[LB361 LB428 LB528]

The Committee on Health and Human Services met at 1:30 p.m. on Friday, March 1, 2013, in Room 1510 of the State Capitol, Lincoln, Nebraska, for the purpose of conducting a public hearing on LB428, LB361, and LB528. Senators present: Kathy Campbell, Chairperson; Bob Krist, Vice Chairperson; Tanya Cook; Sue Crawford; Mike Gloor; Sara Howard; and Dan Watermeier. Senators absent: None.

SENATOR CAMPBELL: Good afternoon, and I would encourage you to find a chair. And welcome to the hearings of the Health and Human Services Committee. I'm Kathy Campbell, and I represent District 25, east Lincoln and eastern Lancaster County. I'm going to go ahead and go through some of the procedures of the committee. If you would like to testify this afternoon, please pick up and complete one of the bright orange neon sheets. If you want to just leave us a note--but you don't want to testify but you want to put down support--there are white sheets on either side of the room that you can make those notes. As you come forward to testify, we ask that you bring your orange sheet and any handouts that you have; and you don't need handouts, but if you have them, to the clerk, Diane Johnson, and she and the pages make sure that the committee receives them. As you sit down in the chair, please state your name and spell it for the record, and that's so that the transcribers who listen can hear your name spelled correctly for their records. In the Health Committee, we do use the light system. You have five minutes in total. The first green light will take you all the way through to four minutes; and a yellow goes on, means you have one minute left; and when the red goes on, we really encourage to wrap it up so that the first person who testifies in the day...no, no, no, not yet. (Laughter)

SENATOR HAAR: Not yet. (Laugh)

SENATOR CAMPBELL: I know you're going to be first. The first person in the day gets the same amount of time and attention of the committee as the last. If you have a cell phone on you, would you please double-check that it has been put on silent or turned off. It is very bothersome to hear something ringing while you're trying to testify. I think that's all the usuals. Our pages today are Deven and Kaitlyn, and they do a great job. They anticipate sometimes what you need. So if they come up and ask you a question, they're just trying to be helpful. With that, we'll start with introductions. Senator.

SENATOR COOK: Good afternoon. My name is Tanya Cook. I am the state senator representing Legislative District 13 in Omaha and Douglas County.

SENATOR KRIST: Bob Krist, District 10 in Omaha. And I don't want to be rude, but I'm presenting in two other committees today so if I duck in and out, you'll know. I'm still being attentive, but I'm not going to be here.

MICHELLE CHAFFEE: I'm Michelle Chaffee. I'm legal counsel to the committee.

SENATOR GLOOR: I'm Mike Gloor. I'm the senator from District 35, which is Grand Island; and I have to duck out briefly around 2:00.

SENATOR CRAWFORD: I'm Sue Crawford from LD45, and that's Bellevue, Offutt, eastern Sarpy.

DIANE JOHNSON: And I'm Diane Johnson, the committee clerk.

SENATOR CAMPBELL: We have two other senators. They are both presenting bills in other committees. And so people will be coming and going all afternoon. With that, we will open the public hearing on LB428... [LB428]

SENATOR HAAR: That's me. [LB428]

SENATOR CAMPBELL: ...and that's you, absolutely, Senator Haar's bill to change permitted practice provisions for certified nurse-midwives. Welcome, Senator Haar. [LB428]

SENATOR HAAR: Thank you very much. My name is Ken Haar, K-e-n H-a-a-r, and I don't have the lights used on me, right? [LB428]

SENATOR CAMPBELL: No. [LB428]

SENATOR HAAR: Oh, good. [LB428]

SENATOR CAMPBELL: You get to speak within reason, Senator Haar. Let's put it that way. [LB428]

SENATOR HAAR: (Laughter) Thank you very much. Thank you very much. Well, today you might notice the button I'm wearing. It says Ronald Reagan and Ken Haar. What do we share? We were both born at home. Okay? There are only two places in the world that I know of where you can't have home births by certified midwives. One is Alabama and one is Nebraska. LB428 removes the prohibition on certified nurse-midwives from attending a home birth. Certified nurse-midwives would still have to practice under the supervision of a doctor, of a physician. We haven't changed that. And it does not create an autonomous practice for certified nurse-midwives. As I said, they must still operate under the supervision of a doctor. But, currently in the law, if a certified nurse-midwife would attend a home birth, that's a felony. As I said, only Nebraska and Alabama, the only two places in the world where certified nurse-midwives cannot attend a home birth, and we feel this would provide a safe option for women who want a home birth. And right now it's happening, in many cases, without any medical professional present. If I'm

a father in my home or a neighbor, I can perform a home birth; but not if there's a certified nurse-midwife. Now I will be leaving soon, too, because I have another bill in Natural Resources. Tom is going to take very careful notes and so I will not close. But you'll be hearing from us certainly after the hearing. So thank you very much, and I will give the rest of my five minutes to whoever wants it. (Laughter) [LB428]

SENATOR CAMPBELL: Senator Krist wanted me to say, well, no, you really only have three minutes but... [LB428]

SENATOR HAAR: That was 2 minutes and 30 seconds, Senator. [LB428]

SENATOR CAMPBELL: Thank you, Senator Haar. Senator Krist. [LB428]

SENATOR KRIST: Thank you, Chair. Who's responsible for the yellow roses today? [LB428]

_____: That would be Melanie Osborn (phonetic) for (inaudible) Matters provided the roses for you (inaudible) Nebraska Nurse-Midwives (inaudible). [LB428]

SENATOR KRIST: Well, thank you, because the scent in here is wonderful. (Laughter) We had a rather long hearing last night, and it didn't smell this good. (Laughter) [LB428]

SENATOR CAMPBELL: Senator Gloor. [LB428]

SENATOR GLOOR: Thank you, Senator Campbell. Senator Haar, I know it has been...there's a letter from Joann Schaefer, state medical director, and she points out that this is, as we know, not the first time this bill has come in; but it has been since 2006 that this has gone through the LB407 review process. There are a lot of new faces in the LB407, which is where the Board of Health gets down and takes a look at scope of practice and whatnot. And not only a lot of new faces who are involved in those decisions; there's a new process in place. LB407 was revamped pretty substantially and went through this committee last year for approval. So there's even a new LB407 review process that in fact takes into consideration information it couldn't in the past, like the fact Nebraska and Alabama are the only two states remaining where certified nurse-midwives can't participate in a home delivery. So, I mean, was there a specific reason the LB407 hasn't been pursued again, or has it just not really been part of the discussion? [LB428]

SENATOR HAAR: It hasn't been part of the discussion, but I appreciate that and it will be. [LB428]

SENATOR GLOOR: Okay. Thank you. [LB428]

SENATOR HAAR: Yeah. [LB428]

SENATOR CAMPBELL: Any other questions for Senator Haar? Seeing none, thank you. And good luck in Natural Resources. [LB428]

SENATOR HAAR: Okay. And if the rest of you would like roses, I think there were some more left. Weren't there some more left? You might just have someone bring those in. So we have a room down there that's full of young women and a lot of children, and it's really neat to see. So you'll enjoy the testimony. Thank you so much. [LB428]

SENATOR CAMPBELL: Thank you, Senator Haar. With that, we'll start with our first proponent to testify in favor of the bill. Good afternoon. [LB428]

THERESA HOSPODKA: Good afternoon. [LB428]

SENATOR CAMPBELL: Kaitlyn will take your orange sheet. [LB428]

THERESA HOSPODKA: (Exhibit 1) Okay. Thank you. Good afternoon, Senators. My name is Theresa Hospodka, H-o-s-p-o-d-k-a. I live in District 13 so, Senator Cook, yes, it's especially good to meet you today. I've talked to some of your staff and have enjoyed that. I'm a member of Nebraska Friends of Midwives, the consumer group which sometimes visits the senators' offices with M&M treats and information about mothers and midwives. I haven't been able to be as active as I once was. I have four children. The oldest is in middle school, and the youngest was born in December at the freestanding birth center in Bellevue. I have been helping to advocate for this legislation for several years, so I thought I'd give you a short history of the 12 words, "except that a certified nurse-midwife shall not attend a home delivery," which we're asking you to remove from Nebraska statutes. And I don't speak off the top of my head, so...when Ann Seacrest, a registered nurse in Nebraska who some of you might know, moved to the state 30 years ago, she was very disappointed to find that she could not continue receiving midwifery care through her pregnancy. At that time, Nebraska was one of 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-saving aspect, she worked with a number of local groups to initiate and organize an interim study before the Legislature, helped to draft the legislation, and lobbied for passage of a bill that licensed certified nurse-midwives in the state of Nebraska, and I am one of those happy recipients of that, the work that was done before, and I am very thankful for that. In order to get the bill out of committee, Ann and her co-organizers were asked to sit down in a room and work out a compromise with the Nebraska Medical Association. The NMA asked for a clause prohibiting home births. Ann has explained in previous years' testimony about this same legislation that they had spent two years gathering information, educating senators, going to meetings, walking the halls, and when faced with this expectation to make a deal, they had to decide whether to start all over again

or accept the compromise. They 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. It's been 30 years now, and once again Nebraska is in the position of being two states that restrict access to midwifery care. The issue really before you today is whether this restriction creates a safer environment for the babies of our state or whether we are contributing to an unsafe environment with this restriction. Do we deny Nebraska infants a skilled birth attendant when 48 other states provide this element of safety? Please advance this bill to the floor so that Nebraskans can have access to this excellent care when giving birth at home. Thank you very much for your time. [LB428]

SENATOR CAMPBELL: Questions from the senators? Thank you. Would you like to introduce the person who's with you? [LB428]

THERESA HOSPODKA: Oh, I'm sorry. Yes, this is Adeline (phonetic) Rose, and she was born December 27 at the Bellevue Birth Center, and we're very thankful for that opportunity as well. [LB428]

SENATOR CAMPBELL: And she's doing well. [LB428]

THERESA HOSPODKA: She's doing great. Thank you. [LB428]

SENATOR CAMPBELL: Good. Well, all good wishes. [LB428]

SENATOR COOK: Thank you for helping populate District 13. (Laughter) [LB428]

THERESA HOSPODKA: Yes. [LB428]

SENATOR CAMPBELL: That's right. We're adding constituents for Senator Cook. [LB428]

SENATOR KRIST: 37,333. [LB428]

THERESA HOSPODKA: Yes. Awesome. Thank you very much. [LB428]

SENATOR COOK: Thank you. [LB428]

SENATOR CAMPBELL: Our next proponent. [LB428]

BECKY SHERMAN: (Exhibit 2) My name is Becky Sherman, S-h-e-r-m-a-n. [LB428]

SENATOR CAMPBELL: Go right ahead. [LB428]

BECKY SHERMAN: Good afternoon, Senators. I'm very glad to see you today. Thank you for hearing LB428. As a representative of Nebraska Friends of Midwives, a consumer-based nonprofit organization, I will provide a preface to the collection of testimony that you are about to hear, as well as point to some of the indicators that it is time for Nebraska to legalize the option of certified nurse-midwife-attended home birth. You will hear today from a small handful of Nebraskans who have chosen or would like to have the opportunity to choose home birth. Their reasons for preferring home to hospital are diverse, and include dignity, privacy, benefits of health and safety, financial value, personal autonomy, and much more. Since Nebraska statutes made CNM attendance of home birth illegal in 1983, our state has seen more than 2,646 home births. That's 2,646 home births. And a handful of these births were most likely planned for the hospital, but there's also a handful of hospital that were planned for home. Some have found direct entry or certified professional midwives, which are unlicensed in Nebraska, to attend them, but others cannot and choose to birth at home unattended. The current law does not prevent home birth; it only prevents the attendance of this specific care provider. Also testifying today is a CNM who is currently a clinical director at a freestanding birth center in Texas, a state which recognizes that home birth is fully within the scope of CNM training and practice standards. In fact, Nebraska's maternity care consumers are unusually limited in their access to midwifery care. In 48 states, CNMs can provide maternity care and attend births in homes. Nebraska Friends of Midwives is not alone in desiring the passage of this bill. You can find attached a list of supporting organizations and businesses, including American College of Nurse-Midwives, the Nebraska Nurses Association, the Nebraska Association of Family Practice, the Nebraska Chapter of the National Association of Social Workers, and the YWCA of Lincoln. In my experience, when this topic of home birth arises, one of the first questions usually is: But is it safe? And it is a question that I do find difficult to answer, not because there aren't good studies, because there are good studies from high-quality sources demonstrating excellent outcomes of CNM-attended home birth. But giving birth is a very personal experience, and people of both sides usually have a vested interest in why they hold their opinion. After a couple years of involvement with Nebraska Friends of Midwives, though, I have come to realize that these polarizing debates of home versus hospital, safe versus unsafe are not really the bottom line. We don't all have to agree about the best place to have a baby, only that those who give birth at home have the right to be attended by licensed care providers. And finally, Nebraska Friends of Midwives is aware of recent charges of practicing medicine without license and manslaughter filed in Custer County, Nebraska, against a nonnurse-midwife from South Dakota. Sadly, this is a case in which a baby died. Nebraska Friends of Midwives, however, has no special knowledge of the circumstances relating to this arrest, and can make no comments about the specifics involved in this pending case. Nebraska Friends of Midwives has received confirmation from the North American Registry of Midwives that Ms. Jones does hold the credential of certified professional midwife, CPM, a category of nonnurse-midwives who practice legally...whose practices are legally recognized in 27 states and for which the nationally known organization, The

Big Push, seeks licensure. Recognizing their valuable practice and the demand for CPM care in our state, NFOM pursued legislation to license CPMs in 2005, an effort which was unsuccessful. The legislation before you today addresses only certified nurse-midwives, which have for almost 30 years been licensed in Nebraska. [LB428]

SENATOR CAMPBELL: Questions? Yes, Senator Cook. [LB428]

SENATOR COOK: Thank you, Madam Chair. Explain to me how certified nurse-midwives are permitted to practice now, under what conditions. [LB428]

BECKY SHERMAN: I am probably not the best person to ask that question of. [LB428]

SENATOR COOK: Okay. I'll save that. [LB428]

BECKY SHERMAN: We do have a certified nurse-midwife on her way who is extremely familiar with... [LB428]

SENATOR COOK: Okay. [LB428]

BECKY SHERMAN: ...all of the hows and ins and outs. Is there any other way that I could answer that question that would help you out? [LB428]

SENATOR COOK: I don't know, and I don't want to guess. It's probably written down. Jeff might be able to. [LB428]

BECKY SHERMAN: They are licensed in Nebraska... [LB428]

SENATOR COOK: Uh-huh. [LB428]

BECKY SHERMAN: ...and they are allowed to practice in-hospital in Nebraska. [LB428]

SENATOR COOK: With a physician in the room or with another...? [LB428]

BECKY SHERMAN: With a physician, underneath a practice agreement. [LB428]

SENATOR COOK: Okay. [LB428]

BECKY SHERMAN: So a physician would not be in the room. [LB428]

SENATOR COOK: But the physician would have a practice agreement with that hospital. [LB428]

BECKY SHERMAN: Yes. Yes. [LB428]

SENATOR COOK: But he or she needn't be in the room... [LB428]

BECKY SHERMAN: Correct. [LB428]

SENATOR COOK: ...with the certified nurse-midwife to attend the birth. [LB428]

BECKY SHERMAN: Correct. [LB428]

SENATOR COOK: Okay. [LB428]

BECKY SHERMAN: Unless, fill in the blank, something arises or there's a need. But I'm sure that the midwife can answer that question more suitably. [LB428]

SENATOR COOK: All right. Thank you. Thank you. [LB428]

BECKY SHERMAN: Yeah. [LB428]

SENATOR CAMPBELL: Any other questions? Thank you very much. [LB428]

BECKY SHERMAN: Oh, thank you. [LB428]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB428]

SHANNA WRIGHT: (Exhibits 3 and 4) Good afternoon. I'm here on behalf of the National Association of Social Workers, the Nebraska Chapter. I am here to inform you that the NASW, Nebraska Chapter, is officially supporting LB428. [LB428]

SENATOR CAMPBELL: And we do need you to give your name and spell it. Sorry. [LB428]

SHANNA WRIGHT: My name...that's okay. My name is Shanna Wright, W-r-i-g-h-t. [LB428]

SENATOR CAMPBELL: Do you need the first name, Madam Clerk? [LB428]

SHANNA WRIGHT: Shanna, S-h-a-n-n-a. [LB428]

SENATOR CAMPBELL: Thank you. [LB428]

SHANNA WRIGHT: The Eighty-Eighth Legislature gave legal status to certified nurse-midwives in 1983. As mentioned previously, in giving legal status to certified nurse-midwives, the line "except that a certified nurse-midwife shall not attend a home

delivery," was added was added to the statute, regulating the practice of certified nurse-midwives. The home birth restriction language was added at the last minute as a compromise to ensure that the statute would pass. The addition of the home birth restriction is interesting because, as Senator Haar already mentioned, there are only two states in the United States currently that restrict certified nurse-midwives from attending women in a home birth setting. Those two states are Alabama and Nebraska. The other 48 states do not legislatively ban certified nurse-midwives from attending women in a home birth setting. Home birth in Nebraska is not illegal. In fact, according to the Department of Health and Human Services, Office of Vital Records, there were 58 planned home births in 2012 alone. Obviously, this is a self-reported number, so there is a very strong possibility that the number is likely higher. While women in Nebraska are currently going ahead with planned home births, access to qualified medical care has been legislatively banned for the past 30 years. By restricting certified nurse-midwives from serving women in a home setting, women choosing a home birth are being denied access to qualified medical care. A denial of care jeopardizes both the physical well-being and the mental well-being of the mother and child. As mentioned previously, a home birth in Nebraska is not illegal. Women have the right to choose a home birth in the state of Nebraska. It is wrong to continue legislatively blocking access to qualified medical care for Nebraska women. Women deserve access to the best care, whether they choose to birth in a hospital, a freestanding birth center, or at home. It is time that we stop denying access to qualified medical care for the women of Nebraska. As a social worker, a mother of five children, and a citizen of Nebraska, I strongly urge you to support LB428. Thank you. [LB428]

SENATOR CAMPBELL: Questions from the senators? Thank you very much for your testimony. [LB428]

SHANNA WRIGHT: Thank you. [LB428]

SENATOR CAMPBELL: Our next testifier. [LB428]

KRISTEN TREAT: How much time do I have? [LB428]

SENATOR CAMPBELL: Five minutes. [LB428]

KRISTEN TREAT: Okay. Then we don't have to skip. [LB428]

SENATOR CAMPBELL: And your name? Go right ahead. [LB428]

KRISTEN TREAT: (Exhibit 5) My name is Kristen, K-r-i-s-t-e-n, Treat, T-r-e-a-t. I am an internationally board certified lactation consultant, a certified professional counselor, and a licensed mental health practitioner. I am certified in the field of perinatal mood disorders and focus much of my work on pregnant and new moms. The period of labor

and childbirth is one of the most significant events in a woman's life. During this time, a woman faces her most intimate, emotional, and physical struggles. This is naturally a time of vulnerability and, as such, the events, actions, and treatment of those involved in her birthing process can have a profound impact on her psychological as well as physical well-being. When there are negative feelings surrounding the birth experience, it can be overwhelming. The feelings of betrayal by their care provider can linger, making it difficult to return for follow-up care, as well as making it extremely difficult to trust other healthcare providers. They are told time and time again they have a healthy baby and to just get over it; but the images, the thoughts, the feelings, the anxiety, the fear, the dread, and the regrets won't let them. It is a horrific event that fosters every part of their day and they are reminded of every time they look at their baby. To define traumatic childbirth, we look toward Cheryl Beck, a leading researcher on the issue of birth trauma, who concluded, "Birth trauma lies in the eyes of the beholder." When a clinical diagnosis is needed, a therapist utilizes the Diagnostic and Statistical Manual of Mental Disorders, the DSM-IV, criteria for posttraumatic stress disorder. This states that a person must have been exposed to a traumatic event in which both of the following have presented: the person experienced, witnessed, or was confronted with an event or events that have (sic--involved) actual or threatened death or serious injury; a threat to the physical integrity of self or others; or the traumatic event also manifests itself, including replays, dreams, flashbacks, and/or avoidance of stimuli associated with the event. Triggers in birth trauma can be anything related to the birth itself: location, care provider, the sound of medical supplies opening at a subsequent checkup, the clothes that were worn, smells, foods, etcetera. Feelings of disrespect in the childbirth process can also create feelings of traumatic birth. Penny Simkin concluded...conducted a study looking at the permanence of the birth story over time and found the women in her story (sic--study) were still angry and disappointed by what care providers had done to them 20 years later. Simkin found the way a woman is treated by professionals on whom she may depend determines largely how she feels about the experience for the rest of her life. Now that you have a basic understanding of what birth trauma is, how it happens, and why it matters, I'd like to address the two major reasons why this issue is important in regards to LB428. Mothers who have a home birth with a qualified care provider are less likely to report experienced birth trauma. In an article entitled, "When a Bad Birth Haunts You," Dr. Pauline Slade described a major study of posttraumatic stress linked to birth. Dr. Slade says: A woman's emotional state after a home birth tends to be very different. She is positive, self-confident, often exultant. Birth is something she has achieved rather than something that has been done to her. Afterwards, she can cuddle the baby in her own bed. A woman who controls the space in which she gives birth and who can, therefore, risk losing her self-control and can surrender to the overwhelming feelings welling up insider of her is much more likely to look back on the birth as a positive experience. Childbirth is an adventure in which she has discovered her inner strength, joy in her body, and growth in self-awareness and self-confidence. Birth is empowering. For women who have already experienced a traumatic childbirth and are preparing for a subsequent childbirth, allowing home birth to be a viable option is

especially important. As mentioned earlier, these women are likely to have very strong feelings of distrust in their care providers and be very resistant to returning to a hospital environment. In a small study conducted by Beck and Watson in which they explored subsequent childbirth after a previous birth trauma, they found these women were strongly motivated to make sure the birth was different this time. Nearly one fourth of the women in this study opted to strive for a home birth. This is especially a high number when you reconcile that with only 1 percent of the general population is born outside the hospital. It's clear that while home birth isn't a desirable option for everyone, for women who experience a home birth are less likely to experience the very real traumatic effects of traumatic childbirth. Women who experience a traumatic childbirth are much more likely to have a healing experience after a subsequent birth that occurs at home. As a mental health professional and a women's advocate, I implore you to please spend some time thinking about the growing population of women experiencing traumatic childbirths. Think of how these experiences shape them as a woman and a mother. Then please give the women of Nebraska an option to birth at home with a certified nurse-midwife. [LB428]

SENATOR CAMPBELL: Thank you. Senator Cook, do you want to pursue your questions? [LB428]

SENATOR COOK: Perhaps you might be able to help me. Thank you, Madam Chair. Who may currently attend a home birth in the state of Nebraska? [LB428]

KRISTEN TREAT: Legally, nobody. There is no...as far as I know, somebody else might correct me later, but as far as I know there is no statute that allows anybody to attend a home birth. [LB428]

SENATOR COOK: Okay. And the other inside-out version of that question--I think I got the beginning of an answer to that--so currently a certified nurse-midwife may attend a birth inside a hospital or... [LB428]

KRISTEN TREAT: Or a birth center. [LB428]

SENATOR COOK: ...or a birth center... [LB428]

KRISTEN TREAT: Uh-huh. [LB428]

SENATOR COOK: ...under the...what's the term? [LB428]

KRISTEN TREAT: Under a practice agreement with a physician. [LB428]

SENATOR COOK: Under a practice agreement with a physician, and this physician need not be present at the birth. [LB428]

KRISTEN TREAT: Correct. [LB428]

SENATOR COOK: Okay. Thank you. [LB428]

KRISTEN TREAT: You're welcome. Anybody else? [LB428]

SENATOR CAMPBELL: Have you practiced in another state? [LB428]

KRISTEN TREAT: I have not. [LB428]

SENATOR CAMPBELL: Oh, okay. So it's mainly been in Nebraska that you have practiced. [LB428]

KRISTEN TREAT: Correct. [LB428]

SENATOR CAMPBELL: Okay. [LB428]

KRISTEN TREAT: Thank you. [LB428]

SENATOR CAMPBELL: That's all. I was just looking for somebody... [LB428]

KRISTEN TREAT: Oh, no problem. [LB428]

SENATOR CAMPBELL: ...who might have practiced in another state. [LB428]

KRISTEN TREAT: Yes. [LB428]

SENATOR CRAWFORD: So if I understand correctly, you are not a nurse... [LB428]

KRISTEN TREAT: I am not a certified nurse-midwife. I'm a therapist. [LB428]

SENATOR CRAWFORD: Right. Right. Right, you are a therapist. Have you worked with women who have experienced this traumatic birth and have you... [LB428]

KRISTEN TREAT: Yes. [LB428]

SENATOR CRAWFORD: ...counseled and seen what's happened in their experience when they've been able to choose a home birth in another state? [LB428]

KRISTEN TREAT: I have worked with women who have decided to choose a home birth in the state of Nebraska. [LB428]

SENATOR CRAWFORD: Despite the risks. [LB428]

KRISTEN TREAT: Despite not having a certified nurse-midwife to be their care provider, absolutely. [LB428]

SENATOR CAMPBELL: Okay. Thank you. Our next proponent. Good afternoon. [LB428]

JESSICA FREEMAN: (Exhibit 6) Good afternoon. My name is Jessica Freeman, J-e-s-s-i-c-a F-r-e-e-m-a-n, and I've been living in Lincoln for the last six-and-a-half years. I'd like to testify to two points today: one, women who want a home birth are going to have a home birth; and number two, to have a safer home birth, women should be supported in their search to find a legal attendant for their home birth. I have borne three beautiful children. My first was a fairly typical hospital birth with an ob-gyn in Syracuse, New York. When it came time for my second, I had started reading everything I could get my hands on about birth, midwives, and home birth, and I was determined to have a home birth. I found two lovely midwives who came and supported me throughout my labor at home. My first home birth was a truly empowering experience and ended with a very healthy and intact family. Shortly afterwards, we moved here to Nebraska where I quickly learned that midwives were either barred completely or severely discouraged from attending home births. Within a few months of arriving in Nebraska, I was already dragging my three-year-old daughter and my infant son to the Capitol to pass out information and M&Ms requesting the senators to change the laws regarding midwives in Nebraska. Six years later I'm still pounding the pavement at the Capitol. My children are older and they have been joined by a brother who was born at home in our bathtub. I'm not someone who is comfortable being by herself during birth, so I managed to find an experienced person to come and support me during my third labor, and all ended successfully again. I've attended the hearings for the last two times this bill has been introduced to the Health and Human Services Committee. Each time they listen to this bill, they question how safe home birth is. My question for them is, how safe is it to continue to deny families access to trained professional attendants when they choose to birth at home? Home births will never be a large percentage of births in Nebraska; however, each year the statistics report an average of 100 out-of-hospital births occurring here in Nebraska. This year we know that at least 58 of those births were planned to be at home. That is 58 families who are birthing alone, without assistance; importing a midwife from somewhere else, who may or may not be arrested before they are able to give birth; or otherwise taking a risk with a birth attendant who may not be qualified to help them. I have a friend who has been attending people's births lately. She feels that if she does not attend these births, these women will be alone if something goes wrong, and she would rather be there to help them. I would rather that she didn't have to help them because they would have a legal option. Doctors are legally able to attend home births in Nebraska; but for whatever reason, they don't. They probably don't have time to wait patiently at home with a

woman while she labors. They are not exposed to natural, unmedicated birth, and they wouldn't know how to assist at a home birth. That's the great thing about certified nurse-midwives. They are trained to deal with normal birth in normal environments, including the hospital and at home. They are trained to recognize emergencies and forward those emergencies to the appropriate experts for further help. They are trained to handle any minor incidents that could result in emergencies in the wrong hands, for instance, cervical lips, placenta delivery, or helping the baby get a good start breathing and/or breast-feeding. Best of all, they have protocols to follow to help birth be safer at home or in the hospital. Most emergencies that happen at home are not like the emergencies that happen in the hospital. Emergencies in the hospital often involve Pitocin, epidurals causing fetal hearts to crash, and if the baby isn't surgically removed quickly, the baby will die. Home births are very different. Emergencies that happen at home are much more likely to develop slowly with lots of warning signs, that there is usually plenty of time to transfer a mother to a nearby hospital if things are not going well. That can only happen when the mother is being supervised by a trained and qualified professional who knows how to help her. Birthing at home is not a decision taken lightly by most families. With both of my home births, the first topic discussed with the midwives was the plan of action if something were to go wrong, and the realization that once in a while things can go very wrong. This is a discussion I did not have with my hospital birth because at the hospital they promised that everything will be fine if you follow the dictates of the doctors and the hospital staff. Ironically, the doctors then take full control of the birth in the hospital and often cause riskier births through their many interventions and protocols. It makes me sad to hear about the frightening close calls that happen in hospital births every day. I also worry about the mothers who choose to avoid the hospital and are then forced to birth by themselves or with unqualified attendants. Personally, I will choose to have any future babies at home, because once you've educated yourself about your options, you generally don't change your mind just because one of them is harder to achieve. Please help myself and all the women in Nebraska, who choose a home birth, to have safer home birth by passing LB428 out of committee and allowing us to have certified nurse-midwives legally able to attend us at home. [LB428]

SENATOR CAMPBELL: Questions for Ms. Freeman? Senator Crawford. [LB428]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you for your testimony. So your second birth was with a certified nurse-midwife. Is that correct? [LB428]

JESSICA FREEMAN: I believe she was a certified professional midwife, but she was in...she was trained in England and she was practicing in New York at that time. [LB428]

SENATOR CRAWFORD: Oh, okay, practicing. Now could you tell us just a little bit about that planning? You mentioned briefly in your testimony that you made some plans

for emergency. I mean was this something that you sat down and planned together? [LB428]

JESSICA FREEMAN: Yeah. The first thing that they do is they sit you down and they say, these are the things that are likely to go wrong in a home birth; this is what we will do: If this happens, we will give you this herb; if this happens, we will be going to the doctor; if this happens, we'll be, you know, rushing you to the hospital. So they always had a plan. They brought oxygen for the baby. If the baby...sometimes the baby doesn't breathe right when it comes out, so they have oxygen. They had supplies to stitch me up. I tore a little bit when I had the baby, and they stitched me up afterwards. And so they have basic supplies that help make the birth safe and then they also have a plan of action if something were to go wrong that was more serious. [LB428]

SENATOR CRAWFORD: Okay. And was there any other communication or any other health provider involved in those discussions or prenatal visits? [LB428]

JESSICA FREEMAN: Usually, midwives like to recommend that you develop a relationship with a doctor... [LB428]

SENATOR CRAWFORD: Uh-huh. [LB428]

JESSICA FREEMAN: ...as a backup... [LB428]

SENATOR CRAWFORD: Okay. [LB428]

JESSICA FREEMAN: ...in case something goes wrong. So with both pregnancies, I did have an appointment with a doctor beforehand, and he was aware that I was going to do a home birth. [LB428]

SENATOR CRAWFORD: Did you talk...did he have any role in talking to you about that plan with the midwife as well or...? [LB428]

JESSICA FREEMAN: Not specifically. [LB428]

SENATOR CRAWFORD: Okay. [LB428]

JESSICA FREEMAN: I mean they definitely say, are you sure you know what you're doing,... [LB428]

SENATOR CRAWFORD: Uh-huh. [LB428]

JESSICA FREEMAN: ...have you done your research, and things like that. [LB428]

SENATOR CRAWFORD: Right. Right. So and then if...the plan, if something were to happen and you had to go to the hospital then, this other doctor would have been somebody who knew your case and would be able to come in... [LB428]

JESSICA FREEMAN: Right. [LB428]

SENATOR CRAWFORD: ...to the situation at that point? [LB428]

JESSICA FREEMAN: I believe the plan was to call the doctor as soon as... [LB428]

SENATOR CRAWFORD: Uh-huh. [LB428]

JESSICA FREEMAN: ...he would need to be involved and then meet them at the hospital. [LB428]

SENATOR CRAWFORD: Okay. Thank you. [LB428]

JESSICA FREEMAN: It was a while ago. (Laugh) [LB428]

SENATOR CAMPBELL: Any other questions? Thank you for your testimony. [LB428]

SENATOR CRAWFORD: Thank you. [LB428]

JESSICA FREEMAN: Thank you. [LB428]

SENATOR CAMPBELL: Our next proponent. [LB428]

REBECCA WINGEBACH: (Exhibit 7) Good afternoon. My name is Rebecca Wingebach, R-e-b-e-c-c-a W-i-n-g-e-b-a-c-h, and I am also a District 13 lady. [LB428]

SENATOR COOK: Yea! (Laughter) [LB428]

REBECCA WINGEBACH: I would like to thank the senators of the Health and Human Services Committee for having this hearing today. It is a pleasure to get the opportunity to talk with you about something deeply important to my family and me. As I mentioned, my name is Rebecca. And my husband, Jacob, and I have three children; and we are expecting our fourth baby in August. Our first child was born at home in California, where we were attended by two licensed midwives, and thank goodness, because I had a 44-hour labor. In a hospital, I probably would have had to have fought very hard not to have a C-section; but at home, because the baby's heartbeat stayed strong and healthy, it was a nonissue. Anyway, by the time I was pregnant with my second child, we had relocated to Nebraska for my husband's job. He works for the federal government as a regulator. As you might imagine, licensure is very important to him, and neither of us felt

comfortable having a home birth in a state where no such oversight existed. However, we had done extensive research into the safety statistics of both hospital and out-of-hospital birth during my first pregnancy, and neither of us had any desire to step foot in a hospital unless my health or the baby's health warranted it. We wanted a home birth, and we felt like we had no options in Nebraska. Luckily for us, my husband's mother lives in Topeka, Kansas, where there are both legally practicing, licensed home-birth midwives, and an out-of-hospital birth center. Seeing as we were already going to be away from home, we opted to have our baby at the birth center. I planned to go to my mother-in-law's house two weeks before my due date with my toddler son and settle in. My husband had to remain behind and work in Omaha; but when I went into labor, I would call him and he would get on the road and join us. Surely he would have enough time to make the three-hour drive. My last labor had been 44 hours, after all. (Laughter) Unfortunately, it didn't work out that way. My second baby came much quicker than my first. Even though I called him to come as soon as I was sure I was in labor, he couldn't drive fast enough. I had a beautiful, easy birth at the birth center; but when my daughter made her first cry, my husband was driving on a highway someplace in Kansas with no cell phone reception. He missed her birth, and there's no getting that back. There are no do-overs. Now I am pregnant again. Thankfully for us, there is now a freestanding birth center in Bellevue, run by a certified nurse-midwife. It is only a 35-minute drive from our home in north Omaha, but my husband and I would both dearly love to have this baby born at home. My third baby came even more quickly than my second, and I would much rather have a midwife come to me than hope I didn't deliver on the road. Thank you for listening to me today. Please advance this bill to the floor for a vote. Nebraska's families are just as deserving as the rest of the country for licensed home birth professionals. Any questions? [LB428]

SENATOR CAMPBELL: Any questions? Senator Cook. [LB428]

SENATOR COOK: Thank you, Madam Chair. At your first birth, do you know whether or not those were certified nurse-midwives or California has a different licensure for... [LB428]

REBECCA WINGEBACH: They were both. California has both certified nurse-midwives that can practice home birth and certified professional midwives that can practice home birth. [LB428]

SENATOR COOK: Okay. [LB428]

REBECCA WINGEBACH: One was a certified professional midwife, the other was actually...had her RN; but then, instead of getting her master's in midwifery, which would have made her a CNM, she also chose to have the CPM credential. So they were both certified professional midwives. [LB428]

SENATOR COOK: All right. Thank you. [LB428]

REBECCA WINGEBACH: No problem. [LB428]

SENATOR CAMPBELL: Any other questions? Thank you. [LB428]

REBECCA WINGEBACH: Thank you all so much. [LB428]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB428]

EMILY JOHNSON: Good afternoon. My name is Emily Johnson, E-m-i-l-y J-o-h-n-s-o-n. My first baby was born in the hospital, after eversion, an induction, drugs, an epidural, a failed vacuum extraction, and a Caesarian. He was born drug-doped, bruised and swollen, and spent a week in the NICU from the birth trauma and a hospital-acquired infection. The bill was $35,000, and our family was financially devastated. I was told by my obstetrician that my pelvis was just too small to ever give birth naturally; but thanks to an experienced home birth midwife, I gave birth to my second and third babies, one of whom was nine pounds, at home. Since these births were free from medical interventions, they went smoothly and naturally. I was protected from the trauma of major surgery and the extreme hemorrhaging that I had experienced with my Caesarian. My babies were born calm and alert, into the loving arms of their family. I was able to cuddle and bond with my newborns, instead of missing out on their first precious days as I had with my first. The cost--$1,500. Birth is a natural part of the human life cycle. It is not a medical crisis. Not everyone can or should birth at home, but every woman should be allowed to assess her own circumstances and have the option of a nonmedical birth. Nebraska families should have the same access to skilled home birth midwives the rest of the country has. Are there any questions? [LB428]

SENATOR CAMPBELL: Any questions? Thank you very much for your testimony. [LB428]

EMILY JOHNSON: Thank you. [LB428]

SENATOR CAMPBELL: Our next proponent. [LB428]

LINDA JENSEN: Hello. [LB428]

SENATOR CAMPBELL: Hello. [LB428]

LINDA JENSEN: (Exhibit 8) I'm Linda Jensen, L-i-n-d-a J-e-n-s-e-n, speaking to the honorable Senator Campbell and committee members regarding support of LB428. I am testifying as a representative of the Nebraska Nurses Association and a former OB nurse and instructor for about 20 years. Certified nurse-midwives in the United States

are prepared in two healthcare specialties--midwifery and nursing. They have at least a master's degree. Some even have a doctoral degree, including hundreds of hours of clinical practicum, plus have been OB nurses. The nurse portion of their credentials aligns them with nursing, and they are recognized as one of the advanced practice registered nurse professions. On the national front, the American College of Nurse-Midwives is an organizational affiliate of the American Nurse Association, and they partner together to support the practice of nursing as a whole and the unrestricted practice of APRNs. ANA supports the removal of barriers and discriminatory practices that interfere with full participation by advanced practice registered nurses in the healthcare delivery system. ANA supports initiatives that remove arbitrary practice restrictions or prohibit policies that promote barriers for APRN practice, education, abilities, and competence. So consistent with our national organization, the Nebraska Nurses Association is supportive of policy changes and legislation that eliminates practice barriers to APRN and certified nurse-midwife practices. Like other certified nurse-midwives, like other APRN types, certified nurse-midwives have experienced unjust practice restrictions here in Nebraska. Specific to this bill, our membership includes those who have been restricted from the full scope of APRN practice by prohibiting certified nurse-midwives from attending home births. We acknowledge that Nebraskans who are currently choosing home births are limited to unlicensed and unregulated care providers. Lack of licensure and regulation are known to carry more risk to the woman and family than securing a licensed and regulated home-birth provider, like a certified nurse-midwife. This gap is one that certified nurse-midwives can fill to improve patient safety, as it is within their trained and certified scope of care. Nebraska Nurses Association supports LB428. We urge your support of this measure and full support of scope of practice across Nebraska. Thank you for your time and the opportunity to testify on behalf of nurses and NNA members, and thank you for your service to the state of Nebraska. [LB428]

SENATOR CAMPBELL: Thank you, Ms. Jensen. Questions from the senators? Senator Crawford. [LB428]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you for your testimony and your service to the citizens of Nebraska in their healthcare. I wondered if you...are you familiar with the training for the master's in midwifery? [LB428]

LINDA JENSEN: I haven't taken it, of course,... [LB428]

SENATOR CRAWFORD: Uh-huh. [LB428]

LINDA JENSEN: ...because I never did become a midwife, although I was kind of a closet...I would love to have been one, you know? But by the time I got around to that, I decided it was too late, you know? (Laugh) But, yeah, they do have a master's degree. I have some friends who have...close friends who are certified nurse-midwives and most

of them have...they have a master's degree. They take...I teach, actually, in a graduate master's program; but it's not in midwifery. They have, you know, a lot of courses; and I couldn't tell you exactly what they have. I'm sure someone here can...that will testify next can tell you more about the courses they take. [LB428]

SENATOR CRAWFORD: Okay. [LB428]

LINDA JENSEN: They do have a lot of practical experience as, you know, the clinical experience. [LB428]

SENATOR CRAWFORD: Clinicals,... [LB428]

LINDA JENSEN: Uh-huh. [LB428]

SENATOR CRAWFORD: ...okay, and that, okay. [LB428]

LINDA JENSEN: Yes, that they take as they go along through their practice, yes. [LB428]

SENATOR CRAWFORD: Okay. Thank you. [LB428]

SENATOR CAMPBELL: Any other questions? Thank you, Ms. Jensen. [LB428]

LINDA JENSEN: Okay. [LB428]

SENATOR CAMPBELL: Our next proponent. Good afternoon. Deven is going to help you there. [LB428]

_____: Thank you. [LB428]

DOROTHY MARKS: Good afternoon. [LB428]

SENATOR CAMPBELL: How are you today? [LB428]

DOROTHY MARKS: Good. [LB428]

SENATOR CAMPBELL: And we need your name and if you could spell it for us. [LB428]

DOROTHY MARKS: (Exhibit 9) My name is Dorothy Marks, D-o-r-o-t-h-y M-a-r-k-s, and I will be ten years old on Monday. [LB428]

SENATOR CAMPBELL: An early happy birthday. [LB428]

DOROTHY MARKS: Thank you. [LB428]

SENATOR CAMPBELL: You go right ahead. [LB428]

DOROTHY MARKS: When I grow up, if I have a baby, I will have it at home. I would not want to drive around in that condition, worrying about not getting to the hospital on time and then have my baby in a strange room, surrounded by strange things. I would want to stay in my nice, cozy house with my loved ones and my midwife. I was there for the two home births of my brothers. They both ended fine. And even if there was a complication, the midwives would have moved them to a hospital. If you want to have your baby at home, you will have it at home, with or without a midwife. Unfortunately, most midwives cannot legally attend home births in Nebraska, so they are hard to find. Some women can't find one at all, but they have their baby at home anyway. It would be a lot safer if it was legal to have midwives at home. And how long have hospitals been around? Only a few centuries. In Jesus Christ's time, women had their babies at home and they survived, but they had midwives to make their home birth safer. There are only two states that do not allow home births--Alabama and our own state. We don't want to be the last. Please change the law so that I do not have to move to another state to have the kind of birth I want. [LB428]

SENATOR CAMPBELL: Good job, Dorothy. Way to go. [LB428]

DOROTHY MARKS: Thank you. [LB428]

SENATOR CAMPBELL: Tell us how old your brothers are. [LB428]

DOROTHY MARKS: Six and four. [LB428]

SENATOR CAMPBELL: Six and four. Do they bug you a lot? (Laughter) I know, I had an older brother, and brothers do that. Dorothy, you did just a great job on your testimony today and thank you so much for coming. Would you tell us one more thing? Where do you go to school? [LB428]

DOROTHY MARKS: I am homeschooled. [LB428]

SENATOR CAMPBELL: You're homeschooled. And what's your favorite subject? [LB428]

DOROTHY MARKS: Reading. [LB428]

SENATOR CAMPBELL: Reading. I was an English teacher. I love to hear that. (Laughter) Dorothy, thanks for coming today and your great testimony. [LB428]

DOROTHY MARKS: You're welcome. [LB428]

SENATOR CAMPBELL: I'm sorry, I didn't let...any other questions? I think we're all very pleased to have you. Thanks, Dorothy. Our next proponent. [LB428]

RENE DOCHERTY: My name is Rene Docherty, R-e-n-e D-o-c-h-e-r-t-y. I'd like to apologize at this time. I'm very sorry, Senators, I was so quick leaving the office, I never brought any copies of my testimony for you guys, so I'm very sorry. Also, I have a small accent. You might notice that. If at any point you wish for me to repeat what I said, please feel free to gesticulate or whatever else and I will do my best. My wife and I have...we currently have six children. I have four girls and two boys. I lose count very regularly. We're part of a demographic in Nebraska, a growing demographic in Nebraska, who are seeking home birth who have had home births and will continue to have home births. Once you've discovered the liberty, it's very hard to give up, much the same reason why I don't really intend to go back and live in Scotland, having discovered the liberty of America. Our decision to have home births was definitely not something we took on a whim. Firstly, I love my wife. I love my children. I would not just stand by and just let something bad happen to them in any circumstance. So after appropriate extensive research by reading, talking to other people who had had home births, we were convinced that this really was the best. And truthfully, I have to say as a man, in front of all the ladies, there is nothing, nothing on this planet that is more powerful and more moving then seeing a woman give birth. As a man, I was brought to my knees by the experience because I thought I knew what strength was. I had no clue at all. The main issue why I'm here, a proponent of LB428, is that I truly believe this bill provides a safer option for families like myself, for husbands who want to make safe decisions for the wives. I actually made that plea two bills ago, in front begging for assistance in making safe decisions of that nature. When we planned a home birth, obviously the main issue was not being able to have a midwife, and this was a bit of a surprise. In the U.K., of course, we have nationalized health. You have tons of access to doctors. The entire birthing system is run by midwives unless there is a problem. You can get access to advice any time of day or night. You just phone them up there, you get home birth, no problem at all. When I came over here, I was shocked in the hospitals to find a customer care center. I discovered this thing called consumerism when it came to hospitals, being able to have your ability to choose where you want to go with your healthcare. And for any other medical condition or problem, anything at all, any one of my children's, I can choose at any point to customize the care for my child or my wife. It's no problem. It's one of the beautiful things about the way the healthcare operates over here. But let me be clear, when we had our home births, they were unassisted. That means there was no one there, no one medically there to help. And shockingly enough, there were no problems at all. But one of the things I would very much like to stress, there's a big difference between a debate on the safety of home births and a debate of whether or not it is more safe with the presence of midwives; and please, let's

get that clear. It's going to be very easy in the process of this discussion in here to get drawn into your own personal concerns about the safety of home births. Personally, I don't think that's up for debate. People are having home births. People are going to continue to have home births. The whole U.S. is moving towards that as people realize the freedom they have. But all the home births were fine. The babies were awesome. My last baby, which we had eight months ago, was a whopping 11-pound baby. I swear she came out sideways; she was huge. And I would like to know, and truthfully, my wife was also overdue. She'd gone past the 40-week mark with an 11-pound baby, and she delivered naturally without any problems. I wonder what would have happened in a hospital situation. I wonder if there would have been medical intervention that would have led to problem after problem. Thankfully, I don't have to worry about that. Really, at the end of the day, this bill is about that simple question: Does it make it more safe or less safe to allow a midwife to go and attend a home birth; more or less? It's that simple. There's not a middle ground in that. Thank you for your time and for the honor of this, and I'm happy to answer any questions. [LB428]

SENATOR CAMPBELL: Questions from the senators? We had no problems understanding you, so. (Laughter) We enjoyed the accent. [LB428]

RENE DOCHERTY: Thank you very much. Thank you. [LB428]

SENATOR CAMPBELL: Thank you. Our next proponent. Good afternoon. [LB428]

REBECCA LAWSON: Good afternoon, Senators. My name is Rebecca Lawson, R-e-b-e-c-c-a L-a-w-s-o-n. I'm here on behalf of my own business, Heartland Hypnobabies, and the Nebraska Friends of Midwives. I am a member of that as well. I am currently a certified childbirth educator here in Lincoln. I was certified in 2011, and I provide education to prenatal couples for their birth. I am also currently pregnant myself. I have a three-year-old daughter at home, and I am planning to have my baby in June. For myself, we have chosen a hospital birth with a certified nurse-midwife. Unfortunately, when I educate couples on birth, I am unable to give them much in the way of home birth. Our curriculum does have a portion for home birth. There's about 250 certified childbirth educators through Hypnobabies around the country, but I teach in one of the states that home birth is not a great legal option for women. I would love to see that change, mainly because I believe that women have the innate ability to choose the safest option for them and their families. Were home birth a better option, I might consider it. However, I feel so strongly that I feel safe with the certified nurse-midwife that I am currently able to choose either the birth center in Bellevue or a certified nurse-midwife here in Lincoln. The birth center is about an hour from my home in south Lincoln. And being my second baby...and my first birth was in Tennessee. Had a very wonderful hospital birth with a certified nurse-midwife in Tennessee that went very smoothly and naturally. I would love to have a better option here. But unfortunately, for myself, I feel that I would be best served close to home here in Lincoln. But through all

my education and training in childbirth education, I just find that women have the innate ability to choose what is safest for them and their babies, and I hope that it will become an option for women to choose to have their child at home should they so desire. Thank you for your time this afternoon. [LB428]

SENATOR CAMPBELL: Thank you, Ms. Lawson. Questions from the senators? Thanks for coming. [LB428]

REBECCA LAWSON: Thank you. [LB428]

SENATOR CAMPBELL: Our next proponent. [LB428]

TIFFANY DALTON: Hello. [LB428]

SENATOR CAMPBELL: Good afternoon. [LB428]

TIFFANY DALTON: (Exhibit 10) My name is Tiffany Dalton, T-i-f-f-a-n-y D-a-l-t-o-n, and I am a Montessori Early Childhood educator and language educator in Nebraska, and have been since 2001. I'm also a certified doula. And I left Nebraska in 2007 when I was pregnant with my daughter, who was born in March of 2008. I moved to California, where home birth attended by certified nurse-midwives is legal and regulated. Lydia was born at home in Santa Barbara, California. I knew that I would have the best opportunity for a safe, peaceful, "uninterventive" birth experience if I were able to give birth to my daughter at home. My husband, who grew up in a Third World country, was skeptical at first of my decision to give birth at home. He was convinced that birth in a hospital, with all of the technological advantages inherent in that experience, would be safer. However, he soon realized that home birth could be a safe choice and was eager to support me in giving birth in a way that I felt to be safe and appropriate. We were attended throughout the pregnancy and during birth by two wonderfully competent certified nurse-midwives. The fact that they attended the birth equipped with the necessary tools for emergency intervention, such as oxygen and medications to stop hemorrhage, was comforting to both myself and my husband. The midwives also had a strong working relationship with the hospital and the obstetrician I saw concurrently throughout my pregnancy. If we were in need of a transfer to the hospital at any time during the birth, we felt confident that the transition would be a smooth and safe one. Also, our certified nurse-midwives made it clear when we contracted with them that they would only attend a birth at home in the case of a low-risk, healthy pregnancy. It is my strong feeling that competent, regulated, professional services provided by my midwives, in concert with the continuity of care that I received with my obstetrician and the local hospital, contributed to a safe, positive, healthy, and peaceful birth experience for our family. When I receive my graduate degree from UNL in, hopefully, two years, I plan to have another child. And I still feel strongly that a home birth experience is the safest and most desirable option for me if I have a low-risk, healthy pregnancy.

However, I would only feel comfortable having a home birth experience attended by a certified nurse-midwife qualified to attend such a birth. Therefore, if by that time home birth attended by a CNM is still not legal in Nebraska, I will be relocating to a state where it is in order to give birth. Thank you for your time and your support of LB428. And it's my hope that safe, healthy home birth will become an option for mothers in Nebraska. [LB428]

SENATOR CAMPBELL: Thank you, Ms. Dalton. [LB428]

TIFFANY DALTON: Uh-huh. [LB428]

SENATOR CAMPBELL: Questions? When you talk in the...in your testimony about that in California it was legal and regulated,... [LB428]

TIFFANY DALTON: Uh-huh. [LB428]

SENATOR CAMPBELL: ...what were the regulations put into place? [LB428]

TIFFANY DALTON: I don't know what the specific regulations are but just, I guess, what I meant to say is they're licensed. You know, there's oversight by the state as to how they're able to practice, so. [LB428]

SENATOR CAMPBELL: But as to... [LB428]

TIFFANY DALTON: And I think part of that, according to them, was the fact that...the low-risk pregnancy. For instance, my daughter was born three weeks early. My labor started on the day that I was at 37 weeks. If she had been born any earlier than that, they would have attended my birth in the hospital. They wouldn't have felt comfortable attending it at home, since she would have been preterm, so, yeah. [LB428]

SENATOR CAMPBELL: Okay. But you weren't, at that point, when you went through all of the instruction by them, there weren't any other regulations that you remember. [LB428]

TIFFANY DALTON: Not specifically. [LB428]

SENATOR CAMPBELL: Okay. That's fine. [LB428]

TIFFANY DALTON: Yeah. [LB428]

SENATOR CAMPBELL: I just thought you might have remembered. [LB428]

TIFFANY DALTON: Yeah. I think that, yeah, you know, just knowing that there was

oversight, that they were certified, that I knew their credentials were trustworthy. [LB428]

SENATOR CAMPBELL: Right. [LB428]

TIFFANY DALTON: And I think that, you know, the other part of it for me that was just so important was the continuity of care that I, you know, I was...you know, they strongly suggested that I be seen concurrently with the obstetrician with whom they had a partnership so that, you know, as you heard in earlier testimony, if there was a need for a transfer to the hospital, there was a working relationship between my midwives and the hospital. [LB428]

SENATOR CAMPBELL: Okay. [LB428]

TIFFANY DALTON: So that if that came to be necessary, those relationships were already in place and there was that confidence in knowing, if we need this, it can happen quickly, it can happen easily. There's a relationship there and there's no doubt that if there's need for that transition...and the continuity of care. Just the fact that I was seen by a physician and the midwives throughout my pregnancy, that gave me a lot of confidence in the home birth process. [LB428]

SENATOR CAMPBELL: You said they had a partnership with a physician. [LB428]

TIFFANY DALTON: Uh-huh. [LB428]

SENATOR CAMPBELL: Was that the physician that you saw? [LB428]

TIFFANY DALTON: Yes. Uh-huh. Yeah. [LB428]

SENATOR CAMPBELL: Okay. So you were really under a continuity of care between the doctor... [LB428]

TIFFANY DALTON: Uh-huh, exactly, yep. And he would have been the person who would have attended me in the hospital if we had had to have a transfer with them, so. [LB428]

SENATOR CAMPBELL: Okay. That does... [LB428]

TIFFANY DALTON: Yeah. [LB428]

SENATOR CAMPBELL: ...answer that. [LB428]

TIFFANY DALTON: Uh-huh. [LB428]

SENATOR CAMPBELL: Any other questions? Thank you very much for your testimony. [LB428]

TIFFANY DALTON: Yep. Thank you. [LB428]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB428]

SHAHAB ABDESSALAM: Hi. Thank you for your time, Senators. My name is Shahab. You want me to spell that as well? S-h-a-h-a-b, and the last name is Abdessalam, A-b-d-e-s-s-a-l-a-m. I am a pediatric surgeon up at Children's Omaha, and Children's Hospital up here in Omaha. I am board certified in general surgery, surgical oncology, surgical critical care, and pediatric surgery. When my wife first became pregnant, it was during my general surgery residency, towards the end of that, and she came to me with the proposition that she wanted to have a home birth. It was still legal in the state of Nebraska at that time. And naturally, being a surgeon, I am inherently a skeptical person, as well as one that questions everything. So having been immersed in a hospital situation and that being really all I had ever seen, I didn't even know that that was even a possibility. So of course I said, you're crazy, and she said, well, why don't we just go talk with the midwife and see what she has to say. So I went there with guns blazing, ready to just shoot her down and say there's no way we're going to do this, we're going to have this in the hospital. And at our first visit, she said something which has stuck with me all along, and she said that pregnancy is not a disease so it doesn't need to be in the hospital. And that inherently made a lot of sense to me in most circumstances. Obviously, a high-risk mother, a high-risk baby, of course they have to be in the hospital. I deal with that every single day. I deal with babies that are on...you know, the tiniest of babies and of course they have to be in the hospital. But for a healthy mother, healthy baby, uncomplicated pregnancy, it is truly not a disease; it does not belong in a hospital. So that made a lot of sense to me. So since then, I have five children. We've had five wonderful, wonderful separate midwives at each one of those births, and they've all been born at home. They're all healthy. They're all wonderful. And it just...the bond and the relationship and the fact that I was able to participate in the deliveries of all my babies was very, very special. The relationships that the midwives develop with the families is unique outside of medicine. It is truly a very tight-knit relationship. They see their patients, I believe, more frequently. They have lower volumes of patients so they're able to spend more time and really get to know the individual circumstances and make sure that the delivery is as safe as possible. I have a couple of notes, I wanted to make sure I wasn't forgetting anything. So that's basically my story. So I've had all five of my children at home with an attendant midwife. And obviously, I have a lot of training myself. I could have potentially done it myself. But the value of their knowledge and their expertise and their training way, way far exceeded anything that I could have accomplished at this point. So having them as a tool and those resources--invaluable. Obviously, whenever we approach anything in medicine,

we approach it as a risk-benefit ratio; so when you look at healthy mothers, healthy babies, and the home environment, your risks are unbelievably low and there's no reason to introduce excessive risk by bringing them into a hospital situation. I think there's a potential for bad outcomes, and I've seen bad outcomes both in the hospital and heard about things at home. Obviously, mine was not that way. But I don't think we should punish these midwives from keeping them from an environment where it is safe. And again, I just want to highlight that pregnancy in most cases is not a disease. I think it's happening. I've partaken in it. The best way to keep track of it and make sure that it is maintaining its safety profile is to make sure that we can legalize it and regulate it. Thank you. [LB428]

SENATOR CAMPBELL: Senator Krist. [LB428]

SENATOR KRIST: You...all your children were born in Nebraska? [LB428]

SHAHAB ABDESSALAM: No, that's not...three have been born in Nebraska; two were in Ohio. [LB428]

SENATOR KRIST: Okay. And... [LB428]

SHAHAB ABDESSALAM: I was in different areas of training. [LB428]

SENATOR KRIST: And I'm not trying to pin you down or incarcerate you, but (laugh) as I understood, in Nebraska we couldn't have a midwife attending at home. So is it because you were there as a physician that they were, or was it somebody from outside the state or...? [LB428]

SHAHAB ABDESSALAM: No, even as a physician, I am not allowed to attend a home birth, so. [LB428]

SENATOR KRIST: Home births? [LB428]

SHAHAB ABDESSALAM: Back in the '90s, when my first child, it was my understanding it was still legal back then. Obviously, in Ohio it is legal and a great experience there. My last two, which were here in Nebraska; yes, they were attended, but it had to be kind of hush hush. [LB428]

SENATOR KRIST: Got it. Yeah. Got it. So given that experience... [LB428]

SHAHAB ABDESSALAM: And obviously I wouldn't disclose any names. [LB428]

SENATOR KRIST: Oh, absolutely not. No, that's not about this. What I'm trying to do, though, is you're probably one of the most qualified people to have attended a home

birth with a midwife that we maybe will see today so...maybe we'll see today. But point being, if you could design it, would you say that they would always have to be in conjunction with a care plan that would include a pediatrician or an OB or that they would work in concert with that? [LB428]

SHAHAB ABDESSALAM: I, yes, absolutely. I think that's a valuable relationship that the midwives develop with a backup physician of some sort, whether it's a family practitioner who also does deliveries, whether it's just a straight obstetrician or even a pediatrician potentially. [LB428]

SENATOR KRIST: And we did... [LB428]

SHAHAB ABDESSALAM: Yeah, that's a valuable adjunct. [LB428]

SENATOR KRIST: So we did a lot of work last year and a lot of prep with LB599, which I think is monumental, and in that I learned so much about how just a small vitamin or folic acid or whatever it would be during the pregnancy. Does that kind of treatment happen also with midwifery? [LB428]

SHAHAB ABDESSALAM: Absolutely. The thoroughness of which they cover the entire health of the mother; obviously in conjunction with the baby; but mostly looking after the mother, far exceeded anything that I had seen in the hospital during my training. Obviously, I went through ob-gyn and would, you know, deliver babies in the hospital. [LB428]

SENATOR KRIST: Right. [LB428]

SHAHAB ABDESSALAM: I saw those relationships and compared it to my own, and topnotch. I mean just really, really enough. Had five different midwives, just because of the environments that we were in and the spacing out of the children, but every one of them exactly the same. I mean it just was really incredible to see the similarities amongst them. [LB428]

SENATOR KRIST: Last question, and if you don't want to answer it, that's fine. But we have the LB407 process that Senator Gloor talked about earlier. I don't know if you...are you familiar with...? [LB428]

SHAHAB ABDESSALAM: I'm sorry, I arrived late. I was... [LB428]

SENATOR KRIST: Okay. Are you familiar with the LB407 process? [LB428]

SHAHAB ABDESSALAM: I am not. What is that? [LB428]

SENATOR KRIST: Okay, essentially, just to make it short, it is a process whereby if you wanted to increase the scope of someone's practice in any way, and it wasn't currently part of the scope of practice, you would meet this board and discuss whether...and it's really, I think after Senator Gloor's tweaks last year and this committee sending things forward, it's a much better process. Do we need to do a LB407 scope of practice in order to get there, or do you feel like the certification of the midwives that you've come in contact with or that are out here are capable of moving forward without that LB407 process? [LB428]

SHAHAB ABDESSALAM: The ones I have come into contact with, and even beyond my five; I've obviously met quite a few other ones, I don't know that that extension is necessary. [LB428]

SENATOR KRIST: Okay. Thank you, Doctor. [LB428]

SHAHAB ABDESSALAM: Thank you. [LB428]

SENATOR CAMPBELL: Any other questions? Our next proponent. Thank you, Doctor. [LB428]

HEATHER SWANSON: (Exhibits 11 and 12) Hello, my name is Heather Swanson, H-e-a-t-h-e-r S-w-a-n-s-o-n. The first part of my testimony will be on behalf of the Nebraska affiliate of American College of Nurse-Midwives, and the second half will be on my own behalf. I'm submitting a letter from one of our ACNM members, Heather Ramsey, who is unable to make it today. She's the owner of the birth center in Bellevue. And also her consulting physician, Dr. Finley, submitted a letter. He was unable to come as well. So those letters are from them. The American College of Nurse-Midwives, I believe you guys have received a letter from our national office in support of this bill. Our state affiliate is also in support of it. This is something that is a standard of care across the U.S. for nurse-midwives to be a part of. Now a majority of nurse-midwives elect to practice in the traditional settings of clinics and attend births in the hospital. A small percentage of births in the U.S. are out of hospital, about 5 percent. About 1 percent of midwives attend home births. Internationally, though, a large majority of the care in developed countries that pay less per capita for maternal healthcare and where in those countries there's a lower maternal and infant mortality rate, most of the care is being provided by midwives. And the U.S. model of midwifery care for certified nurse-midwives is modeled after the English model where CNMs are trained in nursing and midwifery. Of course, there's a different type of midwives and this bill is not about the direct entry midwife, so we don't want to confuse the two, although I know that can be very confusing at times for senators and also for consumers. And so it is...the ACNM feels it's quite an injustice to have this restriction in statute. And for those that were a part of license in this bill, in the '90s the expectation was that this would easily be removed...or in the '80s, that this would have been overturned because there's

not...there's stronger evidence to support having somebody licensed and regulated at a home birth than not. And when you take a group of women with the same demographics and same risk factors and give them to...have them deliver in the hospital and have them deliver at home, and the studies that have controlled for those demographics, the outcomes are consistently as good, if not better, because of the reduction in other interventions that are easy for a woman to say yes to, like epidurals, that we know do have some complications with them. So we're surprised this hasn't changed. We're hopeful it will and that this restriction will be removed. There are still obstacles regarding the written practice agreements. It is wonderful for nurse-midwives to practice collaboratively with physicians. From a national level, the American College of Nurse-Midwives has been working with ACOG, the American Congress of OBs and Gynecologists, to build better practice relationships. I sat on the ACNM board of directors for a term as a regional representative. My term ended last year. We spent a lot of work with them on how do we learn...or how do we work better together so we can ensure safe outcomes. And the ACNM is not supportive of written practice agreements. We know that's been restrictive in states and has prohibited nurse-midwives licensure and practice in locations. From a professional standpoint, if I'm going to provide optimal care, then I need to do the work to build a collegial relationship with the physician to earn their respect, and when there's an out-of-hospital birth that I'm attending, to have a written plan, to be certain that the clients know the risks associated with wherever they deliver, whether it be hospital, birth center, or home. And the standard of care for...or standard of practice for out-of-hospital birth is to have people sign consent forms, to be certain that they know the risks associated, just like when you go into the hospital to have a baby. Even though you show up in labor, we make people sign a consent form about having a baby. And to have an established plan if something goes wrong: what do we do, who do we call, how do we get there. ACNM is the professional organization for CNMs. We have guidelines for practice and for home birth to guide the rules and regs process in states, and to guide the practice for nurse-midwives that are choosing to deliver out of hospital. From a LB407 standpoint...or I'll end my testimony on behalf of Nebraska ACNM at that point. On my own behalf, I was a part of the LB407 review that was done in 2006. Of course, there was a LB407 review done in 2000, excuse me, '93 and '94, at the direction of this committee. The findings from that were that nurse-midwives should be able to attend home births and nothing was changed. Then when bills came up after that, I remember Senator Erdman that would sit over there and say, was there not already a LB407 review on this; why do we need to do one again? But Senator Johnson insisted on it before a bill came forward again, so another LB407 was done. And if Wesely is...if Don Wesely is still in the audience, I do want to...I think it's a great process to review things, but there were limitations with that; and I felt that there was a lot of bias in that process. I'm thankful for the changes. I think it has improved a bit. I don't think this needs to go back to LB407. The technical review committee found that nurse-midwives should be able to attend home births. When it went through the further steps, the final decision by the state medical officer was to not allow CNMs to attend home births. So I feel like this process has already cost the state

twice. At this point it hasn't been the best academic review that it could have been. I think it would be hasty to go through that process again because it was a lot of work, time-consuming, and money invested in it. And we know that in other states home birth is being done appropriately by people that are held to standards of practice. There's a couple things that came up, the questions that you guys had, if I can speak to them as a nurse-midwife who attends out-of-hospital births. [LB428]

SENATOR CAMPBELL: Yeah, but let's stop at that point just to make sure. [LB428]

HEATHER SWANSON: Okay. [LB428]

SENATOR CAMPBELL: Let's take the current questions and then... [LB428]

HEATHER SWANSON: Okay. [LB428]

SENATOR CAMPBELL: ...we can come back to that, if that's okay. [LB428]

HEATHER SWANSON: Okay. [LB428]

SENATOR CAMPBELL: Senator Krist, you had a question. [LB428]

SENATOR KRIST: You were going to answer the...go ahead. Finish what...go... [LB428]

SENATOR CAMPBELL: Were you going to answer his question? [LB428]

HEATHER SWANSON: Well, I do attend birth centers and home births in the state of Texas. [LB428]

SENATOR CAMPBELL: Oh, okay. [LB428]

HEATHER SWANSON: I work for a College of Nursing division in Kearney, but my clinical practice, because I'm not able to practice here how I'd like, so I practice out of state. [LB428]

SENATOR KRIST: Okay, that's my first question. [LB428]

HEATHER SWANSON: Okay. [LB428]

SENATOR KRIST: My second question was in the LB407 process, you felt that the LB407 took you to a point which would have allowed for home births by midwives,... [LB428]

HEATHER SWANSON: Uh-huh. [LB428]

SENATOR KRIST: ...but that it was a decision of the current...that current chief medical officer made the final decision that that was not. [LB428]

HEATHER SWANSON: And also the steps are technical review committee, Board of Health, there's a subcommittee, then the full Board of Health, and then the state medical officer. So those that were present there and this (inaudible) that were present there, there were very...people would vote and then get the support for it, and it wasn't based on evidence that was presented to them or the research presented. So there were some biases involved there. Daryl Wills chaired the technical review committee and was on the Board of Health, and I believe he submitted a letter to you guys about his feelings about that. [LB428]

SENATOR KRIST: And that is precisely what's different about this LB407 process that was not in place. Then my last question is this. You talk about...actually, the doctor talked about low risk... [LB428]

HEATHER SWANSON: Uh-huh. [LB428]

SENATOR KRIST: ...and being able to have it at home. Do you establish a patient transfer agreement with a hospital or the local hospital or local clinic, or how...if you...you've been there, done that, worn this T-shirt. So tell me, how would you design it? What will we require to have in place? [LB428]

HEATHER SWANSON: Well, this is an interesting topic. Right now in Texas, the Texas Medical Association is trying to implement a requirement to have a written practice agreement with...transfer agreement with a hospital to be willing to accept transfers in order for a birth center or home-birth midwife to be licensed. This is a huge obstacle in other states that have implemented this and it's put businesses out of...nurse-midwifery practice out of business. In my practice, we have a consulting physician, so if we have a need for a transfer...well, we do risk assessments throughout their care: before we take them on to care, throughout their care. Definitely at 36 weeks, when they're appropriate then to deliver out of hospital, we reassess. We reassess when they're admitted to care and then throughout their labor we're providing assessments. And if at any point there's a need for transfer, we do. Thankfully, most of the transfers are low risk. They're ones that could go in their own vehicle. There's not a high cost associated to that. If there are major ones, then we would take an ambulance. But what we end up doing is we consult with the physician and say here's why I think we need to transfer somebody. They never turn down...when I call, I've never had my consulting physician turn down a transfer, because he knows if I call him, it's now not appropriate to stay out of hospital. And a hospital can't turn somebody away. So even if he didn't accept, I could take her to any closest hospital and they would have to treat her. [LB428]

SENATOR KRIST: Which is the last question. [LB428]

HEATHER SWANSON: Yeah. [LB428]

SENATOR KRIST: The obstacle in Texas now being provided, is it on the hospital end, making it more difficult for a transfer agreement to be put in place, or...? [LB428]

HEATHER SWANSON: I think it would be the pressures from the Medical Association. But hopefully this bill doesn't pass. It just got introduced last week. [LB428]

SENATOR KRIST: This one? [LB428]

HEATHER SWANSON: No, no, no. [LB428]

SENATOR KRIST: Oh. (Laughter) [LB428]

HEATHER SWANSON: This bill I'm talking about... [LB428]

SENATOR KRIST: Just to be clear. (Laughter) [LB428]

HEATHER SWANSON: ...that would require the transfer agreements with hospitals. [LB428]

SENATOR KRIST: Okay, I'm just kidding. Good. Thank you. [LB428]

HEATHER SWANSON: Yeah, so, no, this bill. So I work at a birth center that has over 6,000, nearly 7,000 births and incredible outcomes. And birth center births, we now allow...we have birth center births here. Outcomes are incredible. There was an article that came out this past month about the outcomes of birth centers, and people don't realize often that we take the same thing to a home that we have in a birth center. There's no difference in what we have for medications or supplies. OBs, ACOG is supportive of birth center births attended by nurse-midwives. They're still not supportive of home birth. There's a lot of kind of work yet to be done there, but it looks no different. Sometimes we're actually closer to a hospital than we were at the birth center, and then people don't have to drive in labor. So from a supply standpoint and standards of practice, it's consistent. They're the same. [LB428]

SENATOR KRIST: Thank you. [LB428]

HEATHER SWANSON: Uh-huh. [LB428]

SENATOR CAMPBELL: Senator Crawford. [LB428]

SENATOR CRAWFORD: Thank you, Senator Campbell. Now we discussed the packet of outside testimony when we first sat here, so I haven't had... [LB428]

HEATHER SWANSON: Uh-huh. [LB428]

SENATOR CRAWFORD: ...a chance to read it thoroughly. But it looks like to me that the 2006 review, in that review they were also wanting to remove the requirement for a practice agreement with a physician. And it's my understanding that in this bill, what you're asking for is...you're not asking for the independent practice. You're asking to provide birth at home, and there would still be a collaborating licensed physician in the mix. [LB428]

HEATHER SWANSON: Correct. [LB428]

SENATOR CRAWFORD: Is that correct? [LB428]

HEATHER SWANSON: Those...there are two big topics and it really warrants more than one committee hearing. The removal of the written practice agreements is something that the Nebraska Action Coalition is working on. There's a LB407 review right now for NPs to look at that. I don't think, if this line is struck, there's not going to be a huge influx of people providing home births. There's going to be midwives willing to do it, nurse-midwives willing to do it, but we're going to have to find a consulting physician to sign our practice agreement so we can be licensed so we can do it. So there's still a huge obstacle. This is just the early steps in getting to that point where it's no longer prohibited; something is allowed. So if we can build those relationships, there is potential for nurse-midwives to be able to attend them. So it doesn't solve the problem right now of we're having people attend births at home that are not being screened appropriately; that are being cared for by people that, when they're transferred to the hospital, they're not going to submit their documentation and their paperwork. So there's going to be a real huge gap in continuity of care. So there's room for improvement yet, but this isn't removing the written practice agreement. We'll get there. The recommendations from the National Council of State Boards of Nursing and National Institutes of Health is by 2015 to remove written practice agreements for all advanced practice nurses. I think it's going to be a little bit later in Nebraska for that. I'm hopeful, though, it will happen by then. But this is, of course, just striking the home birth restriction. [LB428]

SENATOR CRAWFORD: Could you talk a little bit about the assessment of the home or...that you would do with someone that you're working with as you're developing your plan for the birth. [LB428]

HEATHER SWANSON: Uh-huh. So generally, a nurse-midwife or any midwife that's going to be attending a home birth, usually they'll have at least, if not more, at least one

visit at the home to assess not only can we get to it easily, can we find it? If we're going to a hospital, where's the route for that? If we have to call EMS, where do they come from; how long does it take for them to get there? So those are some initial things. Then the other issues which most people wouldn't think are a big deal but if you're attending home births on a reservation, or I'm in an area that has colonias, which are lot like reservations: Is the home clean enough? Is there running water? Is there heat? What are...can we do the things that we do at a birth safely and appropriately? And sometimes there are living conditions where it's not appropriate. The birth center I'm at, the nurse-midwife...there were Catholic sisters that founded it. They started to attend home births, then built the birth center because some of the living conditions weren't appropriate for home birth, and then now they've since resumed them, but it's a selective process. So just like risk assessment, some women are not appropriate to stay out of hospital. Likewise, sometimes the living conditions of their home environment is inappropriate for it, so. [LB428]

SENATOR CRAWFORD: Could you talk a little bit about the prenatal and postnatal care that you provide as a certified nurse-midwife? [LB428]

HEATHER SWANSON: So nurse-midwifery care, when it comes down to labs that are done and follow-up, it's going to be...there are standards of care established in the U.S. by the CDC. And a lot of the standards have been established by ACOG actually, the American College...Congress of OBs and Gynecologists. So the labs are done at the same time, the same appointment schedule is usually adhered to, follow-up is adhered to as well postpartumly. The hallmark with midwifery care in the U.S. and across the world tends to be that there's more time allowed for education, to get to know people, to do those early screenings. And unfortunately in the U.S., our model of care doesn't allow physicians the luxury of having a lot of time, so a lot of the work is done by the nurses regarding some of the education and time taken. We are seeing improved outcomes with education when time is taken. So the prenatal schedule--exactly the same in clinic except that visits are longer. New OBs, return OBs are an hour...or, excuse me, postpartum visits are an hour; return visits usually a half hour. They typically run longer so we always have extra nurse-midwives available to see people where I'm at. And then postpartumly for home birth and for a birth center birth, it's traditional to do early home visits, so usually two or three days, sometimes one day, depending on what was going on, at their delivery and immediate postpartum. And then generally a two-week postpartum visit at home or a ten-day. And then generally, a baby is seen by whoever the pediatric provider is at two weeks. Depending on the state, some insurance companies require by a month. So if they're perfectly healthy and fine, then the nurse-midwife will follow them up to the first 28 days. It's in our training and education. So usually we'll follow them up to a month. Medicaid/CHIP requires that most kids in most states are seen before that month is up to keep them on their plan. And the nurse-midwives do provide the traditional follow-up six- to eight-week postpartum visit. [LB428]

SENATOR CRAWFORD: So could you tell me a little bit about some people who have testified talked about their midwife encouraged them to have a relationship with a physician so there was some continuity of care. Could you talk about your experience with patients and with a partner on that front? [LB428]

HEATHER SWANSON: Depends on...how it's working right now, my understanding is, is that because the midwives aren't licensed and they aren't regulated, they aren't able to build that relationship with a provider themselves. [LB428]

SENATOR CRAWFORD: Sure. [LB428]

HEATHER SWANSON: So it's up to the family to build that relationship. And most providers aren't going to turn them away. If they show up at the door, they aren't going to turn them away. And if they do need lab work done and if their decision is...if the patient is not going to have things done versus that provider being willing to do some of it, then most providers are going to be willing to do some of those, the lab work and if they need to be transferred. Typically what happens though is the midwife in most states--like South Dakota as an example... [LB428]

SENATOR CRAWFORD: Yeah. [LB428]

HEATHER SWANSON: ...for the home birth, it's allowed up there--the midwife has to have a plan for transfer. So depending on where she's at, that sometimes will dictate who she consults for delivery-related things. And then it might be a different provider that she would consult for, like, during birth or during, excuse me, pregnancy. That may be somebody that she works with a lot that's going to do follow-up ultrasounds if needed, a higher level ultrasound, or consulting at that time. So there usually is a relationship that's established. Now it isn't always in writing. When things get in writing, that does increase the risk of vicarious liability, and I can see why a physician would be hesitant to get in that. Vicarious liability to a great degree is considered a myth. It doesn't happen that often that physicians are held liable for what a provider did before them. They're held responsible for the care that they're providing at the time when they took over care, accepted care, not for what led up to it. So written practice agreements, there's a lot of thought that it's going to ensure patient safety. It tends to be more of an obstacle to care and for people getting access to care versus ensuring it. But a wise nurse-midwife is going to build the relationship so that when they're in a bind, when something comes up and before it gets to be a big complication, that they're able to consult and transfer appropriately. Otherwise, I don't want to take care of them, because my profession relies on me providing optimal care, and the safety of that mom and baby rely on me providing optimal care. So when people are licensed and regulated, they can have those conversations, transfer appropriately, consult without fear that they're going to be totally, you know, out of business after that, so. [LB428]

SENATOR CRAWFORD: Thank you. [LB428]

HEATHER SWANSON: Yeah. [LB428]

SENATOR CAMPBELL: Any other questions? When you go for a home birth, and you've had a lot of experience I know in states, and that's...I mean I was looking for somebody who had actually done them. I knew you did. [LB428]

HEATHER SWANSON: Yeah. [LB428]

SENATOR CAMPBELL: What equipment do you take with you at a home birth? What equipment should be there? [LB428]

HEATHER SWANSON: We definitely want something to resuscitate a baby, if need be, so an Ambu bag. We take items to do a UVC line so to place essentially an IV line in the umbilical cord; medications we would need to do full resuscitating. There are standards for neonatal resuscitation established by the American Academy of Pediatrics, so all the nurse-midwives and nurses that...all the nurses that we take along with us are also required to be certified in that so if we need to do an initial resuscitation. Thankfully, it doesn't happen that often in populations that have been risked out, because we're getting the cream of the crop, healthy of the healthy that are staying at home. And those things haven't even...in a lot of states haven't been even designated in rules and regs. They certainly...the feeling is they shouldn't be in statute because those are things that are hard, if general practice standards change and research changes, you don't want those in statutes because it's really tough to change those. Rules and regs is a better place, or for professional accountability to be held accountable for that. We take medications in case there's a postpartum hemorrhage, which is one of the huge reasons why maternal healthcare has improved in the last, you know, many years, is because we can treat postpartum hemorrhages through medications now. We take IV supplies. We take an oxygen tank, that we've learned that we gave babies too much oxygen for years and we don't need to use as much as what we used to, so we're learning things in even newborn care. So we take everything we'd have at the birth center, short of...what we don't have is we don't have an OR, we don't have a physician that can do a C-section right then. So that's what we don't have, but everything else is the same as what we have in a birth center, so. [LB428]

SENATOR CAMPBELL: So you've got the baby on a fetal monitor. [LB428]

HEATHER SWANSON: Well, continuous fetal monitoring actually is not found to be appropriate for...it doesn't improve outcomes for low- to moderate-risk women. The thought was that we would reduce the rate of cerebral palsy if...when we started doing continuous fetal monitoring in the U.S., and it was found in ACOG as a statement to this

effect that it actually did not reduce CP rates, actually increased rates of C-sections, vacuum deliveries, and forceps. So what we do for women that are low to moderate risk, we do intermittent fetal monitoring. So we listen to the heart tones intermittently with a handheld Doppler versus a continuous fetal monitor, so. [LB428]

SENATOR CAMPBELL: That answers. [LB428]

HEATHER SWANSON: Yeah. [LB428]

SENATOR CAMPBELL: Thank you very much. [LB428]

HEATHER SWANSON: You're welcome. [LB428]

SENATOR CAMPBELL: Any other questions? Thank you very much. [LB428]

HEATHER SWANSON: Yes. There...I know there were some other questions that came up. I'll submit some documentation afterwards. And I have a great little video about the history. If you guys haven't seen it, I'll be certain to get that in an e-mail as well. So thank you. [LB428]

SENATOR CAMPBELL: Thank you. Our next proponent. How many others wish to testify in favor? Okay. I wanted to make sure I'd gotten them all. Thank you. [LB428]

NICCI WALLA: My name is Nicci Walla, N-i-c-c-i W-a-l-l-a. I'm here today speaking to you as a consumer and a participant of home birth. I have had three home births: my first birth in 2006, a birth in 2008, and a birth in 2010. My first four children were born in a hospital setting, all natural, with quite a bit of fighting and struggles to get what I would like, you know, out of my birth experience. So I decided to become a childbirth educator to help assist others in taking on that fight to get natural birth in a hospital setting. I was a Bradley Method natural childbirth educator for ten years. I'm also a certified professional doula. I have been attending births since 2004 as a professional doula. I have attended 109 births: 57 home births, 52 hospital births, not all 57 of my births in the state of Nebraska for home. My concern and the reason I am here today is because I only attend home births as a doula alongside a certified professional midwife. Our certified professional midwife that was willing to come to this area has been incarcerated, is no longer practicing in the state of Nebraska. I attended births alongside a professional and only would suggest and choose that for myself as well, and had midwives at all three of my births, although my second birth in 2010, she was about 20 minutes away so my husband had to help out a little bit with that one. We have lost our certified professional midwife, and we have no one to work alongside as doulas. Doulas are nonmedical providers. I provide comfort, support for children and other family members that are at a birth, and we also do...I do birth pool setup and take down and cleanup. And I work with mostly, mostly comfort and reassuring and educating. And I

am no longer able to do that. My husband and I are not comfortable with me attending births at home any longer without someone there. In November of 2011, I had my first hospital transfer with a client. The certified professional midwife did not go along to the hospital for fear of prosecution for having been at the birth. Within two weeks of transferring my client to the hospital...which, by the way, was still a wonderful and amazing and beautiful outcome once we arrived at the hospital. It was an unforeseen complication. Once the water broke, with the presence of some heavy meconium, we had to transfer in. We transferred in, in less than ten minutes. I received a written complaint to my certifying doula body that, by helping mothers and babies at home, I was harming the health of babies and mothers, signed by several physicians who were at the hospital the day that we transferred my client in. I then moved out to Wahoo, Nebraska, and stopped attending births for quite some time because I just could not believe that I was being accused of harming mothers and babies by simply going to a home where a woman was in labor, providing back support and education for her family and reassurance to her during labor. Just because I was there, I was seen as some sort of threat. My husband and I are moving out of the state of Nebraska because of this issue. When our lease is up in July, we will no longer live in the state of Nebraska because I am trying to get pregnant as we speak. And I have two moms who are having unassisted births right now. The support that I am providing for my client is I will go to their home in early labor and set up a birth pool, I will leave, and I will stay nearby. About two to three hours after the birth, I will come back and I will clean. And that is what is happening with me and my clients currently. I'm only doing that for previous clients who would have unassisted birth with or without my help. Birth is happening here in Nebraska at home. Unassisted birth is happening probably this weekend. I'm lucky to be here today with...I have a mom in early labor right now. But I can no longer do my job here in the state of Nebraska without a certified midwife to come along and make sure that the birth is safe. Any questions? [LB428]

SENATOR CAMPBELL: Thank you for your testimony. Any questions? Thanks for coming today. [LB428]

NICCI WALLA: Thank you. [LB428]

SENATOR CAMPBELL: Any other proponents? Good afternoon. [LB428]

KIM MOSS-ALLEN: (Exhibit 13) Hi, good afternoon. Senators, thank you so much for hearing us today, giving us this chance to speak. My name is Kim Moss-Allen, K-i-m M-o-s-s-dash-A-l-l-e-n. I want to ask you, because studies demonstrate that home births attended by certified nurse-midwives are a safe option, please advance this LB428. I wanted to just tell you a little bit about my personal situation. And if you have further questions, you know, don't let people like the Certified Nurse-Midwife Swanson leave, because she's got a font of knowledge. There aren't many of us who choose home birth, but those who do, we deserve to be able to hire a certified nurse-midwife. I am married.

I live in Bellevue; I have since 1994. My spouse is named Dudley Allen, and is retired Air Force. My first two kids were born in military hospitals in Bitburg, Germany. I knew that some of my German friends and many mothers in Europe, especially in the Netherlands and England, had their babies at home with a midwife. I didn't consider that. We lived rather far from the hospital in Germany and didn't know as much as I knew now...as I know now. When we moved here, we moved here in '94. When I decided in '98 to seek a midwife and a home birth for my third baby, I was dismayed at Nebraska's bizarre law that kept the one person, the most qualified--a certified nurse-midwife--away from my birth of my son. But there was a happy ending. We sought out a highly qualified midwife, believe she was a certified professional midwife, and had a safe and fabulous birth. My midwife was originally trained in New Mexico, where I'm originally from, and Arkansas, where my husband is originally from. Both states have a strong history of midwifery care and home births, which is why it was such a shock to come to Nebraska and find it kind of being talked about only behind closed doors, and we didn't name names, and we had euphemisms. It's just ridiculous. It was good to hear the doctor speak and hear it from his side of the story, his side, his story as well. This underscored the point to me that women who choose a home birth are kind of bullied by Nebraska law into several options: birthing unassisted--I wouldn't consider that a good option; or using a midwife who is not a certified nurse-midwife or using a physician, and both are impractical here in Nebraska; or, of course, heading to a hospital where her chances for a drug-free or natural birth are near zero and one in three new moms goes home recovering from major abdominal surgery. It's time to listen to the evidence-based practices and allow all women access to certified nurse-midwives. And I hope you will vote LB428, the bill for mothers and midwives, out of committee and on to the floor. Let's see... [LB428]

SENATOR CAMPBELL: Any questions? Thank you for coming today. [LB428]

KIM MOSS-ALLEN: Thank you. [LB428]

SENATOR CAMPBELL: Any other proponents? Is there anyone else besides...? I just want to make sure, because I thought I had them all, but I missed one. Good afternoon. [LB428]

KAYLA BREWER: Hello. My name is Kayla Brewer, K-a-y-l-a B-r-e-w-e-r. I recently graduated from UNL with distinctive honors, and am currently employed at the Nebraska Auditor of Public Accounts Office. I like to consider myself an educated woman and my experiences are very low risk. All three of my pregnancies were very low risk. While attending UNL, I gave birth to two children. And because of the limited options in the state, I gave birth at Bryan here in Lincoln. That in and of itself isn't a problem, except for I wanted to have a noninvasive, very personal experience with the birth of my second and third child as I had with my first in Colorado. Having a noninvasive, natural birth is a minority at Bryan, and my labors didn't follow hospital

policy--(laugh) I don't think they read the manual--and I didn't have contractions consistently the entire time. I didn't dilate a centimeter every hour. And when I confronted the nurse and said I needed to push, she told me it wasn't time. Only after I had to prove myself by having her check during a contraction was she even willing to get the doctor into the room, and he was born five minutes later. The nurses there don't really do anything to support you until you're past the point of no return, seven or eight centimeters, where they consider not doing an epidural. Then a lot of them have become helpful, giving you different tips, providing water, doing...you know, just trying to help you go through the process of birth, which is beautiful. It's great. The bill isn't forcing anybody to have a home birth with a midwife. It's giving educated women the option of having the home birth with somebody who can take care of them. I myself, personally, didn't want to have a home birth without a professional, and I wasn't willing to take a risk. The birth of a child is the most beautiful and memorable experience you'll ever have, and if we work hard enough during labor we shouldn't have to fight nurses or doctors to have a birth that many women have gone into a forest and done on their own without anybody around. I just...I really hope that you wholeheartedly consider passing and moving this bill forward. And God bless. [LB428]

SENATOR CAMPBELL: Any questions? And you're...? [LB428]

KAYLA BREWER: This is Landon (phonetic). [LB428]

SENATOR CAMPBELL: Landon. And how old is Landon? [LB428]

KAYLA BREWER: He just turned four. [LB428]

SENATOR CAMPBELL: Well, he's being very patient. [LB428]

KAYLA BREWER: He slept until about a minute ago, so. [LB428]

SENATOR CAMPBELL: I can understand that. There's probably times when we all get impatient, too, so thanks for bringing Landon and telling us your story. [LB428]

KAYLA BREWER: Thank you. [LB428]

SENATOR CAMPBELL: Anyone else? Okay. [LB428]

KAMELLE EBERS: (Exhibit 17) Hello, Senators. My name is Kamelle K. Ebers, that's K-a-m-e-l-l-e, K. Ebers, E-b-e-r-s. This is kind of a last-minute thing I'm doing. One of the things that I don't think has been addressed here is the cost, the cost to the state of Nebraska possibly for healthcare. Myself, I have had three children, two were planned in the hospital, the third I would have loved to have done at home. My son was born in 2010 and during that time my husband and I, we're home, we work from home, we have

our own business. We don't have insurance. We don't have health insurance. We take care of things as they go. We try to keep ourselves healthy. So we are one of those numbers. We would have loved to have had a certified nurse-midwife home birth for the cost of maybe $2,000 to $3,000. We could have afforded that. Because that wasn't an option, we had to file for help through Medicaid in order to have a safe birth. I'm not exactly sure what that cost is to you guys. I didn't get the bill; you guys got the bill. I could have afforded the $2,000 to $3,000. I wasn't looking to get help from the state. I would have liked to have made more choices on my own. And I just thought that that was something that you guys need to keep into consideration. It's a huge expense for you guys. It's a huge expense for our taxpayers. I'm not too proud. I'm not exactly overjoyed or I usually don't stand up in public and say, hey, I've been on the welfare system, but it was something that pushed me in that direction because that was really my only option for a safe and healthy birth, so. [LB428]

SENATOR CAMPBELL: Any questions for Ms. Ebers? Thank you very much. [LB428]

KAMELLE EBERS: Yes. [LB428]

SENATOR CAMPBELL: Any other proponents? Okay. Those who wish to testify in opposition to the bill? Those who wish...oh. Good afternoon. [LB428]

SARAH CADA: Hello. My name is... [LB428]

SENATOR CAMPBELL: You go right ahead. [LB428]

SARAH CADA: (Exhibit 14) My name is Sarah Cada, S-a-r-a-h C-a-d-a. I am an obstetrician that practices in Lincoln, and I went to medical school and then I did four years of training in ob-gyn. What led me to the field is my first delivery that I did when I was a med student, and it was a beautiful experience; and I was hooked. I have an article that I've distributed from the American Journal of ob-gyn going over some of the actual numbers related to the safety of planned home birth versus hospital birth. It compares numbers in the U.S. to numbers in European countries, such as England and the Netherlands that people have talked about today. The rate of planned home birth in the U.S. is around .75 percent. And in England, for example, it's twice that; it's 1.5 percent. In the Netherlands, it's closer to 20 percent. When we look at similar populations of women that have a planned home birth versus a hospital birth, so that would be low-risk women, first-time moms, the rate of transport during labor for unexpected complications in labor in England ranges from 56 to 75 percent transport rate to a hospital during labor. And so those are women that are felt to be low risk that have some kind of complication come up during the labor that the person attending their labor decides they need to be transported to the hospital. Of that group of women, so 59 to 75 percent of first-time moms that are low risk that are transported, there is a risk of up to 54 percent of having some kind of severe neonatal injury, such as neonatal

encephalopathy, which is one of the things associated with cerebral palsy. Eight percent of those women have babies that end up having brachial plexus injury, which is damage to the nerves in the arm; and there's a 13 percent neonatal death rate in that population. So this, again, is women that are felt to be low risk, that could deliver at home, that have up to a 75 percent chance of getting transported to a hospital because of complications that were not foreseen before they went into labor, that end up having up to 54 percent neurologic damage in their infants. In the U.S., the American College of ob-gyn says that the neonatal death rate for planned home birth versus hospital birth is two to three times what you experience with hospital birth. In the Netherlands, where the planned home birth rate is about 20 percent, of that group, 49 percent of first-time moms who are felt to be low risk and that could deliver at home, 49 percent of those women end up getting transferred to the hospital during labor. And one of our proponents of the bill talked about the long-term mental anguish that women experience after hospital birth. In that group of women, so 49 percent, first-time moms that get transported to the hospital during labor, three years later, in one of the studies in the Netherlands, 17 percent of those women cited severe psychologic damage from the transport process and the unforeseen complications they had with their pregnancy and with the delivery of their baby. So those are women who had wanted to deliver at home, had complications, got transported to the hospital and then had psychologic trauma after that. So I think it is possible to, you know, have a midwife deliver in a hospital, where you're in a safe environment, where you don't need to transport in the state of Nebraska. And you know, in England they looked at what are the risks of...or what is the cost of raising a neurologically impaired or handicapped child, and they said $5 million pounds, which, you know, in our country would be, what, $10 million to raise a handicapped child. So that is some cost that the state would experience if we increase the number of home births. I'm open to any questions that you might have. [LB428]

SENATOR CAMPBELL: Questions? Dr. Cada, I have a couple of questions. Have you, in your practice, ever worked with a certified midwife? [LB428]

SARAH CADA: Yes, I have worked with two. [LB428]

SENATOR CAMPBELL: And they are...I'm assuming that you're working with them as they help deliver in the hospital. [LB428]

SARAH CADA: Yes. [LB428]

SENATOR CAMPBELL: Is that correct? [LB428]

SARAH CADA: Yes. [LB428]

SENATOR CAMPBELL: But you have worked with two of them. [LB428]

SARAH CADA: Uh-huh. [LB428]

SENATOR CAMPBELL: Okay. Do you know, I mean you've given us a study in Europe. Are there any studies that have been done in the United States? [LB428]

SARAH CADA: So the article that I gave you is from a group of obstetricians in the United States... [LB428]

SENATOR CAMPBELL: Oh, okay. [LB428]

SARAH CADA: ...and it looks at numbers for the U.S. and then, because of the larger number of deliveries...percentage of deliveries done at home in England, it compares numbers in Europe, so. [LB428]

SENATOR CAMPBELL: Okay. Okay. Do you have an idea why the other 48 states allow this? [LB428]

SARAH CADA: You know, I don't know. We have a Unicameral Legislature, too, so we are... [LB428]

SENATOR CAMPBELL: That's true. [LB428]

SARAH CADA: ...we do have some unique points from other states. [LB428]

SENATOR CAMPBELL: Okay. Are you familiar with any of the other states in terms of what they put in regulations or how they structure that? [LB428]

SARAH CADA: You know, I did some of my training in Iowa, and while I was in training there, they passed a law allowing home births by a certified nurse-midwife. And one of the stipulations of that law was that the women that were candidates had to have a visit with an obstetrician ahead of time to go over the risks and see if they were low risk. [LB428]

SENATOR CAMPBELL: To your knowledge, when you worked with the Iowa law, did they require a certain amount of ultrasounds and doctor visits or any of that... [LB428]

SARAH CADA: No,... [LB428]

SENATOR CAMPBELL: ...in the prenatal period? [LB428]

SARAH CADA: ...not when I was there, uh-uh. [LB428]

SENATOR CAMPBELL: Okay. Any other...? Senator Krist. [LB428]

SENATOR KRIST: In the Iowa program, was it an informed consent kind of visit where you'd go over risk and assessments? [LB428]

SARAH CADA: Yes, uh-huh. [LB428]

SENATOR KRIST: Okay. And then this is way off track and I apologize. If you don't know, that's fine, but first time I've seen this word "nulliparous," n-u-l-l... [LB428]

SARAH CADA: Nulliparous means that you haven't given birth before, so first-time mom. [LB428]

SENATOR KRIST: Oh, there you go. And multiparous obviously you've given... [LB428]

SARAH CADA: Yeah. [LB428]

SENATOR KRIST: Okay. Thank you. [LB428]

SARAH CADA: Yeah. [LB428]

SENATOR CAMPBELL: We learn something every day. [LB428]

SENATOR KRIST: Saved me looking it up. Thank you. [LB428]

SARAH CADA: Yeah, no problem. [LB428]

SENATOR CAMPBELL: Senator Crawford. [LB428]

SENATOR CRAWFORD: Thank you, Senator Campbell. I was curious. I haven't read the article yet, obviously, but it seemed that the comparison in Europe where if home birth is much more common, that I wonder if we would assess that it's also likely that the risk factors are different in a situation where you have a much more common home birth situation versus in the U.S. if it's much more rare. [LB428]

SARAH CADA: Uh-huh. [LB428]

SENATOR CRAWFORD: And that might impact the percent who have to deliver...have to have or transported during delivery. [LB428]

SARAH CADA: In what way? [LB428]

SENATOR CRAWFORD: In that if in Europe it's much more common... [LB428]

SARAH CADA: Uh-huh. [LB428]

SENATOR CRAWFORD: ...that you might have women... [LB428]

SARAH CADA: So the percentage would be... [LB428]

SENATOR CRAWFORD: ...with a higher risk choosing the home birth, as opposed to the United States, if it's much more rare, you would be more likely to have lower risk. [LB428]

SARAH CADA: Oh. They looked at, in the study, in England they looked at women that had...so they took a group of first-time moms that were, you know, healthy, young, no risk factors, no history of high blood pressure, diabetes, that kind of thing. They compared a similar population of women, and out of that group it was a transport rate up to 75 percent. [LB428]

SENATOR CRAWFORD: Okay. [LB428]

SARAH CADA: So, you know, if we...I don't know if we can compare our population to England's population... [LB428]

SENATOR CRAWFORD: Uh-huh, right. [LB428]

SARAH CADA: I don't know what their obesity rates are, for example. [LB428]

SENATOR CRAWFORD: Right. Right. [LB428]

SARAH CADA: You know, one of the concerns about why the C-section rate has risen in our country is because of the obesity rate, because women that are physically out of shape have higher risk pregnancies. The other concern I would have just about the state of Nebraska is our large rural population, and I can tell you that if, for example, one of the risks during labor is that a baby can get stuck when they're coming out. Their head comes out; their shoulders won't come. It's a very scary thing. And if that happens, you have to think how long can that baby go without oxygen? How long can they hold their breath? How long for the emergency transport team to arrive at that house and transport that baby? So, you know, when we think about our rural population, home birth, how long would it take to get somebody who...you know, if the transport rates in England, which is...I would think not have the rural population like we have, the distances to a hospital, if the transport rate is up to, you know, 50 percent that get transported, how would that go in our rural population? I mean how would that happen? I mean it's... [LB428]

SENATOR CRAWFORD: Thank you. [LB428]

SENATOR CAMPBELL: Any other questions? Dr. Cada, I have one, I think, last question. As you are working with moms and moms to be, is there just a routine list of things that you do to determine risk? Or do you...you know, it's almost as if a risk has to be presented before you do something. And I'm going to give you an example: gestational diabetes, for instance. [LB428]

SARAH CADA: Uh-huh. [LB428]

SENATOR CAMPBELL: We heard a lot last year in terms of moms not getting any prenatal care, not even knowing. [LB428]

SARAH CADA: Right. [LB428]

SENATOR CAMPBELL: So could you kind of explain how you...because you're saying, well, very healthy, young, no risk. [LB428]

SARAH CADA: Uh-huh. [LB428]

SENATOR CAMPBELL: But you must be testing or determining those risks at some point. [LB428]

SARAH CADA: Yeah. So we have a list of things we test for throughout the pregnancy, to not only screening by asking questions--what's your history, what's your family history--but blood tests and urine tests and other kinds of testing that we do throughout the pregnancy--that's what prenatal care is--to pick up complications like diabetes and that. [LB428]

SENATOR CAMPBELL: And I'm making the assumption that in a lot of states in which they form a partnership with a physician, those tests are going on. I was just curious how, you know, you make that determination... [LB428]

SARAH CADA: Uh-huh. [LB428]

SENATOR CAMPBELL: ...about who's at risk; at what point do you make that determination. [LB428]

SARAH CADA: Right. Well, I think in this article, what the point is raised is that you can have a group of women that are considered low risk that are felt to be safe to deliver at home, and the transport rate, for example, in England, in that population, you know, was close to 50 percent. So low risk going into the actual labor process, so that means their pregnancy was low risk, they didn't have diabetes, they didn't have high blood pressure, they didn't have any foreseeable reason why they felt that they had to deliver in a

hospital, and yet 50 percent of those women were transported to the hospital because of complications that arose that were not foreseen during the actual labor process. [LB428]

SENATOR CAMPBELL: Got it. Okay, any other questions? Thank you, Dr. Cada. [LB428]

SARAH CADA: Yeah. [LB428]

SENATOR CAMPBELL: Our next opponent. Anyone else? Anyone who wants to provide neutral testimony? All right. And the senator has waived closing. And so with that, concludes the hearing this afternoon on LB428. (See also Exhibits 15-16; 18-33) If you are leaving, please leave as quietly as you can and take all conversations. We know our next senator is here. So, Senator Howard, go ahead and set up and we'll let everybody leave who needs to leave. All right, you take your time because I'm not all...got all my papers sorted here yet either. Okay, I think we're just about set to go. We will open the public hearing on LB361, Senator Howard's bill to name the Child and Maternal Death Review Act and change review procedures. Senator Howard, go right ahead. [LB428]

SENATOR HOWARD: Thank you. Good afternoon, Senator Campbell and members of the committee. For the record, I am Senator Sara Howard, H-o-w-a-r-d, S-a-r-a, and I represent District 9. Today I'm introducing LB361 on behalf of the Nebraska Medical Association. LB361 seeks to ensure that maternal deaths are counted and the causes for such deaths are examined. The bill amends the current sections of Chapter 71 governing child death reviews by expanding reviews to include maternal deaths during pregnancy and postpartum, and adds additional members to the death review team. And just for a little bit of history, the Child Death Review Team was actually created in 1993, which was a year when there were 300 child deaths in the state of Nebraska. And so this Legislature decided that they wanted to learn more about the causes of those deaths and created the Child Death Review Team. In instances where a mother has also died along with the child or even independent of giving birth, it's critical that professionals are able to look at the mother's records and understand what's happened. To that end, LB361 pursues a need for a comprehensive, integrated review system to include a statewide retrospective review of existing records relating to maternal deaths, where HHS can review trends and recommend changes. The bill defines these records to include...and they mirror those in the child death review. These records include, but may not be limited to: medical records, coroner and autopsy records, social services, educational, emergency and paramedic records, and law enforcement reports. Postpartum is defined as the period of time beginning when a woman ceases to be pregnant and ending one year after a woman ceases to be pregnant, which seems like a long time, but this is actually the CDC-recommended time period for maternal mortality review. I think it gives you a broader view of some of the issues that surround

maternal mortality and include postpartum issues that may arise, specifically postpartum depression. LB361 also expands the death review team from 8 to 12 members, and assigns the Department of Health and Human Services general administration over the team, with administrative support provided by a team coordinator. This coordinator would be employed or contracted by HHS and may be a local public health department. LB361 simply allows the state to stop important data from slipping through the cracks. This bill is critical to comprehensive mortality review. I did bring a copy of...they, in October of 2011, that's the most recent "Nebraska Child Death Review Report," and in that there were 176 deaths that were pregnancy related, where they could only view the records of the child and not get a fuller understanding of what happened if there was a maternal death as well. And those go back...they look at 2007, 2008, so there's a data lag for the team, but that's not anything that this bill would be able to fix. I'm hoping that this would be perfect for consent calendar, but thank you for your time and attention to LB361. I would be happy to answer any questions. [LB361]

SENATOR CAMPBELL: Questions for Senator Howard? Senator Gloor. [LB361]

SENATOR GLOOR: Thank you, Senator Campbell. Senator Howard, I'm reading as fast as I can,... [LB361]

SENATOR HOWARD: Yes. [LB361]

SENATOR GLOOR: ...but I'm getting confused. Are we talking about death of both the child and the mother? [LB361]

SENATOR HOWARD: There it could be a death that's incident to pregnancy, so if there was an incident where both the mother and the child died during pregnancy, then it would cover that. Right now they would only be able to look at the child. But it would cover from the moment that she ceases to be pregnant to a year after that date. [LB361]

SENATOR GLOOR: So when this was identified...when the committee was set up, we were dealing with child deaths, either prenatally or, yeah, before birth. [LB361]

SENATOR HOWARD: Uh-huh. Yeah. They actually looked at ages 0 to 17 for the Child Death Review Team. [LB361]

SENATOR GLOOR: Okay, the Child Death Review Team. And so have there been reports or...? [LB361]

SENATOR HOWARD: They do. They put out a...the most recent report was from October 2011, and they look at sort of grouping, so one is pregnancy related, one is unintended, accidental deaths. There's a variety of sort of circumstances that they look at and sort of compile them into groups to make recommendations for the state overall.

[LB361]

SENATOR GLOOR: So are we amending... [LB361]

SENATOR HOWARD: Yes. [LB361]

SENATOR GLOOR: ...the process that we currently go through? [LB361]

SENATOR HOWARD: We're not changing the process. We're just adding moms. [LB361]

SENATOR GLOOR: Okay. That's what I'm having a hard time with, that we're adding moms. And are we adding moms, looking for something specific? I mean is this a...are we concerned that this is a medical issue, a domestic violence, a postpartum depression, all of the above? I mean are we trying to get a handle on... [LB361]

SENATOR HOWARD: I think it's all of the above. It's really...and I think, really, as they were...when this bill was brought to me, it was brought to me with a discussion that they're looking at child deaths during pregnancy, but they're not able to get a full picture of what's happening. But the CDC recommends an entire year, which means that you could pick up domestic violence, postpartum depression suicide, other issues that may have arisen from pregnancy that occur after the birth. So I think it would...they would get a much broader picture of maternal mortality in the state with this review team. [LB361]

SENATOR GLOOR: Okay. [LB361]

SENATOR CAMPBELL: Senator Crawford. [LB361]

SENATOR CRAWFORD: Thank you, Senator Campbell. So this would include maternal death where there's not a child death or...? [LB361]

SENATOR HOWARD: Yes. [LB361]

SENATOR CRAWFORD: Yes. [LB361]

SENATOR HOWARD: Yes, absolutely. [LB361]

SENATOR CRAWFORD: So with any death of a female, someone has got to first...I mean we've got pregnant, the pregnant part is probably pretty easy. (Laugh) [LB361]

SENATOR HOWARD: When she ceases...when she ceases to be pregnant. [LB361]

SENATOR CRAWFORD: But find out if that person is postpartum and, if so, then there

would be some mechanism that kicks it into this category. [LB361]

SENATOR HOWARD: Absolutely. [LB361]

SENATOR CRAWFORD: That's...oh, sorry, that's it. [LB361]

SENATOR CAMPBELL: Okay. Senator Krist. [LB361]

SENATOR KRIST: Just deaths? [LB361]

SENATOR HOWARD: Just deaths. [LB361]

SENATOR KRIST: Not postpartum depression. [LB361]

SENATOR HOWARD: No, it would only count suicides that go along with postpartum depression, if only... [LB361]

SENATOR KRIST: Thank you, Senator. Thanks. [LB361]

SENATOR CAMPBELL: Someone is probably going to correct me when they come up and testify, but I thought that the death review teams had come into play quite a bit because of child abuse deaths, that had a number in, like, one year. And the death review team was put together to try to ensure that there was a spotlight put on this and reviewed. So if I...at least as I remember it, we reviewed...Michelle and I reviewed the report when we looked at LR37. And in fact, the chair of the Children's Commission is a member, not by virtue of that, she had already been, is a member of the death review team. So there's...it's made up of fairly professional... [LB361]

SENATOR HOWARD: Oh, yeah, we've got great folks. [LB361]

SENATOR CAMPBELL: ...people from disciplines that are looking at this. [LB361]

SENATOR HOWARD: Uh-huh. Uh-huh. And this would add three members as well that can be from those disciplines that focus on maternal health. [LB361]

SENATOR CAMPBELL: Okay. As you did the research on this, Senator Howard, does the department track any maternal info? I mean they must track some maternal information. [LB361]

SENATOR HOWARD: You know, not to my knowledge, but there may be somebody who could answer that question better. [LB361]

SENATOR CAMPBELL: Okay. I suppose it was just an assumption on my part. Senator

Crawford. [LB361]

SENATOR CRAWFORD: Thank you, Senator Campbell. So how does this work or who does this work that there would be no fiscal note? [LB361]

SENATOR HOWARD: Oh, awesome! Thank you. That is a wonderful question. I apologize for not including that in my opening. They are volunteers, and so the folks who are on this review team do it on a voluntary basis so there is no fiscal note attached to this. [LB361]

SENATOR CRAWFORD: And their...what's their authority for getting the information that they need? [LB361]

SENATOR HOWARD: I believe that's through DHHS, and the coordinator has already been allocated so there's no fiscal note to add the additional three volunteers. [LB361]

SENATOR CRAWFORD: So the coordinator that exists for the child death would now add this to that responsibility. [LB361]

SENATOR HOWARD: Uh-huh. [LB361]

SENATOR CRAWFORD: Is that correct? [LB361]

SENATOR HOWARD: Yes. [LB361]

SENATOR CRAWFORD: Thank you. [LB361]

SENATOR HOWARD: I know it's rare to get no fiscal note. [LB361]

SENATOR CAMPBELL: I'm going to clarify one thing. And so this is a bill that the Department of Health and Human Services wants. [LB361]

SENATOR HOWARD: Yes. [LB361]

SENATOR CAMPBELL: Okay. Senator Krist. [LB361]

SENATOR KRIST: I'm going to...I'm going to bring the big elephant in the room. Does this include women who have elected to terminate a pregnancy? [LB361]

SENATOR HOWARD: And they die incident to an abortion? [LB361]

SENATOR KRIST: Exactly. [LB361]

SENATOR HOWARD: That's a good question. I... [LB361]

SENATOR KRIST: By definition... [LB361]

SENATOR HOWARD: They cease to be pregnant at that moment. I could see it capturing women like that. But, you know, I think it would also be good for us to know that as a state, if something like that was going on. [LB361]

SENATOR KRIST: It absolutely would. And so for the record, we're asking the facilities that terminate pregnancies, whether it's by medical necessity, D&C, or whether it's by termination of pregnancy for other reasons, or whether it's an abortion facility, to report anything that happens to the mother one year after the termination or conclusion of the pregnancy. [LB361]

SENATOR HOWARD: Uh-huh, when she ceases to be pregnant. Absolutely. [LB361]

SENATOR KRIST: Thank you, Senator. [LB361]

SENATOR HOWARD: Thank you, Senator. [LB361]

SENATOR CAMPBELL: Other questions? Thank you, Senator Howard. We know you're going to stay around, so don't have to worry about that one. All right, our first proponent for the bill. Good afternoon. [LB361]

ANN FROHMAN: Good afternoon, Madam Chair, members of the Health and Human Services Committee. My name is Ann Frohman. For the record, that's spelled A-n-n F-r-o-h-m-a-n. I'm an attorney and registered lobbyist here on behalf of the Nebraska Medical Association, and I want to thank Senator Howard for introducing this bill. Your questions are right on point in terms of the need for this expansion of the act. The CDC had originally taken on the idea that they were going to do this collection. And at some point in the process, perhaps because states were already doing, at each state level, the child death reviews, pushed it back to the states. One piece of this that's pretty important to it is the reciprocity of it. You can have an individual who dies in the state of Nebraska. They may need access to do their investigation because records may be housed in another state. And as I understand it, if you have this expansion in there to allow for, essentially, the postpartum mother's death, then what you have is the ability among the states to be very fluid in their ability to get the information they need to do the study. And much of this is about statistics and being able to develop reports in terms of what they find. They may find a termination. They may find, you know, all sorts of different things within that 12 months. I did ask HHS, I said what are you seeing in terms of volume, how large is this? Maybe zero in a year, maybe two, maybe three, not many. They didn't feel it was a burden that they couldn't absorb in that respect. I think that's...I'm trying to remember if I got all the questions. But if there are any other

questions, I'd be happy to attempt to answer them. [LB361]

SENATOR CAMPBELL: Senator Gloor. [LB361]

SENATOR GLOOR: Thank you, Senator Campbell. Ann, as the committee will tell you, I always raise questions about gathering data for data's sake, with good intention maybe, but that ultimately we don't do anything with the information we gather. In this case, there's not a lot of expense to it, since volunteers seem to be involved. But your comment was they want to look at their gathering the data. Is the "they" at the state level with the commission,... [LB361]

ANN FROHMAN: Yes, it is. [LB361]

SENATOR GLOOR: ...or is it the...is it... [LB361]

ANN FROHMAN: And it's not gathering data for just the sake of gathering data. They do...they, in the law now, they want to learn something; and they want to take that information. And in the law there's an education component so that the physician community can be educated and say, hey, if we can learn something here and save lives, let's do it. So that's a piece of this as well. [LB361]

SENATOR GLOOR: Well, and I don't doubt that there's good intention behind it, but are we putting out reports, are we finding anything with what we're doing so far? I mean we're expanding something that's already out there and adding women to it and looking at women. Have we done anything with the information related to infant deaths so far? [LB361]

ANN FROHMAN: I know the annual reports go to the Legislature. I do not know if there have been opportunities learned from that, that required legislative work. But I am sure, certain that there has been information learned that the physician community has probably incorporated into their knowledge base. [LB361]

SENATOR GLOOR: Is the CDC involved at all or do they just put it all back on the individual states? [LB361]

ANN FROHMAN: I think they put it all back on the states. I think they really wanted to do it nationally, and I think it was a funding issue or something and didn't happen. [LB361]

SENATOR GLOOR: Okay. Thank you. [LB361]

SENATOR CAMPBELL: Other questions? I would just have to say, Senator Gloor, that I think in the early years after this came about there was probably some very close

attention by some of the senators that might have framed some child welfare legislation. But that's just...I mean just from our anecdotal discussion with Karen Authier, who is the woman that I indicated serves on both of these, in our discussion with her, I think that's probably what they've watched. [LB361]

SENATOR GLOOR: Wonder if they looked at anything related to prenatal care for mothers. [LB361]

SENATOR CAMPBELL: I don't...I mean I'm looking at Senator Howard. I don't think so. I think they focused in when the actual death occurred and, again, a lot of that probably came from reports of child deaths that were to be revealed because of abuse/neglect. [LB361]

SENATOR GLOOR: Okay. Helpful. [LB361]

SENATOR CAMPBELL: Okay. Thanks, Ms. Frohman,... [LB361]

ANN FROHMAN: Thank you. [LB361]

SENATOR CAMPBELL: ...as always. Our next proponent. [LB361]

HEATHER SWANSON: My name is Heather Swanson, H-e-a-t-h-e-r S-w-a-n-s-o-n. I'm speaking on behalf of the Nebraska Affiliate of the American College of Nurse-Midwives and we are in support of this bill. We are pleased that nationally there's a closer look at maternal deaths within a year, and we think this is a very helpful measure for the state to keep track of things and to review practice. Thank you. [LB361]

SENATOR CAMPBELL: Any other comments or questions? Thanks, Ms. Swanson. Our next proponent. Anyone else? Those who wish to testify in opposition to the bill? Okay. Those who wish to testify in a neutral position. Good afternoon. [LB361]

JIM CUNNINGHAM: Good afternoon. Senator Campbell and members of the committee, my name is Jim Cunningham. I'm the executive director and registered lobbyist for the Nebraska Catholic Conference. I don't have any concern about the premise of this bill or the purpose or what's intended. But I've been reading the bill and listened to the testimony, and I just...basically, I want to testify in a neutral capacity to preserve an opportunity on the record to probe this bill just a little bit more with regard to Section 7. That section expands, in a fairly broad way, the access that will be to records. It now apparently includes school districts and schools. It now includes educational records. And I'm curious as to what that might mean in terms of what the expectations or duties are going to be of schools with respect to educational records; might not be a problem at all, but it's not beyond reason that there could be some potential conflict. It also applies to any social services agency. When I first read that, I

just assumed that meant social services agency operated by a governmental subdivision or by the state, because that's the context of that section as you read it in current law. But now that I see that it's being broadened, I'm not so sure that it is limited to a social service agency of the government, state or local. And it adds, of course, pregnant or postpartum women; and not only records with regard to the woman, but with regard to the family of the child or the woman. And I'm just wondering, and I don't know the answers, it just occurred to me that there could be some possible conflicts with confidentiality requirements, maybe even some federal regulations that might apply to a social services agency. I'm speaking here in the context of, for example, Catholic Charities, Catholic Social Services of the Diocese of Lincoln, who do an awful lot of rendering of social services and counseling. So my only...my only point is just hopefully to have an opportunity to research this a little bit more and find out more about it so that we have a fuller understanding of what is expected of us by virtue of this bill. Thank you. [LB361]

SENATOR CAMPBELL: Mr. Cunningham, you are well known as a very thorough, thorough, thorough, I underline that word, reader of bills, so I appreciate that. Whatever questions or what you might come upon, I'm sure Senator Howard would be glad to... [LB361]

JIM CUNNINGHAM: Sure. [LB361]

SENATOR CAMPBELL: ...sit down with you and would welcome any comments, because we want to make sure that it's...when the bill goes to the floor, we're very clear about what we're doing. [LB361]

JIM CUNNINGHAM: Well, with many other things going on, I probably didn't do this as much in advance as I should have; but I wanted to make that comment for the record anyway. Thank you. [LB361]

SENATOR CAMPBELL: You need not apologize to a group of people who always feel they're behind. (Laugh) [LB361]

JIM CUNNINGHAM: Okay. [LB361]

SENATOR CAMPBELL: So thank you very much for your testimony today. [LB361]

JIM CUNNINGHAM: Thank you. [LB361]

SENATOR CAMPBELL: Anyone else in a neutral position? Okay, Senator Howard, I think we're back to you. [LB361]

SENATOR HOWARD: Since I have to be here for the next one as well. Just to answer

your question, it doesn't deal with prenatal care, mostly because they were not able to look at maternal records prior to this time, so they wouldn't be able to assess prenatal care at that point. And then in regards to Mr. Cunningham's comments, the changes to the bill, social service agencies and the family relationship was already in the bill before we made these changes and added the mother. But I would be happy to speak with anybody who's worried about how it's been going with the Child Death Review Team and if they've been a burden to social service agencies at this point. But I thank you for your consideration of the bill, and if you have any other questions... [LB361]

SENATOR CAMPBELL: Any other questions? [LB361]

SENATOR CRAWFORD: I... [LB361]

SENATOR CAMPBELL: Oh, Senator Crawford. [LB361]

SENATOR CRAWFORD: Thank you, Senator. I was...I guess I am curious about the inclusion of educational records. [LB361]

SENATOR HOWARD: You know, that is a good question and I'm wondering, too, if it's something where, as the Child Death Review Team was going along, if educational records were an indicator of some type of abuse for the children... [LB361]

SENATOR CRAWFORD: Hmm. [LB361]

SENATOR HOWARD: ...and they weren't able to reach them during their survey. [LB361]

SENATOR CRAWFORD: Interesting. [LB361]

SENATOR CAMPBELL: Senator Gloor. [LB361]

SENATOR GLOOR: Yeah, thank you, Senator Campbell. And I'm thinking about teen pregnancies and the number of pregnant teenagers who are in school and specific programs put together by schools that provide educational opportunities, and thought maybe that's where the educational piece comes into play. But it's just a...I would be interested in knowing also how that piece now comes forward as being important. [LB361]

SENATOR HOWARD: Absolutely. I will find that out. [LB361]

SENATOR CAMPBELL: Senator Howard, counsel gave me a note: Does...is there a requirement to do this in connection to receiving any federal funds? [LB361]

SENATOR HOWARD: Not to my knowledge, but I would happily defer to counsel on that. [LB361]

SENATOR CAMPBELL: We don't know, do we? [LB361]

MICHELLE CHAFFEE: It's just the death review team has an obligation to do that. [LB361]

SENATOR HOWARD: Oh. [LB361]

SENATOR CAMPBELL: Oh, the death team...or the death review team... [LB361]

MICHELLE CHAFFEE: For the children. [LB361]

SENATOR CAMPBELL: ...has an obligation... [LB361]

MICHELLE CHAFFEE: For children. [LB361]

SENATOR CAMPBELL: ...for children. So you might... [LB361]

SENATOR HOWARD: Yeah. [LB361]

SENATOR CAMPBELL: We can check back and forth. The other...and I'm not quite sure. Do you know, Senator Howard, where the report is? Is it on the legislative site? Can they... [LB361]

SENATOR HOWARD: It's on the DHHS Web site. [LB361]

SENATOR CAMPBELL: Okay. [LB361]

SENATOR HOWARD: And I can send the link out as well... [LB361]

SENATOR CAMPBELL: That would be great. [LB361]

SENATOR HOWARD: ...if that would be helpful. They call it the CDR team, if that helps so it's easy to find on the DHHS Web site. And their reports are there, their methodology and processes are there, and then they have a top five causes of death, and key recommendations for prevention that they update. [LB361]

SENATOR CAMPBELL: Okay. So for senators, you may want to take a look at that. Then you'll have an idea what is entailed here. Okay? Anything else? Thank you, Senator Howard. [LB361]

SENATOR HOWARD: Thank you. (See also Exhibits 34 and 35) [LB361]

SENATOR CAMPBELL: With that, we'll close the public hearing on LB361 and open the public hearing on LB528, Senator Howard's bill to provide for partner treatment relating to sexually transmitted diseases. So, Senator Howard, whenever you're ready. [LB361 LB528]

SENATOR HOWARD: (Exhibits 36 and 37) Thank you. I do have some handouts that are going around. There's an amendment that we've been working on, and we are going to continue working on after this. There are also some fact sheets about the two illnesses that are included in the legislation. It's been limited now to chlamydia and gonorrhea, so fun facts about STDs on a Friday afternoon--I apologize. And some maps of the state of where these STDs are at their highest incidence and their highest incidence rates, just for your perusal. So good afternoon, Senator Campbell and members of the committee. For the record I am Senator Sara Howard, H-o-w-a-r-d, and I represent District 9. Today I bring you LB528, a bill to allow medical practitioners to use expedited partner therapy as a tool to combat chlamydia and gonorrhea. For over a decade, Douglas County has been in the midst of a sexually transmitted disease epidemic. I'm frequently...I actually get asked all the time why I brought this bill, which is great. I think everybody on the committee knows I work at a federally qualified health center in south Omaha, OneWorld Community Health Centers. And all of the administrative staff work in an open room setting, and so I have the pleasure of sitting next to our STD outreach nurse, Pat O., and at least twice a week he spends an afternoon making phone calls; and he says the same thing every time, sometimes in Spanish, sometimes in English, and he says, I'm calling you to let you know some bad news. The bad news is that you have chlamydia. The good news is that it's treatable. And if you've had to hear that 15 times over and over, a day, you too would also want to find a way to stop chlamydia from its expansion in the state of Nebraska. So, unfortunately, the one thing that...one of the things that makes chlamydia and gonorrhea so pervasive is that despite the tractability of these diseases is the high likelihood of reinfection. So if one partner is left untreated, there's a really high likelihood that they will subsequently reinfect each other. Because the likelihood of reinfection is so high, medical practitioners must have innovative tools outside of the traditional treatment model to stem the tide of these illnesses. One method that the CDC has recommended--it's CDC day at HHS today--is to address the problems of STD infection and reinfection, is expedited partner therapy, or EPT. This is the practice of allowing a provider who has a patient with a diagnosis of chlamydia or gonorrhea to provide an additional prescription to his or her partner or partners in order to treat the STD. This practice is expressly permitted in statutes in 32 states, and currently in use in 43 states, including Nebraska. Our statutes are silent. EPT is not expressly permissible in Nebraska statute and this omission deters some providers from using this critically important treatment method. LB528 rectifies this ambiguity, explicitly allowing physicians, physician assistants, nurse practitioners, and certified nurse-midwives to

prescribe, provide, or dispense oral antibiotic samples or prescriptions to a patient for the treatment of that patient's partner or partners. I want to be clear, EPT is not for partners who are able to visit the doctor. The CDC recommends that this is for people who are unable or unwilling to visit the doctor and who are likely to reinfect their partners. These partners are unable to seek treatment for a variety of barriers. These barriers are the same types of things that we discussed in this committee last night and just about every time we discuss healthcare access for low-income individuals and the working poor. Some partners are unable to pay for the additional visit because they're uninsured. Some may not seek treatment because of cultural taboos. Others are unable to find a provider expeditiously because, you know, during the treatment, if you're not able to get in and sort of get on the same treatment cycle as your partner, there's a very high likelihood that you'll reinfect. Quick treatment of these STDs is absolutely critical, and the statistics regarding expedited partner therapy as a method to prevent reinfection are compelling. In three clinical trials where expedited partner therapy was compared with patient referral, chlamydia reinfection at follow-up was reduced by 20 percent, and gonorrhea reinfection at follow-up was reduced by 50 percent. Use of EPT also increased the rate of partner notification, which is really critical in making sure that partners get treatment as well. Because EPT is recommended by the CDC, they've also issued a protocol guidance which is followed in this bill. In that guidance, the CDC points out that EPT is especially useful in preventing reinfection in pregnant women. It's really critical that pregnant women are treated and not reinfected with sexually transmitted diseases, especially these two sexually transmitted diseases, predominantly because gonorrhea can provide...if a woman has gonorrhea when she is pregnant, the baby can be born blind. Chlamydia can also cause eye infections upon birth as well as pneumonia for the child. And gonorrhea can also have a woman have an early birth, which is all in your fun fact sheet, so I apologize. What happens quite a bit with pregnant women, though, specifically, is that they'll come in, in their first trimester; they'll have a diagnosis of chlamydia or gonorrhea; they get treated. By their second or third trimester, they've been reinfected by their partner; and so that will impact the birth of the child. Oh, I skipped some. Senator McGill laid the groundwork for this bill during the last two sessions, but I want to make the committee aware of changes we have made to the bill to address the issues arising from the debate on LB304 last session. The first, as I have indicated, this bill is narrowly tailored to permit EPT only for gonorrhea and chlamydia, as Senator McGill negotiated in the last floor session. In addition, you should have received an amendment to this bill addressing some of these issues, and I anticipate bringing another amendment between now and Exec. We're going to bring the stakeholders together one more time for some new issues that arose in the last two days. The first modification in the amendment is with regard to the dispensing language. The amendment modifies the bill to conform to Nebraska's pharmacy law in several ways. The bill as drafted makes a distinction between physicians, physician assistants, and advanced practice nurses in terms of who can dispense and who can prescribe. The amendment aligns the language with current law where physicians, physician assistants, nurse practitioners, and certified nurse-midwives are all allowed to dispense

samples incident to practice. Additionally, the amendment specifies nurse practitioner and certified nurse-midwife instead of advanced practice registered nurse, because these specific APRNs are the practitioners allowed to prescribe or dispense samples. I want to make it clear that I do not anticipate this bill changing the scope of practice for any of these practitioners. The amendment also requires the prescription to conform to Nebraska law and in terms of storage and labeling. Some states do not require the partner's name be on the prescription, instead using initials or "unknown partner." But I felt it was important that the expedited partner therapy prescription conformed to labeling requirements and include the name of the person who is receiving the oral antibiotics. In addition, the amendment contains language expressly stating that EPT does not violate the standard of care for the treatment of chlamydia and gonorrhea. Expedited partner therapy is not the panacea for an STD epidemic. It will not replace traditional treatment methods, but it's a critical tool in the toolbox for addressing rates of chlamydia and gonorrhea in our communities. I thank you for your time and attention to LB528. I'm happy to answer questions. [LB528]

SENATOR CAMPBELL: Questions for Senator Howard? Okay. I think what we'll do is just go through the testimony and then if there's questions we can come back to it. [LB528]

SENATOR HOWARD: Perfect. Thank you. [LB528]

SENATOR CAMPBELL: Thank you, Senator Howard. [LB528]

SENATOR HOWARD: I'm here all afternoon. [LB528]

SENATOR CAMPBELL: Okay, our first proponent for the bill. [LB528]

JONNA REBENSDORF: And I apologize as well for not having a copy of my testimony. [LB528]

SENATOR CAMPBELL: That's fine. [LB528]

JONNA REBENSDORF: I had some car difficulties this morning. [LB528]

SENATOR CAMPBELL: Oh, no. [LB528]

JONNA REBENSDORF: But my name is Jonna, J-o-n-n-a, last name Rebensdorf, R-e-b-e-n-s-d-o-r-f, and I'm a graduate student at UNO in the sociology/anthropology department. My focus is reproductive health and sexual health education in sociology, so. I did my undergraduate senior thesis in sexually transmitted diseases and sexual health education in Douglas County, so that was the focus of my senior thesis. I did a very extensive survey and a lot of background research on Douglas County, in

particular. According to the Douglas County Health Department's 2012 STD report that they put out, there were 965 new cases of chlamydia in 15- to 19-year-olds; 1,133 in 20- to 24-year-olds; and 512 cases in 25- to 29-year-olds. And the graph kind of has a bell-shaped curve to it, and that means 20- to 24-year-olds are really the main population that are affected by this. So in terms of reinfection rate, when looking at, at least through my surveys, the individuals who were 20-24 years old, they said that for sexual partners they usually had one-three. So that does show that these are individuals who are not necessarily exclusive with their partners. They may not be in long-term relationships and they may not necessarily have the greatest connections with their sexual partners in terms of knowing them very intimately. So because of that survey it really led me to believe as part of my research that EPT was a fantastic way to cut reinfection rate because rather than facing the social stigma of calling somebody out and saying that they have, you know, like well, I have chlamydia, I was diagnosed, and you probably have it too, and making it an awkward conversation, which then implies the other person has to go and take care of their things on their own, it now allows for people to reconnect with their sexual partners and get them the treatment as well. And for cases of domestic abuse, which also have a really high correlation with sexually transmitted infections, it might be hard for a woman or a man who is diagnosed with a sexually transmitted infection to require monogamy of their sexual partner; so getting their partner the medications that they need so that they cannot be reinfected is important as well. And sometimes it's harder to get an abusive or controlling partner to go to the doctor if you would go to them and say that you would have chlamydia or something like that, so. Twenty-one point...or 61.5 percent of the 20- to 24-year-olds that I did survey for my thesis said they thought it was very unlikely on a 6-point scale that they would contract an STD, even though Nebraska is 34th in chlamydia rates nationally, and 37th, I believe, in gonorrhea. So even though a lot of people think that it is very unlikely, a lot of chlamydia and gonorrhea cases are asymptomatic so you won't have any, necessarily any outward symptoms that would tell you to go to the doctor to get an STD test done. So if you are an individual who is asymptomatic and your sexual partner is the first person to tell you that you have an STD, that also then helps you make sure you get the appropriate treatment, because untreated STDs can cause severe scar tissue buildup on the fallopian tubes and the urethra, so it can cause a lot of long-term problems and also lead to infertility problems and infant mortality when pregnant, so. The American Journal of Public Health has recommended this program as well as the CDC and the American Medical Association as well. Fiscally, there is no fiscal note for implementation as far as I have understood, but it does give the legal backing so that professionals who are currently concerned about litigation would be free to practice this method appropriately. And then in terms of reinfection from current sexual partners, it's really important because these are bacterial infections that in terms of antibiotic resistance we get people treated fast and we cut down reinfection rate; because if you're not taking your antibiotic appropriately and you are continually getting reinfected, it can increase bacterial resistance so that our treatments will no longer work the same. So it's important that we make sure we get these infections cut down as we

can. But I would be open to any questions. [LB528]

SENATOR CAMPBELL: Thank you, Ms. Rebensdorf. Questions? Senator Crawford. [LB528]

SENATOR CRAWFORD: Thank you, Senator Campbell. What does your...you were saying that in your research there...they may not have a longstanding relationship with some of the other partners. As you see the way this process is established and perhaps especially with the requirement of having a name for pharmacy labeling, do you think that this process makes sense with what you know from your research about the nature and level of those relationships with partners? [LB528]

JONNA REBENSDORF: I think in terms of...they were few and far between, the individuals who said that they didn't know their partners before their sexual encounter, so most people have at least a familial understanding of who their partner is when they engage. A lot of people said that alcohol was an influence in their sexual activity, so in terms of it might not have just been the best decision at the time, but they would be able to at least give the name of their partner, I assume from the survey responses that I got. [LB528]

SENATOR CRAWFORD: Okay. Thank you. [LB528]

SENATOR CAMPBELL: Any other questions? Thank you very much for coming. [LB528]

JONNA REBENSDORF: Thank you. [LB528]

SENATOR CAMPBELL: And good luck with your studies. Our next proponent. Good afternoon. [LB528]

MELISSA GRANT: (Exhibit 38) Good afternoon. Senator Campbell and members of the Health and Human Services Committee, I'm Melissa Grant. I'm director of business development at Planned Parenthood of the Heartland. I want to thank you for the opportunity to talk about the benefits of expedited partner therapy and the importance of Nebraska considering adopting it as a legally accepted standard of practice. I want to thank Senator Howard for sponsoring this bill; and Senator Campbell, thank you, for cosponsoring the policy. Planned Parenthood of the Heartland provides healthcare services to patients in Nebraska, Iowa, Arkansas, and eastern Oklahoma. And, per state law in 2008, we offer expedited partner therapy in the state of Iowa in our health centers, in addition, just across the river from my Omaha office, in Council Bluffs; so I wanted to let you know about that experience. Women and men who are diagnosed with sexually transmitted infections in our offices are actually oftentimes very surprised, oftentimes they're embarrassed, and many times are very anxious to receive their

treatment. As has been discussed so far this afternoon, chlamydia, for example, is a very, very common sexually transmitted infection--the most commonly transmitted bacterial infection in the United States; and three out of four women and half of men have no idea and no symptoms of the infection. So the education that we provide at Planned Parenthood and the treatment and testing that we provide changes a lot of people's ideas about who can be affected. They also learn from our clinicians when facing a positive test result that if this infection is left untreated it can lead to much more serious complications, like the pelvic infections we've discussed; and ultimately, can cause infertility. So these patients are often very anxious to be treated. Our patients have actually responded very, very positively to the idea of expedited partner therapy. Patients find it's really much easier to share the information about a positive test with a loved one when they can also share the treatment plan together, right away. Taking the treatment together decreases the risk that one partner is cleared of the infection, as you've heard, and then inadvertently exposed again; but also, because there may be no signs or symptoms, coming forth with information, education, and treatment together oftentimes has that partner feel a lot more willing to step in to treatment right away. It's harder to be in denial or surprised when you've got that information in front of you. So it's been very, very successful for us. Nebraska is among those states for which the CDC and Prevention say that EPT is potentially allowable. So the law is vague. And we hear that many in Nebraska offices may already provide EPT, but we think it's important that the Legislature really clarify that this is a legally acceptable standard of practice and that will make even more practitioners comfortable with utilizing this therapy. When the Legislature debated this issue last year, some lawmakers raised questions about the safety. And as the CDC has confirmed, EPT is safe. In our Iowa health centers, we've had absolutely no reported problems from our patients, and I will also note we recently conducted a nationwide search of information on lawsuits related to EPT, and found none. So people cannot be reminded enough of the serious consequences of STIs, and you've heard a lot of them already today. The idea that untreated infections can lead to not only chronic pelvic pain, ectopic pregnancy, infertility, but they can make the person who's been exposed more susceptible to HIV. They can allow babies born of infected mothers, prematurity, low birthweight, blindness, and deafness. This is a serious, serious problem. So EPT is again not the cure-all to eradicate all sexually transmitted infections, but it does work. It helps to increase treatment. As we're working diligently to find ways to educate, test, and treat the greatest number of people about these preventable infections (laugh), it's a proven strategy that helps stop the spread of the disease and helps protect public health. So because of that, healthcare providers in the state of Nebraska deserve equal access to this strategy (laugh) that's successfully used in Iowa and across our country. So I want to thank you in advance for further consideration of LB528, and I thank you for your time. [LB528]

SENATOR CAMPBELL: Questions? Thank you very much for coming today. [LB528]

MELISSA GRANT: Thank you. [LB528]

SENATOR CAMPBELL: Our next testifier. [LB528]

ADI POUR: (Exhibit 39) Good afternoon, Senator Campbell and members of the Health and Human Services Committee. My name is Adi Pour and I am...A-d-i P-o-u-r, and I'm the director of the Douglas County Health Department and I'm testifying in support of LB528. As you have heard a little bit before, STD rates in Douglas County have been high for several years, and they have spurred government and community-based organizations to implement numerous innovative educational and prevention programs. Just as an example, two DVDs have been developed, one for young people, the title is "STD, not me," and the other one is for parents, "How to talk to your teens." More than 200 of these DVDs have been distributed in the community just last year. At the same time, healthcare providers have done a great job in testing more at-risk individuals and treating those that are infected. While standard care for treating STDs includes testing, clinical evaluation, and counseling by a healthcare provider, EPT, or expedited partner therapy, is an alternative when a partner is unable or unlikely to seek care. And I hear this often in our clinic when I ask our nurse practitioner, and she says, you know, often it is a female who is in the clinic who says, my partner is going to say don't bother me with this. And so it is often that we see that the benefit will be to male partners. The main cause of recurrent sexually transmitted infections, you have heard before, results from continued sexual contact with an infected partner. Patients with STDs have reduced risk for recurrent infections when their sexual partners are properly treated. And public health efforts to notify and convince partners to see their healthcare providers for testing and treatment is the fundamental effort of STD control, but it is not always successful. Sometimes, again, a partner's choice is not to seek treatment. They are asymptomatic and they falsely assume that they are not infected, and therefore, it is difficult to bring them to the clinic or to a healthcare provider. And you heard of some of the other barriers. You have heard the question, is EPT effective? I think we have a lot of studies now that talk about the effectiveness, especially as it is related to the occurrence of recurrent chlamydia and gonorrhea. You heard that there are 32 states that have a framework in place where their law indicates that EPT is permissible. There are seven states that were identified in this review by the CDC where EPT is likely prohibited. And Nebraska is one of those 11 states where EPT is potentially allowable, but there is no clear language for or against this treatment modality. This bill will make this explicit. A study published in the Journal of Current Infectious Diseases, in January 2011, with the title, "Expedited Partner Treatment for Sexually Transmitted Infections: An Update," reported that seven different studies evaluated the efficacy of expedited partner treatment. Not only did these studies demonstrate their superiority for percentage of partners being treated, or a reduction in repeat infections, or a cost benefit for EPT compared to the standard partner referral method; most importantly, the study reported there were no adverse events after EPT. So in summary, support of LB528 indicates to healthcare providers in Nebraska that we trust their professional expertise, and this tool is available to them if they so choose, especially in a state where we have areas with

high incidence rates of STDs. The Douglas County Health Department and the Board of Health appreciate your consideration of this testimony in support of LB528. I've given you some attachments there. One compares us to other metropolitan statistical areas. I think when you look at that, you will say, why is Omaha, Douglas County, higher than Kansas City, higher than any of those areas or most of those areas that you see on that list? The last page just shows you the newest data from 2012 about chlamydia and gonorrhea in Douglas County. And as you can see from there, we still see an increase. We had an increase of 8 percent in Douglas County in 2012. I'm happy to answer any questions. [LB528]

SENATOR CAMPBELL: Questions? Senator Cook. [LB528]

SENATOR COOK: Thank you, Madam Chair. And it's good to see you, Dr. Pour. [LB528]

ADI POUR: Thank you. [LB528]

SENATOR COOK: We've been working on this for a little while, and I see the reports of some successes in terms of public education, and I guess I would look to identify some longitudinal trends that we are not just getting (laugh) having the same rates after, at this point, about six or seven years of having various and sundry...I don't know. [LB528]

ADI POUR: You know, Senator Cook, I am as distressed about this and frustrated as you are. So I'm always looking, I'm always a person who sees the cup half full. What I have seen in the 2012 data, and you have a slide of that, is that actually in the 15- to 19-year-olds we see a leveling off of the rate. And that's really where we are doing our outreach mostly is in our young population. Twenty- to twenty-four-year-olds, that's where we see the increase happening. Those are college students. Those are adolescents who want to start a family. We probably are not reaching out to those as we do to the younger ones. So my hope is that this young generation that we have right now is going to be educated, and therefore, those trends are going to follow. I'm also very happy to say that we have made great efforts in your district specifically, Senator Cook, where we have now churches involved who say, you know, it's one thing to preach about your spiritual wellness but we also need to teach them about the physical wellness. And so we have many more partners on board than we have ever had before. And again, this bill is not going to make a change in the rate of chlamydia that we see in Douglas County, but it is one tool. And why should we not provide this tool, if it is safe, to our healthcare providers? [LB528]

SENATOR COOK: Thank you. [LB528]

SENATOR CAMPBELL: Any other questions? Senator Gloor. [LB528]

SENATOR GLOOR: Thank you, Senator Campbell. And thank you for taking the time to come down, Dr. Pour. I've heard a lot of percentages. I haven't heard any exact numbers. I mean, how many...in Douglas County...does...how does this translate into partners who are going untreated? Are we talking...and it would sure help me if I knew if we were talking about 15, 50, 500, as opposed to the percentages, because I'm having a hard time deciding on the scope of the problem. [LB528]

ADI POUR: I tell you, Senator Gloor, when I talk to staff in our public health clinic, I ask them if this law would go into place, how often do you really think we would write a prescription? We are not giving out pills, so I mean, I kind of want to bring that to a stop. But how often would we give a prescription to an individual that now has been treated in our clinic at this time, to take home with a partner? And what my staff is saying, that our goal would still be to bring the partners in. There is some incentive to bring a partner in; the treatment will be free of charge. And that's not going to happen if you have a prescription. But what they are telling me, that you probably talk about one-two prescriptions a week. So from the public health...in a public health clinic, that number would be small. However, I am questioning what the number would be in a west Omaha clinic's office. For example, in an ob-gyn clinic where you have an individual, now a female in front of you, and she's positive with chlamydia and you will tell her that she needs to get her partner in, she wouldn't come in to the ob-gyn. That partner actually would have to go to his or her healthcare provider. So I think it may be more used in private clinics than it actually will be used in public health clinics. Now CDC always says for everyone infected and knows that they are positive, there are two out there who do not know that they are positive. So we have 3,300 cases in Douglas County just of chlamydia, so multiply that by 2, so potentially there are 10,000 cases out there. [LB528]

SENATOR GLOOR: Well, and the other thing I'm wondering, when I look...and I believe...I may not have brought it up last year but I remember thinking about it last year, and candidly was surprised by the amount of objection we got last year, if what we're passing would be a law that affects the entire state. What we have here doesn't appear to be, across the entire state, a systemic issue. We have a Douglas County problem. That's where the statistical abnormality is. That's where, you know, our chlamydia rates seem to drive up all of the Nebraska rates, and the Nebraska rate is below the U.S. rate. The Douglas County rate, as you pointed out, is incredibly high. Would we reduce the amount of objection we had for this bill if we were just trying to address the problem county? Should we be more exacting in this and would that help us gather a degree of enthusiasm rather than something that appears to be forced upon everybody else across the state? I'm not saying that's a bad idea. I'm talking about the ability to get legislation passed that...I'm talking about the ability as a strategy to get the legislation passed. [LB528]

ADI POUR: You're going to have one colleague of mine from the rural area who

practices public health in a rural area, and hopefully she can talk about what even in rural areas are the missed opportunities. And this bill would address some of that. So... [LB528]

SENATOR GLOOR: I don't doubt that. I have no doubt that we're not pure as the driven snow in outstate Nebraska either. I'm just...you have to admit, if you look at where the problem in the state is, it is one specific area of the state. [LB528]

ADI POUR: And you know, this is an urban area, too, and I think in urban areas we do have a little bit of difference. That's why I thought the data from the MSA was so interesting, because that's really what I would like us to compare ourselves to. So it is an interesting issue. We also do not know how much testing is really going on in rural Nebraska. I always ask that question. [LB528]

SENATOR GLOOR: Sure. [LB528]

ADI POUR: So it's an open question. [LB528]

SENATOR GLOOR: Sure. Lack of health departments means they may not do as good of job capturing the data of people who are actually infected. [LB528]

ADI POUR: Well, they would capture the data. I'm not concerned about that. I mean, the more the question is are healthcare providers testing in rural areas? Because these are asymptomatic individuals. So if you are not aware of this and say, you know, we know we are practicing in Douglas County; we know we have an issue and I need to keep that in front of my mind, and therefore, you may not have the same awareness in rural Nebraska. [LB528]

SENATOR GLOOR: Good point. [LB528]

SENATOR CAMPBELL: Senator Crawford. [LB528]

SENATOR CRAWFORD: Thank you, Senator Campbell. You mentioned something about the incentive for the partner to come in. And I was just curious as this occurs in a clinic what it looks like in terms of what that incentive is for the partner to come in, so that in terms of trying to get ahold of the partner and get the partner to come in and still capture the fact that you can give this partner therapy to somebody while they're present there in the office. [LB528]

ADI POUR: So let me explain to you. So an infected partner who now is...an infected individual who comes to our Douglas County Health Department clinic, after they have been identified as being positive, they get their antibiotics right there in the clinic, and people watch them take those two pills. Have them actually sit down a little bit

afterwards to make sure that there is no reaction. If the partner comes in, we ask for $15, but we do not refuse treatment. So that is the incentive. Because if I give you a prescription to take home to your partner, you're going to go to a pharmacy with that prescription where it potentially costs you--we looked, we kind of asked around--potentially $25 to fill that prescription. So the incentive is still really to come to the clinic where you get screened and then where you get treatment free of charge. But it is in those circumstances where you see that the partner isn't going to come in because he doesn't think he or she is infected, or they don't have the time of the day, they don't want to come to a healthcare provider, they like to be anonymous. And, you know, those are the opportunities that this bill would address. [LB528]

SENATOR CRAWFORD: Thank you. [LB528]

SENATOR CAMPBELL: Other questions? Thank you, Dr. Pour. Our next proponent. [LB528]

LAZARO SPINDOLA: (Exhibit 40) Good afternoon, Senator Campbell and all the members of the committee. Thank you for receiving me today. My name is Lazaro Spindola. That would be L-a-z-a-r-o S-p-i-n-d-o-l-a. I am the director of the Latino American Commission, and I'm testifying also on behalf of my wife who is also a physician and she works with infection control and she told me, you better testify there, so. (Laughter) I'm here to testify in support of LB528, which would make legal expedited partner treatment for individuals with some sexually transmitted infections. The question, of course, is why is this good and why hasn't it been done before here in Nebraska? The CDC funded four randomized controlled trials, as some of the previous proponents espoused, and the evaluation criteria was recurring infection, and all the studies showed a significant difference between the patients who underwent expedited partner treatment versus those who underwent the standard patient referral approach. Figure 3, which is the last page of your handout, shows the results for I believe the Seattle study. Yes. Preliminary economic analyses suggest that EPT is a cost-saving and cost-effective partner management strategy. Chlamydia rates in Douglas and Lancaster Counties, Senator Gloor, is not a limited thing, are 2,731 and 955 per 100,000 individuals respectively. And if we look at the rates in South Sioux City, at the rates in the Kearney area, we will see that they are quite high also. Considering that the national rate for chlamydia is 370, something different must be done, because what we're doing right now is not working fast enough. And when I say this it is because during the last three years, 2008, 2009, and 2010, for which we have the statistics, the rates dropped by 80 per 100,000 individuals; now we're talking here about 2,700 per 100,000. So at this rate I probably will be dead by the time we control this. So why is it not being done? One issue is the possibility of undetected sexually transmitted diseases in partners. Other issues are the legality of expedited partner treatment in Nebraska. See the map that is the second page of your handout. You will notice that in all the green states this is either legal or probably legal; on the red states it is illegal; and on

the pink states, Nebraska is one, we really don't know. The door is open for liability. Now the question, of course, is why would a sound-of-mind person not go to get their treatment when their partner has a sexually transmitted infection? According to the CDC, only about 50 percent of them do. In medicine, for every argument there is a refutation. We can keep arguing back and forth for a long time, and in the meanwhile, the rates for sexually transmitted infections in the most populous counties of our state will continue to be in between three and eight times higher than the national rates. And this worries me, because tens of thousands of Latinos live in those two counties and they are at risk of acquiring these infections. So I, therefore, urge the committee members to move this bill to General File for consideration by the Legislature as a whole. And I would be happy to try to answer your questions. [LB528]

SENATOR CAMPBELL: Thank you, Dr. Spindola. Questions from the senators? Senator Crawford. [LB528]

SENATOR CRAWFORD: I just wanted to ask about figure 3. [LB528]

LAZARO SPINDOLA: Figure 3. Yes. [LB528]

SENATOR CRAWFORD: It says GC, CT, CG or CT. [LB528]

LAZARO SPINDOLA: Yes. Some of these individuals have both infections. Some of them have only chlamydia and some have either gonorrhea or chlamydia. [LB528]

SENATOR CRAWFORD: Okay. So GC is gonorrhea? [LB528]

LAZARO SPINDOLA: Gonorrhea. [LB528]

SENATOR CRAWFORD: Okay. Thank you. [LB528]

LAZARO SPINDOLA: You said GT? [LB528]

SENATOR CRAWFORD: There is GC and CT. [LB528]

LAZARO SPINDOLA: No, it's CT, chlamydia trachomatis. [LB528]

SENATOR CRAWFORD: Okay. Thank you. [LB528]

LAZARO SPINDOLA: The copy is our office copier machine that is not very good. (Laugh) [LB528]

SENATOR CRAWFORD: Thank you. [LB528]

SENATOR CAMPBELL: Thank you, Doctor. [LB528]

LAZARO SPINDOLA: Is that it? [LB528]

SENATOR CAMPBELL: Thank you so much. [LB528]

LAZARO SPINDOLA: Thank you. [LB528]

SENATOR CAMPBELL: Our next proponent. Good afternoon. [LB528]

RICHARD BROWN: (Exhibit 41) Good afternoon, Senators. My name is Richard Brown and I want to first say I want to thank Senator Howard for taking up the fight and introducing this bill. I am very impressed with the young researcher from the university and her knowledge and what she's done here. Richard Brown, R-i-c-h-a-r-d B-r-o-w-n. I am the CEO of Charles Drew Health Center, and I'm testifying in support of LB528 on behalf of the Health Center Association of Nebraska, which represents Nebraska's six federally qualified health centers. Federally qualified health centers are community-based organizations that provide comprehensive primary care and preventive care, including medical, dental, behavioral health, pharmacy, and support services to persons of all ages and backgrounds, and based upon their ability to pay. Our 25 centers are located in Lincoln, Norfolk, Madison, Plattsmouth, Gering, Columbus, and Omaha. Now, over 30 years ago, I started my career as an STD investigator. They used to call us VD investigators, okay? So I know a little something about the in-depth experience associated with trying to rid a community of a sexually transmitted disease. So I won't repeat the data and the statistics that are in those maps, but the maps are attached to my testimony. It is truly a problem of epidemic proportion and it disproportionately impacts minority populations and low-income persons such as those served by community health centers across our state. And it is an expensive proposition, too, to treat individuals for these diseases when, you know, we have a cure for them. Over 57 percent of the chlamydia cases in Douglas County affect racial and ethnic minorities. Gonorrhea is a similar problem; 73.5 percent of gonorrhea cases affect racial and ethnic minorities in the county. And it is also important to note that about 89 percent of the patients in my health center have incomes at or below 100 percent of the poverty level, and this further illustrates the disparity of this epidemic. And in private offices, we know, or I know, that it is possible for patients to get a large enough prescription to share with their partner. This happens a lot. But in low-income communities, enough medication is not prescribed. What often happens is that patients split the medication with their partner, reducing the strength required to kill the bacteria and neither are properly treated, so the infection continues to spread. I am often asked, at the local, state, and national level, why Nebraska, why Douglas County, why Omaha? The reason is clear. We have refused to do what other counterparts in other parts of the country have already done. We have refused or we have neglected to do what other counterparts in other parts of the country have already done. They have taken the

important steps, like those contained in this bill. The states that have expedited partner therapy are very diverse and you've heard some of that: Texas, Minnesota, Washington, New York, I mean 32 other states. In conclusion, it is clear that our inability to treat people, to cure people, to eradicate this diseases from our population when have a tried and true and proven solution is just embarrassing. From a policy perspective it is important to view this not merely as a problem for individuals, but as a public health problem. And failure to ensure that partners are treated only exacerbates an already critical problem. And I urge you to advance this bill, and I'm happy to answer any questions that you may have. Since the light is still on, I just want to address one of the questions about...okay. (Laughter) [LB528]

SENATOR CAMPBELL: Not fair, is it? [LB528]

RICHARD BROWN: No, it's not fair. You know, you asked the question about, well, it seems to be in Omaha and in Douglas County and the rest of the state maybe is not there. You've been given reasons as to why, well, it just might be there. But aren't the legislators supposed to be about making sure that the population of all of its citizens are healthy? And so the people that are suffering in Douglas County need a cure too. I can look out my window, and if I see seven kids on the corner...if I see ten kids on the corner, statistically seven of them may be infected with chlamydia and gonorrhea. And it costs me a lot to keep serving these kids, these teenagers. They don't have any money, $15 at the most; so I have to have a doctor to see them when they could be seeing someone who will pay for services of a disease that we don't have a cure for. And I'll answer any questions. [LB528]

SENATOR CAMPBELL: That was very well done to get that in, in that last minute. Very impressive. Questions? Senator Gloor. [LB528]

SENATOR GLOOR: Thank you, Senator Campbell. And just to make sure that we understand each other, you're preaching to the choir here. [LB528]

RICHARD BROWN: I understand. Okay. [LB528]

SENATOR GLOOR: The...we've come close, but we've not been able to get over the hump. And so some of my questioning anyway, is if we can win...we may not be able to win the war. But can we at least win a battle, a significant battle here? And that is, get a handle on Douglas County. I know I'm going to have a problem in my district, which is Grand Island. It's large enough, it's metropolitan enough, and it's a population that I would expect would have a higher rate of disease. Yet it seems to me, Douglas County in and of itself is exorbitantly high. And so, you know, if we can at least...is it possible for us to get legislation passed in piecemeal here where we deal with Douglas County and then we continue a strategy to try and get it treated elsewhere? It's simply a comment that I made and I don't know if it's possible, but I've certainly also been frustrated by not

being able to get this legislation passed. But the reality is we haven't been able to. [LB528]

SENATOR CAMPBELL: We've also...oh, sorry, Senator Gloor. [LB528]

SENATOR GLOOR: No, that's fine. [LB528]

SENATOR CAMPBELL: We've also run into problems, and I know that Senator Howard is working on this. We've...it's not just that, but it's also the problem of liability; and that issue has been raised and raised and raised. And Senator Howard, I know she and I had a conversation this morning, and she's putting in every effort to try to get to language that several groups can live with. And I think if we could, you know, somehow get to that, that was also major, which is certainly not just a Douglas County problem, but we'd have to make sure of that for the entire state, so. Always good to see you. Thank you for coming. [LB528]

RICHARD BROWN: Thank you. [LB528]

SENATOR CAMPBELL: Our next proponent. [LB528]

KAY OESTMANN: (Exhibits 42 and 43) Good afternoon, Senator Campbell and members of the committee. [LB528]

SENATOR CAMPBELL: Good afternoon. [LB528]

KAY OESTMANN: My name is Kay Oestmann, K-a-y O-e-s-t-m-a-n-n, and I represent Friends of Public Health, which is an advocacy group of local health departments across the state. I also want to put into record a letter of support from the Public Health Association of Nebraska. I have some good news for you today. I'm not going to go through all of my statistics and things that are in my...I know that you guys haven't put in much of a week or anything (laugh), so I'll just talk a little bit about some of the things that haven't been highlighted yet. This isn't a strategy that's going to replace what's already being done in the STD clinics. It's a new innovation that hopefully we can get some more people treated, people that would otherwise not be treated, and that's an important part of public health. If you can prevent more people from spreading the disease, why, do it. In immunization clinics, we talk about the ability to not miss an opportunity. If a child comes in that's a year old and hasn't had any immunizations, you give them everything that they can possibly get that day. This is another example of not missing an opportunity. If we aren't going to be able to access the partners, we need to look at not missing opportunities. This is especially true across the rural areas where people fear the recognition. They may not have access to the services. They have limited capacity to get the services, and the smaller health departments don't have the ability to do the follow-ups that go on. You know, you sometimes just can't reach the

people, and we don't have the capacity to get to them. This would establish more flexibility for the healthcare providers and the patients and the public health people to provide the needed treatment. It's good public health, and it's the right thing to do. Questions? [LB528]

SENATOR CAMPBELL: Thank you, Ms. Oestmann. Questions? I'm going to follow up a little bit about what Senator Gloor asked earlier, Ms. Oestmann. Is there any...I mean, we've got all kinds of statistics here on Douglas County. Have any statistics been done statewide, county by county? [LB528]

KAY OESTMANN: I was hoping you'd ask me that. (Laugh) Yes, there are. [LB528]

SENATOR CAMPBELL: Oh, good. [LB528]

KAY OESTMANN: And we...these are reportable diseases so we all know what the rates are in our counties, and we have those, most of us, on our Web sites. The...I used to do HIV counseling and testing in another life, and I was in rural southeast Nebraska, and I was testing people from Papillion and Lincoln and Omaha and Hastings, and the people from my area were going to Omaha and Lincoln and Hastings (laugh), because everybody knows everybody and everybody knows who their sexual partners are, and it's a geometric progression. We do have sexually transmitted diseases in rural Nebraska, and it is proportional to what goes on in the larger cities. But you tend to have a little bit more monogamy (laugh). There's still sexually transmitted diseases, but we don't have quite the numbers because people tend to stay with their partners a little longer. So yeah, it's out there. We don't have the capacity to follow up like a lot of places do, but this would help. This would help immensely in the rural areas. [LB528]

SENATOR CAMPBELL: Is the data available on-line someplace for all 93? [LB528]

KAY OESTMANN: The data is available on the DHHS Web site, and most of the public health departments have it on their Web sites. [LB528]

SENATOR CAMPBELL: Okay. [LB528]

KAY OESTMANN: If you need it, let me know and I can get it to you. [LB528]

SENATOR CAMPBELL: That would be great. I'm sure Senator Howard will be... [LB528]

KAY OESTMANN: Sure. [LB528]

_____: (Inaudible). [LB528]

SENATOR CAMPBELL: We'll take care of it. But yeah...thank you, Ms. Oestmann. Oh, sorry. Senator Gloor. [LB528]

SENATOR GLOOR: Sure. Thank you, Senator Campbell. Kay, I was pretty confident that we could come up with the numbers of...the actual numbers of sexually...STDs. But going through some sort of formula, coming up with some solid numbers that might tell us, and of these numbers how many do we think have untreated partners. That, to me, is important. I should also say I'm just shocked that the confidentiality would be a problem coming out of a clinics and other places. I'm kidding. [LB528]

KAY OESTMANN: Well, you know, the problem also is that I don't know that they're always treated, you know. I don't know that they seek the treatment. They...if they go to a doctor's office, sometimes they're treated for something different. You know, they don't do the slides. They treat them for a UTI or they...a urinary tract infection, excuse me...or for something else, you know, and give them the antibiotic for that rather than identifying it as a sexually transmitted disease. Our sexually transmitted...our family planning clinics and those kinds of things that identify them in our areas are in their towns maybe once a month. You don't walk in. It's...you know, they don't have the ability to be treated like they do in Omaha and Lincoln and Grand Island, and you know, the larger cities. So, you know, they...I'm sure that there's a lot of people that are out there that are just totally infertile because...or have cancer, or a lot of things that are due to untreated sexually transmitted diseases that just weren't identified. [LB528]

SENATOR CAMPBELL: Senator Crawford. [LB528]

SENATOR CRAWFORD: Thank you, Senator Campbell. And thank you for your testimony and your work. So just to clarify when we're looking at these maps and we're looking at rates in a county, what we're really seeing is the incidence of tests done in that county and not necessarily people who live in that county in terms of rates. Is that true or am I...? [LB528]

KAY OESTMANN: They're coded according to address. [LB528]

SENATOR CRAWFORD: So you are saying... [LB528]

KAY OESTMANN: They're coded according to address. [LB528]

SENATOR CRAWFORD: Oh, it is according to address. [LB528]

KAY OESTMANN: Yeah. [LB528]

SENATOR CRAWFORD: Not according to where the test was... [LB528]

KAY OESTMANN: If the address is given correctly, yeah. [LB528]

SENATOR CRAWFORD: Okay, okay. Okay, so it is more...so if somebody drove from Hastings to Omaha because they were worried about people knowing they were being tested, and were tested and the data gets entered, it does really show up back in Hastings. [LB528]

KAY OESTMANN: It should show up in the regular county. [LB528]

SENATOR CRAWFORD: In the correct county. [LB528]

KAY OESTMANN: Yeah. [LB528]

SENATOR CRAWFORD: Okay, thank you. Thank you. Appreciate that. [LB528]

SENATOR CAMPBELL: Any other questions? Thanks, Ms. Oestmann. [LB528]

KAY OESTMANN: Thank you. [LB528]

SENATOR CAMPBELL: Our next proponent. [LB528]

HEATHER SWANSON: My name is Heather Swanson, H-e-a-t-h-e-r S-w-a-n-s-o-n. I'm testifying on behalf of the Nebraska Affiliate of the American College of Nurse Midwives. We are in support of this largely because we are seeing partners who are pregnant or for GYN care, and it would make it so much easier if there was clarity about how to treat their partners if they're unable to come in, or even if they can come in, be able to treat them then versus waiting for a test to come back on them. And it's more trips for them to come in, so this really does expedite it. Now on my own behalf I do...I think we...there's going to be amendments to this about nurse practitioners and nurse midwives? I'm also...along with being a nurse midwife, and I'm also a family nurse practitioner, there's a...I think I am still personally supportive of this as long as doesn't limit nurse practitioners and nurse midwives being able to prescribe. Not all nurse practitioners are family nurse practitioners. Some are women's health nurse practitioners. So just because they're an NP doesn't mean that men are within their scope. And this expedited treatment in most states allows somebody that doesn't take care of a certain population to be able to write for that population. I've worked in two settings, Indian Health Service on Pine Ridge, which holds the...I don't know if it's something to be proud of or not, but the highest per capita STI rate in the nation; and then also in Texas we have expedited STI treatment. It's very easy to do. They come in. If the woman is positive, we ask them usually to bring their partner in with them so we can treat them then. But the woman, whoever tests positive, then fills out a form of their recent partners within a certain time period. We can treat them then if they're there. If not, then in most of those settings they get somebody from the health department or from the IHS that

goes out to treat them. Now, on Pine Ridge, they get what they call the STI person that comes out, and nobody likes to see them, so they're happy to come to the clinic to get treated. But this system has worked really well in states where I've practiced professionally, and I would encourage support of this. But if there are amendments, ones that wouldn't limit somebody just because of their scope of practice, but to be able to treat the partners, so. [LB528]

SENATOR CAMPBELL: (See also Exhibits 46-49) Thank you very much. I don't see any questions. Thanks for your testimony. Our next proponent. No, it's not (inaudible). Okay. Those who wish to testify in opposition? Those who wish to testify in a neutral position? Okay. I'll urge the committee, as always, to review all the letters that we have gotten. And I appreciate the clerk is now putting these sheets so that we have a clear idea on letters that have been given to us. Senator Howard, would you like to close? [LB528]

SENATOR HOWARD: (Exhibits 44-45) I don't have too much to add, but I just wanted to see if there were any additional questions that the committee might have. We are working on an additional amendment to...and bringing all of the stakeholders together to make sure that everyone is happy with the language. And to Senator Gloor's point, I think if we are able to bring it to the...if I am able to bring it to the floor, I would absolutely look at a county-by-county legislative district-by-legislative district analysis to see which legislators are particularly impacted by chlamydia and gonorrhea in their districts so that we could see a personal stake from every legislator if possible. Are there any additional questions for me? [LB528]

SENATOR CAMPBELL: Any other additional questions, Senator? Thank you, Senator Howard. We will close the public hearing on LB528 and that concludes our hearings for the day. Everybody have a great weekend. [LB528]