sure that would be true with some... [LB457]

GAIL CONSOLI: And some of that's personality. [LB457]

SENATOR GLOOR: I was going to say I think the same might be true if that same individual were a midwife. If the personality isn't a good match, then they're probably not a good care provider. [LB457]

GAIL CONSOLI: Absolutely, although we're all very sweet. (Laughter) [LB457]

SENATOR GLOOR: And so are we. Thank you for your honest answers. [LB457]

GAIL CONSOLI: Sure. [LB457]

SENATOR GAY: All right. Any other questions? I don't... [LB457]

GAIL CONSOLI: Thank you. [LB457]

SENATOR GAY: Thank you. All right. Other proponents who would like to speak. And then we still...even though many of you are testifying again, we still need you to state your name and spell it out because it is being recorded and it's very helpful when we're going through the tapes. [LB457]

HEATHER SWANSON: (Exhibit 5) Sorry for the stack. A nurse midwife made me promise I would bring that bottom document to you so...since she's probably watching, we have it done. [LB457]

SENATOR GAY: She could be. [LB457]

HEATHER SWANSON: Again, my name is Heather Swanson. I'm a certified nurse midwife from Wilcox. I'm here to speak in support of LB457 as an interested...oh, sorry, S-w-a-n-s-o-n is my last name, to speak in support of LB457 as an interested consumer and as a nurse midwife. The requirement of practice agreements with physicians for nurse-midwives have not shown to improve quality of care and cost effectiveness. They have, though, been effective in limiting nurse-midwifery practice in all settings. This includes clinics, hospitals, birth centers, and home births, the reason being that physicians are allowed to dictate if, where, and how a nurse-midwife may practice. Now I do want to preface this, give a little entry that I'm not here to imply that we don't need physicians. I think we definitely need them. I love to practice within my nurse-midwifery scope of practice, and if it's beyond that, I love to know there's somebody that can take care of a higher level of care than what I can provide. So I am very grateful for the physician colleagues that I've worked with. I'm going to read a couple of excerpts out of a book just to give you a little bit of a background here: In 1985, the American Medical Association undertook a nine-point program of activities to assist state medical associations and medical specialty societies to oppose legislation that would allow healthcare professionals who are not physicians to practice independently. In 1993, the AMA appealed to physicians for funds to help it respond to the flock of nonphysician practitioner groups. In 1995, the AMA House of Delegates added a statement that the physician is responsible for the supervision of nurse-practitioners and other advance practice nurses in all settings to its guidelines for physician/nurse-practitioners practice. So I want to interject before I go on with a couple of other statements there. I practice

midwifery, not medicine. So why should physicians take it upon themselves to control my profession, because we certainly don't have nurses controlling theirs? In 1980, the American Academy of Family Physicians issued a formal statement opposing nurse-midwifery licensure and asserted that the use of nurse midwives is not in the best interest of quality patient care. The AAFP does not believe that the midwife can adequately substitute for the physician in obstetrics and has recommended abolishment of midwifery for many years. In 1990, they went on to say...or they stated strong opposition to the independent practice of obstetrics and gynecology by nonphysicians. CNMs should be employed only as a means of providing limited care, always under the direction and responsible supervision of a practicing licensed physician. In 1993, they revised it, noting that family physicians work with nurse-midwives. However, the AAFP continues to oppose independent practice by nurse-midwives and upholds the principles that all nonphysician healthcare providers should be supervised by physicians, and all payment for services should go through the supervising physician. And that came out of a document from the AAFP in '93. So this is just the tip of the iceberg. I haven't told you about the last 14 years, which there's been a ton of stuff I could bring up. Also, I'm leaving out the things in the early 1900's, which there's been a lot of campaigns against nurse-midwifery providers. There's longstanding opposition that exists and without research evidence to support continuing such opposition. Do I expect physician trade organizations to support removing the written practice agreement? No. It's not in their best interests. There is, though, plenty of research to say it would be in the best interest of consumers regarding the healthcare outcomes, birth outcomes, and would save the U.S. a significant amount of money. Over ten years ago, some experts estimated that nearly $20 billion could be saved in healthcare costs by demedicalizing childbirth, developing midwifery, and encouraging breast-feeding. In comparing data from a 2007 Washington State Health Department review that was used for a legislative report...to compare those numbers to Nebraska, this bill could easily lead to a savings over $1.3 million per year. I'm going to skip down here a little bit. You do have a couple of reports that I do want to point out: the Pew Health Report, the Milbank Report, and the Cochrane Report are pretty significant documents that I wish people would read and listen to and really make some application from them. The Pew Health Report was published ten years ago, and it had recommendations that legislators and policymakers not require that midwives be controlled by physicians or have practice agreements. And nobody has paid any attention to it here, obviously. And I'm hoping that you guys will and you'll help our profession with this. Allowing nurse-midwives to practice without a practice agreement is not a novel idea, although it is very hard to get statutes changed in states that still require them, because such states generally have fewer CNMs and significantly less money than our colleagues that oppose bills like this; nor do CNMs here have a paid lobbyist of their own. The federal government recognizes all APRNs that are employed by them as independent practitioners and does not require practice agreements. As well, the surrounding states of Iowa, Wyoming, Colorado, and Kansas do not for licensure. I should note though that Kansas does require jointly approved protocols, and Colorado has yet to grant CNMs autonomous prescriptive authority. As

well, South Dakota recently enacted a bill allowing a waiver of a written practice agreement for CNMs attending out-of-hospital births. And my testimony got a little bit longer because one of the midwives attending home births in South Dakota was going to come down--she also attends home births in Wyoming--but she had somebody in labor today so she's going to have to make the 11-hour drive from Lead today. CNMs have been licensed in Nebraska since 1984, though the number of practicing nurse-midwives has been around 20 for the last several years. Regarding payer sources for births in Nebraska, nurse-midwives' patient load contains a higher proportion of women on Medicaid than M.D. or D.O. physicians and historically have served a higher proportion of underserved and at-risk populations across the United States. I want to mention that practice agreements are a significant issue for all APRNs and especially for nurse-midwives, because they are restraining our trade without evidence to support them. If this bill passes, I don't anticipate a flood of nurse-midwives into Nebraska, nor do I expect the practice of many CNMs currently practicing in Nebraska to change. For one thing, many enjoy the practice situations they're in. It fits well in their practice model, works well for their family life, and they've invested time into a working practice relationship with physicians. Whatever the reason for job satisfaction might be, this will not dramatically change the face of nurse-midwifery practice. But over time as CNMs graduate from school, we should start to witness some positive effects. I do have...there's a research summary from the American College of Nurse-Midwives that summarizes nurse-midwifery practice well. And I heard about a point last week that I do want to raise to you guys' attention. You also need to be aware that there are real concerns for nurse-midwives publicly supporting this bill as well as other bills. There was a nurse-practitioner who testified in support of LB230 several weeks ago in front of you guys whose practice agreement has since been rescinded. The potential backlash for nurse-midwives supporting this bill is real. I happen to be in a professional work situation where I'm not risking losing a practice agreement. I may, though, never get one that allows me to practice in Nebraska, given my support of these bills over the years. But supporting this bill is the right thing to do, and I feel an obligation to my profession and to the consumers we serve. And I do...I made a little table for you guys in regards to what's going on in other states. Most of this information I got off of American College of Nurse-Midwives' Web site. Some of the data hasn't been updated so...and some of it I got off of practice acts in different states. So I can't promise that all of this is accurate, but it's as accurate as I could find. And the American College of Nurse-Midwives did tell me they would review this and see if there were any updates that need to be made. But there's about 19 states that don't require a practice agreement at all; 10 that only require it for writing prescriptions, that would be like Colorado; 3 that require it for prescriptions and certain other cares; 2 for consultation, which seems a little strange to me--I don't know how that works out in their states; and then there are 17 that require a practice agreement for some sorts other than previously mentioned, so we would be in that group of 17. Sorry I went long, but I thought those were good points. [LB457]

SENATOR GAY: Thank you. Any questions? Senator Wallman. [LB457]

SENATOR WALLMAN: Thank you, Chairman Gay. Yeah, thanks for testifying. Are these children in here all born with midwives? [LB457]

HEATHER SWANSON: Well, do you want a show of hands maybe? [LB457]

SENATOR GAY: No, that's all right. [LB457]

HEATHER SWANSON: There's quite a few that are. I know there are quite a few in here that were. [LB457]

SENATOR WALLMAN: Sure, that's fine. [LB457]

SENATOR GAY: All right, thank you. Any other questions? I don't see any. Thank you. [LB457]

HEATHER SWANSON: Yep. [LB457]

SENATOR GAY: Other proponents who would like to speak. How many more proponents do we have? How many opponents do we have? So one opponents and two I guess...two opponents, and I think you're the last proponent, so. [LB457]

ANNETTE HARMON: (Exhibit 6) Good afternoon, Senator Gay and members of the Health and Human Services Committee. My name is Annette Harmon, H-a-r-m-o-n, and I'm executive director for the Nebraska Nurses Association. We represent the 20,000-plus licensed registered nurses in the state of Nebraska, and believe me, what he's handing out is not my testimony (laugh) as it is quite lengthy. It is instead the consensus model for regulation of advanced practice registered nurses. And what I'd like to speak to you today is about where the future of advanced practice is going. We represent not only registered nurses but advance registered nurses. That includes certified nurse-midwives, nurse-practitioners, certified registered nurse-anesthetists, and also clinical nurse specialist. Those are the four categories of APRNs. We have members of all of those groups as members of the Nebraska Nurses Association. We are proud of their membership. We would encourage your support of LB457, and we encourage your support of the elimination of the integrated practice agreement for APRNs. That is the national model trend--to provide independent practice for APRNs. Nationally, this model is also endorsed by the National Council of State Boards of Nursing, the regulatory body for registered nurses and for APRNs. We would believe that the elimination of the integrated practice agreement is an elimination to barrier of practice and an increase of care and access to all Nebraska citizens; not only in northeast Nebraska, but in Lincoln, Omaha, and around the state. For CNMs, it offers a versatile option of care for families, and we also believe that option in care is a vital component. We support the elimination of integrated practice agreement, and we also

support the consensus model for regulation. I really don't have a lot of other facts and figures as you've heard from those who do actually practice, but I would be open to any questions. [LB457]

SENATOR GAY: Thank you. Any questions? Don't see any. Thank you. [LB457]

ANNETTE HARMON: Thank you. [LB457]

SENATOR GAY: Last call for proponents today. All right, we're going to go to opponents. [LB457]

TODD PANKRATZ: My name is Todd Pankratz, P-a-n-k-r-a-t-z. I'm a practicing OB/GYN in Hastings, Nebraska, representing the Nebraska Medical Association, and we oppose this bill. Just to give some background information on me, my practice...I've been practicing in Nebraska for 11 years now. Our practice was, I think, the second practice in the state to employ or work with a certified nurse midwife. And we have now worked with midwives for 16 years. We have two of them in our office at this point. And with the testimony that's been given about the quality of care, you know, I agree with the majority of the comments that have been made. They do give quality care. The things that I want to talk about, though, just a few points here. Right now we have a system or a model in the state that does work. It's worked for 16 years for us, and changing it I'm not sure gives us all the things that we desire. Medicine over the last couple of years and over the last decade has continued to change and evolve. Patient safety has become more and more important, and the safety should be our very first concern with anything that we consider. If you look at medicine, if you look at the integration of physicians working with nurses, working with nurse practitioners, certified nurse-midwives, medicine has turned and is turning into a team collaborative. It is becoming a team. It is not just becoming a physician-driven practice. And for patient safety, we need a team. We need every single one of those people serving on that team. And so I really would hate to lose that collaborative agreement so that we can continue this team approach. Two comments that were made earlier that I just want to kind of bring up too. First, there was a mention of a difficult time where physicians being very reluctant to sign collaborative agreements. I would disagree with that. If you look at the PAs, the physician assistants that are out there, they...physicians are signing collaborative agreements with them all the time. I'm not sure it's a widespread problem of nobody is signing a collaborative agreement versus a small area. And then the second or third comment I want to make is the very first comment about comparing a certified nurse midwife and referring onto a physician compared to a pediatrician referring onto a pediatric specialist, major difference there is that a pediatrician and the pediatric specialist both did four years of medical school, they did three years of pediatric training, and then the specialist went onto his fellowship training. It is not comparable. That's all I have to say. [LB457]

SENATOR GAY: All right, thank you, Doctor. Senator Gloor. [LB457]

SENATOR GLOOR: Thank you, Chairman Gay. Doctor, if memory serves me correctly, you married very well, I believe. Your wife is a committed dentist to children's issues and has been of great help to the state. [LB457]

TODD PANKRATZ: Right. Most people... [LB457]

SENATOR GLOOR: And I know you've been supportive of her in that... [LB457]

TODD PANKRATZ: Most people say she married below herself. (Laughter) So... [LB457]

SENATOR GLOOR: Now for the serious question, now that I've buttered you up. Assuming this table is correct, it shows that there are only two states where there are statutes that restrict home births. Why is that? Why is Nebraska one of just one other state that restricts home birth do you think? [LB457]

TODD PANKRATZ: You know, I don't know of the specific reasons why the previous 407 processes have not agreed to it. From my personal standpoint, it's going to be a safety issue. And I can either approach that now or I can talk about that with the next bill. [LB457]

SENATOR GAY: Let's wait. [LB457]

SENATOR GLOOR: Thank you. [LB457]

SENATOR GAY: (Exhibits 7 and 8) Any other questions? I don't see any. Thank you. We did receive one letter of opposition from Nebraska Hospital Association. And then, as I had mentioned earlier when Senator Friend was here, we have several letters, personal letters that were written to committee members that will be put into the record. [LB457]

JOANN SCHAEFER: (Exhibit 9) Good afternoon, senators and members of the committee. My name is Dr. Joann Schaefer, J-o-a-n-n S-c-h-a-e-f-e-r, M.D. I'm the chief medical officer of the state of Nebraska and the director of the Division of Public Health. I'm here to testify in opposition to LB457. I'm not going to go into much of the repetitive nature of what we've talked about. However, I do want to comment that certified nurse midwives are fantastic and a valuable resource to the whole healthcare system. And I want to duly recognize that I worked with nurse midwives before in the hospital setting. And I am a board certified family physician and did my own deliveries as well. They are absolutely wonderful and very valuable. Right now, to eliminate the practice agreement we feel that there is still a risk for not having the adequate backup and emergency

coverage needed. And we heard about that already once today. That is our main reason for opposition to the bill. The bill also expands settings for the nurse midwives that may perform at the residence, office, and clinic, or other certified nurse midwife group and a group of certified midwives. It's language in the bill, but it seems to have been retracted. So there's just some confusion as to what is allowed and what is not. I'm submitting to you today an LB...407, I'm sorry, it's the 407 process. It was LB407 and we haven't ever been able to get away from that number. But it's a credentialing review process, and it was done in 2006. I submitted it to you on January 12 of 2007. Within that there are a lot of issues, so I won't address that. One of the issues in there was about the...having the collaborative agreement. There are six studies that were referred to that I had an epidemiologist review for the statistical validity of those studies and the information that it told us. And at the time there was no evidence that was presented that would say that this is a good or bad thing either way. I will say that there was a study that did show that there still is a significant number of women that do have to be referred onto a system for emergency C-sections and whatnot. That's my question as to how that integration would take place, where there's adequate backup so that if a physician needs to arrive for emergent care, that it can adequately be dealt with. I do want to read my closing of the 407 as it's pertinent to our discussion here today. There is much evidence that the medical model for birthing that could be improved. As I noted above, there are excellent examples of hospitals that use CNMs have established low intervention birthing programs that are still...that still assure access to lifesaving technology in an emergency. I strongly endorse the further development of these models that acknowledge the wishes of mothers of a more natural birthing experience within the overreaching parameters of modern medicine. So I just wanted to quote that too. And again the issue is with whether or not the collaborative agreement or the requirement of agreement, wiping that out if it would lower the safety threshold, which is, of course, the focus here and the safety of the child. I think that's all I have to say. And I won't read my testimony for the sake of time. Do you have any questions? [LB457]

SENATOR GAY: Thank you, Dr. Schaefer. Any questions? I don't see any. Thank you. Any other opponents? Anyone neutral? I don't see anyone neutral. All right. And then Senator Friend waived his closing. So we will close the testimony on LB457. And Senator Haar is here on LB481. [LB457 LB481]

SENATOR HAAR: Hello, Senator Gay and members of the committee. If you were to ask me to tell all about my life, (laugh) I would start off by telling you that I was born in Freeman, South Dakota. It's a little town 36 miles north of Yankton. And actually, all my other brothers and sisters...my brothers and sisters were born in Yankton at the hospital. And that was the plan for me, but my mother tells the story where, I don't know what the occasion exactly, but she was having a belly laugh, in here terminology, and there I came. (Laughter) So, I guess, I was born in laughter and what a neat way to start life. (Laugh) So today I am pleased to introduce LB481 to legalize home births by certified nurse midwives. Were we to do this, of course you've heard this before, we

would not be leaders. In fact, Nebraska is only one of two states other than Alabama that restricts certified nurse midwives from attending home births. Home births have always occurred and are currently occurring in Nebraska. And I have some friends, in fact, and this is not recent anymore, but decided to have a home birth. So they basically have to do this illegally. They brought in a nurse practitioner who had had experience as a nurse midwife, and because they felt it was really important to have home births. And those three children are healthy and happy. I think by prohibiting certified nurse midwives for attending home births actually may increase the risk for some women because now they're forced to go to a hospital. There will be testifiers following me who can explain why this restriction was put into place and explain home births with certified nurse midwives, from both the midwife and a family perspective. So I will give it over to them. And then I would like to stay for closing. So if you have any questions for me... [LB481]

SENATOR GAY: All right, thank you, Senator Haar. Senator Wallman. [LB481]

SENATOR WALLMAN: Thank you, Chairman Gay. Welcome, Senator Haar. [LB481]

SENATOR HAAR: Thank you. [LB481]

SENATOR WALLMAN: I, too, was born at home, not by a certified midwife either (Laugh) but a person with an eighth grade education. So thank you for coming up here. [LB481]

SENATOR HAAR: You bet. [LB481]

SENATOR GAY: Senator Howard, did you have a question? Senator Howard. [LB481]

SENATOR HOWARD: Oh, did you finish? Okay. Thank you. Thank you, Chairman Gay. Do you worry about unexpected complications that could arise? I mean, none of us have a guarantee that things couldn't...problems couldn't develop during a delivery. And if you're not in close range of a hospital or medical equipment, does that concern you? [LB481]

SENATOR HAAR: Well, of course, safety is always a concern. But in this case you have certified nurse midwives who obviously have the training. And also these certified nurse midwives have usually worked with the woman through her pregnancy. And so...and I'm not a doctor so I can't say this precisely. But you can pretty much predict if, you know, a birth is going to be normal or...and in those cases, a responsible certified nurse midwife would also want to be in a hospital setting. You know, any birthing has risks involved. And I believe this is a choice that women should be able to make, so... [LB481]

SENATOR HOWARD: Well, not to belabor the point, but my grandmother died in

childbirth. That wasn't uncommon in those days,... [LB481]

SENATOR HAAR: Sure. [LB481]

SENATOR HOWARD: ...but it was pretty typical that babies were born at home back then. And you know, you always think about the things that...you hope for all the things that go right, but you worry about the things that could go wrong at the same time. So thank you. [LB481]

SENATOR HAAR: You bet. Any other questions? [LB481]

SENATOR GAY: I don't see any. Senator Haar, what we're doing, and others...Senator Fulton had a bill, Senator Friend had a bill, and you have a bill all dealing with a little bit different things. [LB481]

SENATOR HAAR: Right, yes, twists of this, yeah. [LB481]

SENATOR GAY: So what we're doing, and we've told...the audience has heard this several times. But what we're doing is then keeping focused on the home delivery portion... [LB481]

SENATOR HAAR: You bet. [LB481]

SENATOR GAY: ...and we're not being repetitive. Just so you know, we're not cutting anyone off, we just have to ask everyone to be specific. So just wanted to kind of bring you up to speed. I know you're coming in later. But that's what we're doing. And then you'll stick around and answer any questions we have for you. [LB481]

SENATOR HAAR: Okay, good, thank you so much. [LB481]

SENATOR GAY: All right, thank you. All right. We'll start off with proponents on LB481. [LB481]

ANN SEACREST: (Exhibit 1) Good afternoon. Thank you for sitting through all of this passionate talk. Senators, my name is Ann Seacrest, A-n-n S-e-a-c-r-e-s-t. I reside at 2309 Lake Street in Lincoln, Nebraska. I'm a registered nurse and I work in maternal child health as the director of a nonprofit organization. Twenty-seven years ago I moved to Nebraska pregnant with my first child. And I had been receiving prenatal care from a certified nurse midwife, or CNM, in Iowa. I was very disappointed when I arrived in Lincoln, Nebraska to find out that I could not continue that same type of prenatal care throughout my pregnancy. At that time, Nebraska was one of only two states, the other being North Dakota, that did not recognize or license certified nurse midwives. Truly believing that midwifery care lends a positive and cost-savings aspect, which you've

heard much about today already, I worked with a number of local groups to initiate and organize an interim study before the Legislature, helped to draft the legislation, the initial legislation, and I lobbied for the passage of a bill which licensed certified nurse midwives in the state of Nebraska. I was pregnant with my second child as I spent time in the halls and the meeting rooms of this building, much like the young families that are here today. I have to say that many of our children back then were nowhere near as well-behaved as the ones that are here today. (Laughter) I'm very, very impressed. Numerous times over the past 25 years, I have appeared before this legislative committee as well as Health Department committees to explain why did the original bill have a clause that forbids nurse midwives from attending a birth in a home. And there have been people who have looked at the bill and said, you can attend a birth anywhere but in a home. You can attend it in a train station, wherever you want to, but not in a home if you're a nurse midwife. I wish I could say that that decision was supported by scores of research documenting its validity. But as you know, in the legislative process that is not always what happens. Throughout that legislative process the Nebraska Medical Association chose not to meet to discuss the bill. Not until the bill's hearing did they speak up in opposition of the bill. In order to get the bill out of committee we, our organization, was asked to sit down in a room and work out a compromise with the NMA to allow the bill to move to the floor. The NMA asked for the clause prohibiting home births. We had spent two years gathering information, educating senators, attending meetings, walking the halls, and we had to decide whether to start all over again or accept the compromise. We accepted the compromise in the 13th hour, thinking that it would not hold up to the test of time and knowledge and evolution of what we know is wise and good medical practice. You've heard CNMs are a respectable group of professionals in our state. I am pleased to report my fourth child was born with a nurse midwife in attendance. They've worked hard to get where they are. Their credentials are impeccable, they provide a type of care that enhances the health of our state, and they meet a need in a financially sound manner when healthcare costs are skyrocketing. Birth in itself carries a risk. It's part of nature. Hospital births carry a risk, home births carry a risk. There are rules, regulations and protocols to follow in either situation to help assure a safe outcome. There may be a woman in a small town Nebraska hospital who is nowhere near closer to having a physician in the hospital for her birth than there may be a woman having a home birth who needs to transport to a hospital. Not one of our nurse midwives in our state is going to risk her job security by attending a home birth that she feels is not being done in a safe manner. Once again, we're in the position of being two states that restrict access to midwifery care. And once again, I think it's time to step up to the plate, allow consumers and professionals the opportunity to make healthcare choices that meet their needs. I kind of enjoy living in a state that waits a bit to jump on the bandwagon, okay. But there also comes a time when we stall so long that we miss opportunities to attract families to our state. I'm going to look pretty funny dragging myself down here when I'm 80 years old to talk about this legislation (laughter) again, you guys. So if I felt this move endangered our state, I would not be advocating for it. I guarantee you home birth will not become an

epidemic. I worry more about those families that are choosing to have home births without the safety and security of a licensed healthcare provider in attendance. I encourage you to move this bill forward in the condition it should have been 25 years ago when it was initially passed. [LB481]

SENATOR GAY: Thank you. Any questions? Okay. I've got, I guess, a question. But thank you for that testimony. I think it's interesting how things do evolve and we're... [LB481]

ANN SEACREST: Right. [LB481]

SENATOR GAY: ...we've been on the other end of late agreements that we don't like. (Laugh) [LB481]

ANN SEACREST: Um-hum. [LB481]

SENATOR GAY: But anyway, that's the way it happens. So that was done...you had it out of committee...was it out of committee at the time and then going to the floor, General File? Or when was this agreement... [LB481]

ANN SEACREST: In order to get it out of committee. [LB481]

SENATOR GAY: Oh, okay. [LB481]

ANN SEACREST: So it came back to us and said, in order to move this out of committee, you need to sit down and work out a compromise. And so that's what we did. And it went to the floor and then went through the three votes. [LB481]

SENATOR GAY: Um-hum. [LB481]

ANN SEACREST: And we've got a wonderful group of nurse midwives practicing in our state, as you heard. [LB481]

SENATOR GAY: (Exhibits 3 and 8) Okay. All right, thank you. Any other questions? I don't see any. Thank you. While we're hearing from other proponents, I just want to let you know, we've just received a large, large stack of letters in support. So we do have those on file. I'm not going to go through every single one of them. And we also got one letter just handed to us in opposition, Nebraska Hospital Association. So we did receive those. [LB481]

AUTUMN COOK: (Exhibit 2) My name is Autumn Cook, A-u-t-u-m-n C-o-o-k. Thanks for hanging on through the third bill today. I hope we haven't disappointed you. We're moving along as quickly as we can. I speak to you again as chairwoman and

representative of Nebraska Friends of Midwives in support of LB481. I will provide a preface to the collection of testimonies you're about to hear. And I'll point to some of the indicators that it's time for Nebraska to legalize these services. The issue of home birth is a challenging subject to approach with the same objectivity you can approach many legislative proposals because almost everyone has a personal experience with childbirth which has influenced them. It's a topic hot with emotion. It's not exactly the type of thing a legislative body prefers to handle, I'm sure. So thank you for taking the time to look at this. You will find that as I and other supporters of this legislation lay out the case for removing the restrictions on CNMs attending home births, we will present statistics, research and studies that compose a remarkable body of evidence from highly reputable sources, such as the Milbank Fund and the Pew Health Commission Report, demonstrating excellent outcomes at midwife-attended home births. Each of you serve constituents who fervently want access to a service to which the women and families in every state surrounding ours have access to. In fact, no other state, besides Alabama, prohibits CNMs from attending births at home. Once again, the current statute does not reflect current practice standards. In anticipation of the oppositions' testimony again, and in hope of framing with perspective the differing opinions you will hear, I want to contrast our approach of presenting this large body of evidence, comparing our state's policy with other state's policies, and advocating for the freedom of families to make choices that work for them with what I believe the opposition will present for you. I believe you will find those opposed to this bill pulling out the false trump card of safety. They will play it with a heavy hand of fear. You all know that good public policy, good public health policy is based on fact, evidence and studied outcomes. Good public policy is not based on fear. This topic presents an area in which emotion can play havoc with reason and good policy. Whatever your individual experience with childbirth, we're going to get a good cry here, (laugh) I hope that you will find the research evidence in favor of home birth with a trained and licensed midwife compelling enough to agree with the wisdom of changing our outdated CNM law. I hope you will also find compelling the desire of Nebraskans to give birth in a setting and with the qualified provider of their choice as all our neighbors in surrounding states can do. When we settled here five years ago, I was intrigued to learn that many Nebraska women actually leave the state in order to access out-of-hospital birth with a license midwife. Members of our group have crossed the border into Wyoming, Iowa, Kansas and Oklahoma to give birth with a midwife who could attend them outside of a hospital. I was disturbed to learn that some in Nebraska give birth at home without any trained attendant because they cannot find one. Others are resigned to the fact that they must go to a hospital to have a qualified birth attendant, but would choose the option of home birth with a midwife if that option were available. There are essentially two categories of women who would benefit from this legislation. Those who are giving birth at home already, and those such as myself who would like to access the option of home birth but don't feel comfortable with the lack of a recognized and legal framework for a trained birth attendant. It would be difficult to tell how many women in Nebraska would benefit from this legislation because the number of actual births at home doesn't take into account the two factors I've

mentioned--one, leaving the state to have a baby, and those going to the hospital despite their preferences, like myself. In my own case, I feel very much as though Nebraska law compels me to spend my family's financial resources on services which I otherwise would not choose. I want to emphasize that if there were a need for the services of a hospital, I would access them in a heartbeat and I would pay for them in a heartbeat, so to speak. But for normal healthy childbirth paying the cost of a labor and delivery room, and the cost of a postpartum room, and the cost of a nursery, which I choose not to use, adds up to thousands of dollars I and my family would be able to utilize elsewhere. Three years ago, when my son was born, we paid $2,100 for the hospital. I only stayed one night. So if we'd have stayed another night it would have been about $2,800. And I haven't gotten the bill for this one yet. It's probably a little bit higher now. My family gets its insurance through Union Pacific Railroad. However, we've gone the way of many with the high deductible, catastrophic coverage plan. I believe this is the direction in which a lot of insurance plans are going. And it means that we set money aside into our HSA during the course of the pregnancy and effectively pay out-of-pocket. We're paying thousands more to access the legal services of the nurse midwife at a hospital than we would be to access the services at home. And so in a normal healthy pregnancy and childbirth, care in a hospital adds a financial burden, and families don't wish to assume that burden. LB481 would bring Nebraska law up to date and finally provide Nebraska families with the cost and care benefits of a licensed, legal option for a home birth attendant. [LB481]

SENATOR GAY: Thank you. Any other questions? I don't see any. Thank you. [LB481]

PATRICIA STEAR: Good afternoon and thank you so much for listening. My name is Pat or Patricia Stear. And you do have letters from me also for all three of the bills. I happen to be the mother... [LB481]

SENATOR GAY: Can you spell your last name. [LB481]

PATRICIA STEAR: S-t-e-a-r. [LB481]

SENATOR GAY: Thank you. [LB481]

PATRICIA STEAR: Yes. I happen to be the mother of nine children. These two are my youngest. And I have the wonderful perspective of having had births in three different hospitals, one of those in St. Louis, two in Lincoln. Two of my children were home births. One of my children was a nurse-assisted birth in a hospital. So I have a wide variety of perspectives. And I am here completely to support nurse midwifery. I find them to be literally brilliant in their approach to birth. They have an astonishing practice of working with the woman's body. A woman...a body knows what it needs to do normally. (Laugh) The midwives assist and give wise guidance. And they have many, many, many techniques for aiding. If it's, for example, a large child they know which

position the woman needs to get into. And I've seen this personally. I've assisted in births also with...not as a midwife but as a friend, being the photographer or something. So I've also seen other births assisted by midwives. Ironically...and I must say that I am very supportive of the medical practitioners amongst us. My life has been saved, my daughter's lives, I have children that have been in the hospital for various accidents, etcetera. And in fact, my youngest was taken by Caesarian section when I needed surgery in order to save my life. So yes, there is that need. I must also say that I came to near death because, ironically, my midwife, when she thought...I was going to have twins. She thought it might be better that I go to the hospital. She wanted to be safe. The medical practitioner was of the sort, unfortunately, that gave me no choice, let's get your feet in the stirrups and push, when my...I wasn't ready with the second one. My body wasn't telling me to do that. And I was so obedient that I pushed to the point of going into posteclampsia, had three seizures and was very near death. So yes, I am very happy that we're all worried about safety issues. However, things can happen because of the other perspective as well. And I must say that if I had to do my births over and there was not availability in Nebraska I would certainly go to another state or do what I needed to do. So I'm very happy to promote nurse midwives. Thank you. [LB481]

SENATOR GAY: Okay, thank you. Any questions? I don't see any. Thank you. [LB481]

PATRICIA STEAR: Sure. [LB481]

HEATHER SWANSON: (Exhibit 4) Hello again. Heather Swanson, S-w-a-n-s-o-n. I'm a certified nurse midwife from Wilcox and I'm here to speak in support of LB481 as an interested consumer and nurse midwife. Right now it would be a felony for me to attend a home birth in Nebraska. But with the licenses I currently have I could go to Colorado, Iowa, or South Dakota and provide the same care and I would be practicing appropriately. My main concern...the main concern opposition voices is regarding safety. And safety just happens to be the number one reason families stay at home to birth according to a study just published regarding home births in the U.S. And you're getting a copy of that. I thought it was an interesting table to see why women are choosing home birth. And it's the green tab. With a close second and third reasons being intervention free and negative previous hospital experiences. And these are not uneducated women. Thirty-nine point three percent had a bachelor's degree, 23.1 percent had a graduate or doctorate degree. And as well they tended to be Caucasian, married, homemakers or have a professional occupation. Research shows that home births attended by a trained and licensed midwifery provider is a safe option for women and infants. The opposition made mention of a Washington state study, this commonly comes up, so I want to point this out, that concluded that home births have worse outcomes than hospital births for the same population. But that study included pre-term births that would not be kept at home by a nurse midwife, as well despite the title of the study, which said it was planned home births, it was unknown whether or not the births

were actually planned or unplanned because of the birth certificates in Washington state at the time, thus making it an inappropriate study to base a recommendation to continue to restrict health professions and consumers. So what does the evidence say? Well, this first comment here comes from a book that was a summary of data from the Cochrane database. And the Cochrane database, you do have a part, an intro of a study from Cochrane that I, or I think Alice gave to you before, Cochrane database is the pinnacle of research, especially in regards to obstetric care. And so here's a summary of what they have in regards to home birth. Some observational studies have compared the outcomes of planned home births irrespective of the eventual place of birth, with planned hospital births for women with similar characteristics. A meta-analysis of this study showed no maternal mortality and no statistically significant differences in perinatal risks for mortality. The second comment comes from a really large study done in North America, in Canada and the U.S. and it included over 5,000 women which is a huge study. Planned home birth for low-risk women in North America was associated with lower rates of medical intervention but similar antipartum and neonatal mortality to that of low-risk hospital births in the U.S. This next study comment came from Canada. And Canada is an interesting situation where in recent years the provinces are actually employing nurse midwives. They don't really label them nurse midwives. They're just called midwives. And nurse midwives from the U.S. when they go up there would have to sit for another exam. But women, if they don't have risk factors that would require them to go to a hospital, have to be offered an out-of-hospital birth. And I actually have a friend who attends births up there in that setting. There are no indications that increased risks associated with planned home births attended by regulated midwives compared to those attended by either midwives or physicians in the hospital. And this last comment was from a nurse midwifery study on home birth. Home birth can be accomplished with good outcomes under the care of qualified practitioners and within a system that facilitates transfer to hospital care when necessary. As the opposition has raised some issues, these things came up. They came up a lot during the 407 review. People would bring studies about, oh, meconium could be present, some have some baby poop inside, or there could be a shoulder dystocia, or a cord prolapse. And the fact that some of these issues are being brought up to say this is unsafe and we shouldn't allow this to happen at home seems rather trivial to me because there are situations that nurse midwives are trained to take care of and are also trained to be aware of if somebody is showing signs of risk to transfer to the hospital. Oh, I skipped a comment that I didn't intend to skip. There is the matter of Nebraska being a rural state. That often comes up in opposition. And points are made that people in rural and western parts of Nebraska would be putting themselves and their babies at increased risk if they stayed home to birth, which is not the case. In rural areas, or excuse me, areas of rural and rugged terrain outcomes are similar. But midwives choose to transfer to the hospital sooner. One of these studies in Canada had documented the women who were quite a ways from the hospital, and they had mountains and things like that. So they just found that the practitioners were much more cautious. So instead of staying home, they would just go to the hospital sooner than holding out and waiting. Let me

see here. There was a 407 review on the same topic in 1993 and 1994, and one of the final recommendations was to allow nurse midwives to attend home births. No legislative change was made at that time. During the 2005 hearing on testimony for a similar bill, attention was not given to that 407 review on record about opposition nor did the state medical director base their testimony on it. Though repetitious and likely costly to Nebraskans in 2006, another 407 review was conducted per the recommendation of former Senator Dr. Johnson, who chaired this committee. Despite more research supporting home birth, the subsequent 407 review conclusions were contrary to the prior review and not supportive of the changes this bill would make. I sat on the technical review committee and felt strongly that there were biases and that votes did not reflect the evidence. Also in 2005, Dr. Schaefer spoke in opposition to a similar bill and shared with this committee that in 2003 Nebraska had a 4.4 percent infant death rate, or 44 per 1,000 for out-of-hospital births. If I'm correct, that stat is likely to be misleading because, and I don't know, I didn't get the specifics on that data from '03, but I'm assuming it doesn't reflect whether or not those births were planned or not, if they're pre-term or term. So they probably don't reflect what a typical home birth practice would look like. We need to consider term, planned home birth, and not just any out-of-hospital birth because sometimes they happen unexpectedly. In 2005, 2006, and 2007 combined there was only one term neonatal death of a baby born at home in Nebraska. It is unknown if it was planned or not and I was not informed if the cause of death is known. Practice recommendations cannot appropriately be made based on such information, but we can base policy change on the large body of evidence we have from published studies. The American College of Nurse-Midwives support CNM-attended in-home births and have several published references on their statements on this topic. Other organizations that support...that policy statements that support out-of-hospital birth and home birth is the American Public Health Association, and the National Organization for Women. The American College of Obstetrics and Gynecologists, or ACOG, does have a statement opposing home birth. I do want to note that there aren't references on their statement to support their position. Thank you for taking the time to listen to the testimony today. I'll leave you with a quote from the Pew Health Report, "Midwifery's many strengths and contributions have not been fully utilized to meet today's healthcare needs...legislators, policy makers and researchers will also play important roles in fulfilling the promise midwifery holds for consumers." And I think, some of the questions that came up before, probably answered or I addressed. [LB481]

SENATOR GAY: Thank you. Any questions from the committee? Senator Wallman. [LB481]

SENATOR WALLMAN: Thank you, Chairman Gay. Yes, I have just one short question, I think. I understand your plight here, I guess. But has anybody ever been arrested for delivering a baby at home that you know of, fined or something? [LB481]

HEATHER SWANSON: I do know that there have been some nonnurse midwives that

have received cease and desist orders from the Attorney General's Office. I'm not familiar with any nurse midwife attending home births (inaudible) a felony isn't really a desirable thing. [LB481]

SENATOR WALLMAN: Sure. Thank you. [LB481]

SENATOR GAY: Okay, thank you. Any other questions? [LB481]

HEATHER SWANSON: I am the last woman, like maternal healthcare provider that will be testifying. So if there are questions about specific things, I would probably be the appropriate one. [LB481]

SENATOR GAY: All right, thanks. Any other questions. I don't see any. Thank you. [LB481]

HEATHER SWANSON: Okay, thank you. [LB481]

SHAHAB ABDESSALAM: Hello again. Thank you for the opportunity. I'm Shahab, S-h-a-h-a-b, Abdessalm A-b-d-e-s-s-a-l-a-m. As I said before, I'm a physician and currently a pediatric surgeon up in Omaha and cover the entire five state area in terms of need. And...but basically, my support comes from this...from personal experience and so I wanted to relate that to you all. When my wife was first pregnant with our first child, and this was back in the late 1990's, she came to me a couple...about a month or so into the pregnancy and said, I want to have a home birth. She's a very strong and independent woman and extremely opinionated. And this really, really caught me off guard being from a medical background; I'm very black and white, I'm very critical of everything that comes across my desk. And so I said, you got to be kidding me. And she said, no, and she gave me a whole bunch of literature on the subject. I read it, still extremely skeptical. And she said, well, let's just go meet with the midwife; we'll talk to her about things. And so we met with the midwife and during the first visit, you know, I was prepared to just fire 1,000 questions at her, and I did, and she refuted just about everything I could throw at her. And probably the most important thing that she told me at that time that I learned was that in a majority of cases pregnancy is not a disease. It's not something that needs to be in a hospital. It's a personal experience. Certainly, there are cases where, you know, it's...there are multiple births, or whatever, something with the physiology of the mother or the baby that demand that it be done in a hospital. I deal with that on a constant basis. But in a majority of births it is not a disease. And when she told me that it really, really sunk in for me. Since that time we've had four healthy, beautiful children, all born at home with midwife assistance. And it was really the most spectacular experiences of my entire career. It's an extremely safe, healthy environment to be at home with less intervention. I can say numerous times when medical intervention, it's too much. It's that intervention which then leads to problems and complications. And you can...every disease process that's the case. And in a pregnancy

that is otherwise healthy, it just doesn't need medical intervention. It's, you know, a shame that when we came here to move to Nebraska that we found out that we were one of two states which (inaudible) occasions. And it even gave my wife qualms in even moving to Nebraska because of that kind of backward attitude, backward belief system that would prevent a woman from a free choice, prevent a family from having a healthy, happy delivery at home. And so I'm definitely in support of this bill. I think things need to be changed. The nurse practitioners that I've come into contact with provide superior perinatal care, prenatal care. When they come, you know, the whole system of the prenatal care, the monthly visits, you know, it involves the entire family. It's just really a spectacular experience. When you know you're getting close to delivery they come out to the house. You have all sorts of supplies that are set up. You have oxygen, you have a bag mask device, you have things that are...if you need to resuscitate a baby, just as you would in the hospital, you have those capabilities. Obviously, you don't have drugs. But again, the instances where those drugs would be beneficial are extremely, extremely rare. And midwives have the training, they have the knowledge that they're not going to go into a pregnancy and they're not going to go into a delivery if they know it's not going to be safe. So that ends my comments, but I'm definitely in support. [LB481]

SENATOR GAY: Thank you. Any questions? Don't see any. Thank you. How many proponents are going to be speaking? Just one more. [LB481]

RENE DOCHERTY: (Exhibit 5) My name is Rene Docherty, that's spelled R-e-n-e. Docherty is D-o-c-h-e-r-t-y. I want to speak in support of LB481. I'd like to start by thanking you all for the opportunity to show why this is so important for me. My testimony I've prepared is from the basis of the need to have a midwife present for an at-home birth. I have not prepared anything and would be willing to prepare on the issue of concerns of home births. But I really felt the heart of this bill was the right to physically have a midwife present. I'm a permanent resident. I'm green card, originally from Scotland. You may have guessed that by now. (Laughter) I've been living in Lincoln for a little under two years. I came to Nebraska with my family seeking a new start. My wife and my children are either already citizens or are in the process of naturalization. I have a bachelor's of science degree with honors in computing science. And I work as a software developer here in Lincoln. Before I testify about my own experiences of home birth in Nebraska, I wish to give you a brief accounting of the midwifery care back in my home country. In Scotland when you're pregnant you see a midwife. It is the de facto standard. The care is midwife-led. There is very few instances in which you get contact with a doctor, unless there is an issue that requires it. In those circumstances the midwife and the doctor work hand-in-hand to provide you with care. Thereafter there is no necessary implied elitism in those situations. And indeed to have him present and the number, at least four now, circumstances where there have been doctors and midwives and when my wife has been giving birth there has been an equal power for them. As far as home birth in Nebraska, my wife and I came here, we shortly

became pregnant with our fifth child. We sought our options. From looking at our history of medical...of birth and what was in front of us, we realized that we were considered to be low-risk as far as home birth procedures went. And following that we went to seek midwifery care, only to find that, of course, midwives were not allowed to attend home births. This forced us to seek midwife care outside the state. And following a successful friend of a midwife who was willing to put herself in jeopardy to support us, we went ahead, prepared a house, and waited diligently for labor. As I state in here, that labor occurred on September 18, 2008. The interesting fact is delivery went so fast and so quick the midwife was unable to come to our need at that point. It was quite dramatic, of course. When the midwife turned up my wife and my son were 100 percent fine, there was no problem at all. My wife had delivered the baby. I had been there and there had been no issues. As I said, I did not come here to testify about the concerns of having home birth or not. It's quite simply this, I appeal to you directly as individuals, as people that have families, and as a group, I don't really sit here as a consumer of healthcare. I'm a dedicated father and I'm a dedicated husband. I do not declare that home birth is for everybody, but for those of us who do desire home birth, those of us who do desire to have a birth in the privacy and the comfort and the security of our own home, please help us. Help us choose the responsible option of having a local midwife. With that, I'm open to any questions. [LB481]

SENATOR GAY: Thank you. Senator Pankonin. [LB481]

SENATOR PANKONIN: Thank you, Chairman Gay. I knew when you started that you were a little further away than Fremont or something. (Laughter) But we're glad you're in our state, in our country and that you felt comfortable to come and testify today. You did a good... [LB481]

RENE DOCHERTY: Thank you. It was a real privilege. [LB481]

SENATOR PANKONIN: You did a great job. [LB481]

RENE DOCHERTY: Thank you. [LB481]

SENATOR PANKONIN: And how do you like living in Nebraska? [LB481]

RENE DOCHERTY: I love it here. And I wish to say, genuinely, we were told, we were originally living in Mead, we were told Lincoln, Nebraska was the best place to raise your children. And I swear it is. I stand by that. And until such time I disagree, I'll let you know, but...(laughter) [LB481]

SENATOR PANKONIN: All right. Well, thanks for coming. [LB481]

RENE DOCHERTY: Thank you. [LB481]

SENATOR GAY: Thank you. Any other questions? I don't see any. Thanks again. [LB481]

MATTHEW WHITMAN: (Exhibit 6) Good afternoon. My name is Matthew Whitman, M-a-t-t-h-e-w W-h-i-t-m-a-n. I, too, am from the 35th; I know Senator Gloor. My wife, Camilla, gave birth to both of our children at home. The interesting scenarios is that the first of those children was born in Nevada and the second was born here in Nebraska. Our Nevada experience went a little something like this--we were seeing a CNM and preparing for a hospital birth. We liked what we were seeing. We really appreciated her input, felt like she was capable, ready to go. We were enthusiastic about the setup. When we were in the process of preparing we came exposed to the option of doing a home birth, and for whatever reason it just kind of stuck with both of us. We researched it further and decided that's what we wanted to do, even though we were in the third trimester because midwives attending home births is common in Nevada, it was very easy for us to go and ask around and kind of figure out who would be best at it. After consulting a bunch of people and comparing notes, we found, as far as we could tell, the person with the best reputation in the Las Vegas valley. That's who we got. We went for our first meeting, probably me a little more skeptical than my wife. Maybe that's just how these things go. But it was fantastic. We went to her place. She sat us down and met with us for an hour and a half, maybe two hours that first meeting. And then she continued to do so every time we got together from there on out. At one point she met with my wife for so long, sitting in her room where she did the care, that I just passed out on the bed. They woke me up after a nap later on. And say, hey, we're done. Great. It was that relaxing, it was that calm. And she took so much time to answer every question, to cover every base. Going into delivery we just felt like we knew what we were doing. We felt ready, completely at ease. When that time rolled around we called the midwife in the middle of the night. She showed up promptly, living only a few minutes away. She arrived, she hung out with us for about eight hours, at 11:00 in the morning, give or take, Helaina was born. And then she stayed with us for four hours after that. So she spent half a day of her life just on this one delivery. It was fantastic. It was affordable. It was peaceful, it was private, it was a fantastic experience, no stress whatsoever. Just all we thought about was getting this life into the world and doing this together as a couple. When we moved back here in the summer of 2006, we found out that Camilla was pregnant again. Excited about that and excited to do another home birth. Shortly after that we figured out that that wasn't going to be an option (laugh) or at least not a legal option. We kicked some things around and decided that this would be one place where we would be complicit in civil disobedience. We chose to go ahead and pursue the home birth option anyway. But getting care was very, very difficult. As Autumn mentioned earlier, the whole felony thing is not real attractive to professionals as it is not to me. But after our experience in home birth we just didn't want to go back to a hospital. Early in the pregnancy we received care from our family doctor, who we're crazy about. If we had no other option we would have been completely at ease if we'd

had her deliver Monica. We had several encounters with the hospital in Grand Island. Always had great experiences, no complaints whatsoever. We just experienced a home birth and we wanted to do it again. So we moved in that direction. And after digging around and engaging in some secrecy and espionage and so on and so forth, we finally managed to find somebody who was willing to have a conversation with us about it. So after we decided we were comfortable with this individual, we agreed to have her be present upon the delivery of our second child. As it turned out, she lived so far away that she couldn't be there on time, and I ended up helping to deliver the baby myself. We had a friend of the family on hand, but we were ready. We knew that could be a possibility so we put in the work to be prepared and know what was going on. I'm not a doctor. I'm a history instructor at Doane and Central Community College in Nebraska. I'm also a minister at a church. So this was a little, again, above my pay grade. But I knew what to do in case of the basic things, and I knew what to look for if something went wrong. There were some little complications. I knew what to do. It worked out well. Doorbell rang about three minutes after the birth. And I kind of ran to the door, and opened with my elbows, and the midwife standing there, where are we on things? (Laughter) I just showed off cottage-cheesy vernix all over my hands. And she did the math real quick. If we'd been in danger in any way, we lived two minutes from St. Francis, literally just down the road. It would have been a quick shot. So we felt really good about the situation. It worked out great. I'm grateful to Nevada because they didn't restrict what I consider to be a very basic and fundamental human right which is, as parents, we go through a natural human bodily function process to bring another person into the world. Everybody has done it. It's where everybody came from, it's why we all have belly buttons, it's normal. As mentioned before, this is not a medical condition, it's not a disease, it's not the body failing, it's the body doing exactly what the body is designed to do. Of course, there are exceptions to that, and I'll briefly talk about that in a second. I identify the red and so I'll be quick. Here's the few quick arguments for why this is something I'm committed to and why I hope it's something you really seriously consider and make happen for us. Giving birth at home is a historically established tradition, come on. As a historian, I'm always adding up numbers of how many people have lived and when they lived. It's got to be well into the 99th percentile, 99.9-how many percent of people throughout history have been born at home. Yeah, we just joined a tradition. I appreciate that Nevada gave us the right to join that tradition. I look forward to the day that Nebraska will do the same. As I mentioned earlier, I like hospitals. I'm pro hospital. I'm for them. I don't want them to go away. I've needed them before, I'll need them again, my kids will need them. I've only had really good experiences at them. I just don't want to go if I don't have to. And it's a natural process that I don't think always requires a hospital. If we need it, I'm glad it's there. As stated just a moment before, this isn't for everybody. To say that this is for everybody would be presumptuous and arrogant, I don't want to be that guy. At the same time, I'd like for tolerance of my values to be extended in the same manner. I'd like for those who disagree with me to be able to also say, all right, I can tolerate a different position, I'll allow you that basic human freedom to carry this out. Couple quick things. Permitting a

home birth is consistent with the conservative value of having a small and nonintrusive government. I don't know where you all stand. I know one of you. It's a conservative value issue. At the same time, what do you know. This is a liberal-leaning value issue as well. The freedom of a woman to choose what to do with her body. This just isn't a partisan debate that needs to be divisive in any way. If anything, this is a great opportunity to bring unity or enhance the unity that already exists here in Lincoln. Everyone in the political spectrum has a reason to be on board with this idea. And finally, it's an issue, once again, that has to do with human rights. No state, especially a state in the country that's as dedicated to freedom as is our country should dictate the location where a woman is permitted to carry out the completely natural and healthy process of birth. It's overstepping the bounds of why government exists. I appreciate that government tries to look out for us. At times it's necessary. I'm telling you this just isn't one. The judgment of parents and the judgment of the woman in how to bring her child into the world is something that should be treated with great respect. And that's a sovereignty that should not be violated. I appreciate your time and am open to answering any questions. [LB481]

SENATOR GAY: Thank you. If I would have known you were a professor, I would have watched that light closer. (Laughter) [LB481]

MATTHEW WHITMAN: You could have looked really hard. I think the results would have been similar. [LB481]

SENATOR GAY: We were all listening and...that's a...but you're the last proponent it looks like, so we can bear with you. [LB481]

MATTHEW WHITMAN: Thanks for humoring me. [LB481]

SENATOR GAY: Senator Gloor has a question. [LB481]

SENATOR GLOOR: Thank you, Chairman Gay. Matthew, thank you for your testimony. As usual, when we've had these conversations, you can give (inaudible) very straightforward, fact-based but impassioned argument on your behalf. And you did a nice job. And I appreciate you taking the time to come down and the long drive on a beautiful afternoon. I understand it's a beautiful afternoon. (Laughter) [LB481]

MATTHEW WHITMAN: Yeah, that's the rumor. [LB481]

SENATOR GLOOR: Thank you. [LB481]

MATTHEW WHITMAN: Thank you. [LB481]

SENATOR GAY: Any other questions? I don't see any. Thank you. [LB481]

MATTHEW WHITMAN: I'm grateful, thank you. [LB481]

SENATOR GAY: Very good, you bet. All right. I think that was the last proponent that I saw. So we're going to go to opponents. [LB481]

TODD PANKRATZ: Again, I'm Todd Pankratz, P-a-n-k-r-a-t-z, practicing OB/GYN in Hastings. First of all, I'd like to make two comments to the opening statements that Senator Haar presented. First of all, on his referral to us being the last state and not being leaders, I would turn it around and say that we are leaders in not allowing home births. And then the second comment that he made that certified nurse midwives work with the pregnant patient throughout the labor and can, hopefully, predict complications. So do I, and I still have not been able to predict who will have a complication every single time. So in response to that, first of all, again you know that we have two certified nurse midwives in our office. In the last three years, they have delivered over 385 babies using the midwife model with less intervention, minimal anesthesia, if so desired, and family involvement if they want. And if you talk about family involvement, I've delivered close to 5,000 babies, I've delivered 1,400 to 1,500 at Mary Lanning, and I've had 350 fathers deliver their babies. So there are models that allow family involvement present. I'm not going to present studies. The problem with all these studies is that there are no large randomized studies out there that compare home births to deliveries or home births to hospital deliveries. They are all either chart review, prospective, all of these allowing for a large bias on both sides to be in them. And they all lack the power or the ability to show a significant difference, because they all lack significant enough numbers to potentially show a difference between morbidity or mortality from that standpoint. Another limitation of a number of these studies, especially the ones that come from the UK is that the majority of them take place in very dense populations, where the majority of the population lives within 20 miles from a hospital. That is not rural Nebraska. If I look at the deliveries that we do at Mary Lanning Hospital and through our office, in 2006 we delivered babies from 21 counties, plus the counties of northern Kansas. So our patients are driving a long ways. Also, in this state, especially in the rural part of the state, when we're requiring the volunteer ambulance services to supply care and transport for the people in those areas, we're putting a large strain on them to start transporting babies and moms who may or may not be doing well to a hospital. And that all adds time to the whole process too. Low-risk pregnancies can turn high-risk very quickly. We've seen that, I've seen it multiple times in my practice. My midwives have seen it. I've been walking down the hallway and I hear a cry for help, and there's a shoulder dystocia that nobody can get out. They turn high-risk quickly, you can't predict that. I'm not arguing that 90, 80, or 70, or how many percent of the babies are born without complications, that is true, but there will be some that will not be. In one of the studies presented they talked about 12 percent of the participants being transported to a hospital, 3 percent of these urgently. And so how quickly can we respond in that standpoint? We had a history professor here. And let me show my

history here. Prior to 1940, home births were very common, that is very true. But when you look at the infant mortality rates in the United States at that point we had 47 deaths per 1,000 births, 47 deaths per 1,000 births; in 2004, the rate was 6 per 1,000 births. Still too high, but not as high as it was in 1940. This is due to many factors. This is due to better care of premature babies. This is better care of controlling medical conditions in moms, diabetics, hypertensives. But a lot of this has to be...is due to delivering the baby from the home to the hospital. Let's look at something even more scary--maternal mortality rates, moms who die in labor. In 1950 this rate was 83 per 100,000 births; in 2004 it's 13 per 100,000 births. Again too high, but again we have a lot of patients, a lot of mothers who are having babies who could not have babies in 1950 secondary to medical problems. Still not an excuse, but still too high. [LB481]

SENATOR GAY: Doctor, don't feel rushed either, in all fairness other people went over, so take your time. [LB481]

TODD PANKRATZ: No, we all have places to go. (Laughter) But again there are a lot of issues that we need to take into consideration. An anatomy lesson. The pregnant uterus has 300 to 500 cc's of blood a minute go to the uterus. The human body in pregnancy has about 4,000 cc's of blood. It does not take long to bleed if you're in the middle of Nebraska trying to get to the hospital. These are the things that we're trying to prevent. Not a...I'm going to throw the question out. Do we have complications in the hospital? Yes. Do we have complications at home? Yes. The question I have is, a complication that takes place at home that could be prevented, how much or what cost is the state willing to take to take care of that baby? The cost to the Medicaid system that we're all interested in now, what is that cost to take care of a preventable outcome? Transportation costs, we've talked about that. The last point before I get to closing is the financial burden. People have talked about that. And I know in this time of economic recession this is very important. But my question is, when do we consider the life of a newborn and a mother part of the financial burden? When do we take a risk that some couple may not be appropriate, but because of financial reasons they feel it's their only option. I have a had time morally putting a financial burden into that picture in considering this situation. For the mothers and fathers who have claimed to have negative experiences, it saddens me. A birth should be a time of joy and celebration. Every family deserves a birthing experience that is positive and safe. Hospitals are spending millions of dollars to create patient rooms. Birthing facilities, they may not be freestanding birthing facilities, but they are creating birthing facilities that can offer maximum comfort without compromising patient safety. The whole issue, you've seen the facts, you've seen the emotions. The issue that you all have to consider is patient safety. And that is the thing that you need to really strongly look at. That is the one thing that we have to be interested in here. [LB481]

SENATOR GAY: All right. Any questions? Senator Wallman. [LB481]

SENATOR WALLMAN: Thank you, Chairman Gay. Thank you for coming, Doctor. I'll have to agree with patients. Most of what you say, do you think, though, in the 1800's most doctors did home visits and they delivered babies at home. And there were some midwives I'm sure. But today is it just too handy to...would you be comfortable doing home deliveries? [LB481]

TODD PANKRATZ: No. [LB481]

SENATOR WALLMAN: Okay. [LB481]

SENATOR GAY: All right. Any other questions? I don't see any. Thank you, Doctor. [LB481]

JOANN SCHAEFER: (Exhibit 7) Good afternoon, Senators and members of the Health and Human Services Committee. My name is Joann Schaefer, M.D. J-o-a-n-n S-c-h-a-e-f-e-r. I'm the chief medical officer and the director of the Division of Public Health, Department of Health and Human Services. I'm here to testify on behalf of the department in opposition to LB481 since it would remove the restriction on home birth deliveries by certified nurse midwives, thereby expanding their scope of practice. Currently, the statutes state a certified nurse midwife may not attend a home delivery. I'm providing you a copy again with my 407 report. And I want to touch on a couple of things. I want to explain that the 407 process with the technical committee, getting people, I appoint people to that board to look at the issue from both sides. It usually includes members of the applicant group that want to expand their scope. The second step of that is those technical recommendations are taken to the Board of Health. The Board of Health then has hearings. They have discussion about it. They look at the information presented. They make some recommendations. All of that information comes to me. This is definitely an emotional issue. And as a woman I would never be, you know, supportive of wanting to take away a medical choice for a woman on the delivery of her child. That is one of the biggest reasons why I turned all of the studies that were presented and had a literature search performed by an epidemiologist to look at the statistical validity of any of the studies that are out there currently. I will tell you that it is true and has been said before that all of the studies are very weak. They all come from very different healthcare systems, different situations where they study home deliveries that were done in cities that are small, located next to tertiary care places. So when you look at the risk to the infant in the home setting, yes, it's fantastic when you are two minutes away from a tertiary care hospital that can provide that immediate support. But if you are 50 miles away or, you know, 200 miles away, it is going to make it very difficult to provide the level of care that infant may need. As has been shown before, and I have witnessed in my own deliveries, they can turn...I screened for the healthiest possible pregnant moms. I did not take high-risk OB. And even myself had, even though I had a very low C-section rate, I still had complications that almost cost the life of both the mother and the baby completely unpredicted. Now I don't like to hear

things like the costs should be considered, and cost-sharing when you're talking about the life of a child, and that child has no choice in this factor. The other issue that I would say is that we have a very diverse state and some of the...populationwise the majority of the certified nurse midwives are in eastern Nebraska. They are not in the rural areas. So one could assume that if you expanded the scope that you may have more people interested in performing the function. But that's not necessarily true. We don't have certified nurse midwives out there now. Would they be if we allowed them and fill that access to care issue? I am not certain. What I could wholeheartedly say is that I myself would not attend a home delivery for the reasons that I stated before. I think we are leading in the states in being the one that absolutely say, you know, the child has a right to an opinion here. But I do recognize the passionate desire and that's why in my 407 I did address the fact that the medical model also needs to change. There is no question that certified nurse midwives have a valuable, valuable and wonderful place in the delivery of children and they do incredibly, you know, brilliant care at the time of delivery. There is no argument there. I just think that it needs to be in a hospital or some sort of birthing center that has the ability to provide an emergency C-section, forceps delivery, or something that would get the child out and save the life of the child and the mom when it does come up, and it does come up. And I'll be happy to answer any questions. [LB481]

SENATOR GAY: Thank you, Dr. Schaefer. Any questions from the committee? I don't see any. Thank you. [LB481]

JOANN SCHAEFER: Thank you. [LB481]

SENATOR GAY: Any other opponents who would like to speak? I don't see any others coming forward. Anyone neutral? I don't see any. Senator Haar, you want to close? [LB481]

SENATOR HAAR: Thank you very much. First of all, I'd like to thank everybody who came. Thank you for coming and to the committee for listening. And to "Brother" Wallman, I know there's reasons I like you and here's another reason. (Laugh) Well, when it comes to our bodies, I tend to be a libertarian. In issues of conception and birth and so on, I truly am in favor of choice. I'm somewhat jealous because my kids are now...my kids, are 40 and 42 years old. And when they were born, you know, I took my wife to the hospital and they said, go home, we'll call you in the morning. (Laugh) I'm sorry I never got to be at...so, anyway, I mean, you know. So you know as a man this whole issue of choice, you know, you have to think, well, gosh, why would a woman want a midwife to work with them during pregnancy and in childbirth? I just have to ask that question. I can't answer it. A couple of months ago I was at my general practitioner's to...over a sinus infection I had. And so I told him I was going to introduce this bill, and asked him for his opinion. And he said, well, you know in the case like home births by certified midwives where we're only one of two states, he said, I feel

comfortable with that. He did go on and add, you know, if we were talking about something like doctor-assisted suicide, where there's only, I think, one or two states, he said, then I think we really have to consider what we're doing. But where there have been so many others ahead of us as leaders, he said, I think it makes sense. And then a really important point, I think, here, and I'm not putting down the medical profession certainly, but I've been a computer professional for some 30 years. And as some people have described it, those of us who are professionals create a priesthood, that was the word they used, a priesthood. And as the man who testified earlier, we have special languages. I mean, I could say whole sentences in computer (laugh) and nobody else would understand it. And we have sort of special rituals and we don't give away those statuses very easily. And I think that's true of any profession. And it's understandable. We want to keep our jobs and we want to feel important, and they are important. Tomorrow I'm going to have my eyes checked. And it wasn't too many years ago that Dr. Jeremy couldn't administer eye drops, that was not part of the scope of his practice. And now he does that safely and over and over again. And so I think we really have to look at the whole momentum that occurs to us, to those of us who are professionals, and we have to look and say, is it really something, you know, is there really a base issue here or is it the momentum that's the most important? Obviously, we want birthing to be safe. But some interesting statistics here in terms of where the United States pays more per woman for birthing than any other developed country, and those countries tend to have more midwives and home births. For example, we rank behind Singapore, this is in terms of infant mortality, we rank behind Singapore, Hong Kong, Japan, Sweden, Norway, Finland, Spain, the Czech Republic, France, Portugal, Germany, Greece, Italy, Netherlands, Switzerland, and so on. And when you get down to number 29 in terms of infant mortality, we rank 29th with Poland, Slovakia and, of course, United States. And in all these other civilized countries that are ahead of us there are more home births with midwives. And so I look at this also because I've been very interested in affordable healthcare. We've had a lot of discussions about that, and how we can achieve affordable healthcare. And so that when you talk about the issue of safe, you know, are hospitals really safe. A lot of us know now that hospitals take every precaution, but they're also are staph infections and stuff that go with being in the hospital. So I think again, this whole issue of safe is a matter of choice and it's a matter of choice that we should be able to make. So I think this particular issue, for those who choose it, just like giving Jeremy, Dr. Jeremy the right to administer eye drops, I think for people who want to choose home births by certified nurse midwives not only do I believe that there should be a choice, but I think it's also an issue of affordable healthcare. So having said that, I would urge you to legalize, consider, bring to the floor. I think it will be an interesting discussion to legalize home births by certified nurse midwives. We're not the only one that belongs to this select fraternity of those born at home. And again, I'd like to remind you that we're one of only two states, other than Alabama, that restricts this practice. And I hope you'll bring it out of committee. So be open to questions. [LB481]

SENATOR GAY: Thank you, Senator Haar. Any questions from the committee members? I don't see any. But I would say, too, thank everybody as well. From the committee's standpoint, the kids have been actually very, very good. That is impressive. But I thank you all for being with us today in a little warm atmosphere but...and when there's other things you could be doing. But I know it's important. We'll give it every consideration. And thank you all. [LB481]

SENATOR HAAR: Thank you so much. [LB481]

Disposition of Bills:

LB406 - Held in committee.
LB457 - Held in committee.
LB481 - Held in committee.

Chairperson

Committee Clerk