HARDIN: Good afternoon. Welcome to Health and Human Services Committee. I'm Senator Brian Hardin, representing Legislative District 48, and I serve as the chair of the committee. The committee will take up the bills today in a really special order. And so in a nutshell, we have a total of 5 testifiers on 3 bills, besides the main bill that's going on today. That doesn't mean the others are less important, but it does mean that in order to accommodate just those 5 people, we're not going to make them stick around a long time. We're going to be operating by 2 different sets of rules today. OK. We're going to use, for the big bill today, which will go last, LB374, will be what is called an annotated committee set of rules. And so what that means is we're, of course, going to go with the invited testifiers first for that. After that, anyone who would like to testify can, all day long. Both the earlier bills and the later one will all be 3-minute testimonies. The group-- the committee can ask more questions if they would like to do so. Let's talk a little bit about logistics today, shall we? Because there are people out in the hallway, and we want to try to keep people as safe and as comfortable as they can be throughout the day. And so, unfortunately, the weather didn't help today. Can I state that? So thanks for coming out here and en-- enduring all of that, as well. But what we're going to do is we march through these first 3 bills, we're also going to ask people, if, if you're not a testifier-- we're going to have, in about an hour, we're going to do some shifting. The spawning of the salmon will happen because we're going to have a room available, OK, in about an hour. There's a committee that will be done by then, in 1063.

_____: 2102.

HARDIN: 2102?

_____: They're, they're having it ready right now.

HARDIN: 2102 it turns out, so thank you. And so State Patrol is doing a wonderful job directing traffic here inside today. And so-- I'm sorry. Clint, do you think they'll be ready in about an hour?

_____: They're going to be ready here pretty soon. They're, they're move-- they're trying to get audio in there right now.

HARDIN: OK. What we would ask is that if you're not planning to testify at the mic today, that we would encourage you to actually go to that secondary room so that we can keep the microphone testifiers

in the room, and then kind of move people through. Let me also just say, if, if you need to do some nursing or anything else like that, my office is down the hall. It's 1402, and you're certainly welcome. Truly, any of you are welcome to go down to my office. It's a good-sized office and it's full of musical instruments. That's an important part of life. And so anyway, with that, let me continue with the rest of these de facto readings I need to share with you. If you're planning to testify today, please fill out one of the green testifier sheets that are on the table at the back of the room. Be sure to print clearly and fill it out completely. Please move to the front row and be ready to testify, and that's kind of why we need some help today. When it's your turn to come forward, give the testifier sheet to the page. If you do not wish to testify but would like to indicate your position on a bill, there are also yellow sign-in sheets on the back table for each bill. These sheets will be included as an exhibit in the official hearing record. When you come up to testify, please speak clearly into the mic. Tell us your name. Spell your first and last name. That's the big piece people usually forget. Spell your name to ensure we get an accurate record. We'll begin each bill hearing today with the Introducer's opening statement, followed by proponents of the bill, then opponents, and finally by anyone speaking in the neutral. We will finish with a closing statement by the introducer if they wish to give one. We'll be using a 3-minute light system for all testifiers. When you begin your testimony, the light on the table will be green. When the yellow light comes on, you have one minute remaining. The red light means we're going to eject you through the top of the Rotunda. No, not really-- indicates you need to wrap up your final thoughts and stop. Questions from the committee may follow, which do not count against your time. Also, committee members may come and go during the hearing. This has nothing to do with the importance of the bills being heard. It just means that we're out actually producing bills in other committees. That's what we're doing. A few final items to facilitate today's hearing. If you have handouts or copies of your testimony, please bring at least a dozen copies and give them to the page. Props, charts or other visual aids cannot be used, simply because they cannot be transcribed. Please silence or turn off your cell phones. Verbal outbursts or applause are not permitted in the hearing room. Such behavior may be cause for you to meet one of our fine, strapping officers here in the room, so don't do that. Finally, committee procedures for all committees state that written position comments on a bill to be included in the record must be submitted by 8 a.m. the day of the hearing. The only acceptable method of submission is via the Legislature's website at

nebraskalegislature.gov. Written position letters will be included in the official hearing record, but only those testifying in person before the committee will be included on the committee statement. I will now have the committee members with us today introduce themselves, starting on my left with Senator Riepe.

RIEPE: Welcome. I'm Merv Riepe. I represent District 12, which is Omaha and the fine little town of Ralston.

HANSEN: Ben Hansen, District 16, Washington, Burt, Cuming, and parts of Stanton County.

FREDRICKSON: John Fredrickson, District 20 in central west Omaha.

QUICK: Dan Quick, District 35, Grand Island.

BALLARD: Beau Ballard, District 21, in northwest Lincoln, northern Lancaster County.

HARDIN: Also assisting the committee today to my left is our research analyst, Bryson Bartels. And to our-- far my far left is our committee clerk, Barb Dorn. Our, our pages for the committee today are Sydney Cochran and Tate Smith. Today's agenda is posted outside the room and is largely useless. Sorry about that. And with that, we will begin today's hearings in this order: LB154, that's mine-- LB274, LB248, LB374. I will read faster than you can possibly imagine, I promise.

FREDRICKSON: All right, Chair Hardin. Welcome.

HARDIN: Thank you, Vice Chairman Fredrickson. And good afternoon, fellow senators of the HHS Committee. I'm Senator Bryan Hardin. For the record, that is B-r-i-a-n H-a-r-d-i-n, and I represent the Banner, Kimball, and Scotts Bluff Counties of the 48th Legislative District. I'm here to introduce LB154, which was brought to me by the Nebraska Hearing Society, NHS. This bill simply clarifies that the cerumen-- that is earwax-- removal in tinnitus care services should be within a hearing instrument specialist's scope of practice. You may remember similar legislation I brought in 2023. It was called LB595-- or 593 and it advanced from the committee. But concerns were raised about a scope of practice and clarification changes that had not gone through the 407 process. So the NHS submitted a 407 application with the language from that bill, with some modifications to address stakeholder concerns. And this bill is a result of that lengthy process. Throughout the 407, NHS worked with stakeholders like the NMA and the Nebraska Speech Language Hearing Association and incorporated

their suggestions and tried to address their concerns. They've increased the educational standards for HIS who wish to perform cerumen management by including a 2-year minimum license requirement and mandatory continuing education specific to cerumen management, as well as at least one of the 12 continuing education hours required annually dedicated to pharmacology updates and infection control measures. They removed all references to tympanometry and oral rehabilitation. They clarified that HIS will only work with individ-- individuals over the age of 18, and made updates to the mandatory referral list so they will refer out anyone who has not had any previous ear surgery-- or who has had any previous ear surgery. And they limited cerumen management to the outer one-third of the ear. Finally, the usage of tinnitus care has been limited to permitting the audiologists who work within the hearing aid manufacturers' audiology departments to also work with those tinnitus makers remotely, as that technology ability already exists. NHS applied for a scope of practice change clarification through the 407 process in July of '23. Following May-- the May 21, 2024, public hearing, the Technical Review Committee recommended not approving the HIS application. On June 10, the credentialing review committee of the State Board of Health reaffirmed that recommendation, and the State Board of Health ultimately voted to not approve the application. However, the third requirement of a 407 process is the report from the Division of Public Health director. In that report, from July 14 of 2024, Division of Public Health Director Charity Menefee provided the following feedback. The purpose of the credentialing review process is to ensure that health, safety, and welfare of the public are prioritized during scope of practice adjustments. This includes walking the line of balancing access for Nebraskans and their protection. Given the recommended scope of practice changes in the proposal and the additional training recommendations I included in this report, she continued, I believe that the criteria will be met to safely adopt this scope of practice change while improving access to these services for many Nebraskans, end quote. I agree with this assessment, and think removing barriers to care for individuals across Nebraska is important. We need to ensure we're supporting the healthcare professionals who already live and work in these communities, not just recruiting new healthcare professionals. This is one way we can do that. This concludes my opening statements for LB154. There will be a couple following me in testimony that are much more familiar with the topic than me, so I encourage you to save your questions for them. Thank you.

FREDRICKSON: Thank you, Chair Hardin. Any questions from the committee? Seeing none, will you be here to close?

HARDIN: Yes.

FREDRICKSON: We will now take proponent testimony. Proponents for LB154. Good afternoon.

SCOTT JONES: Good afternoon, Vice Chair Fredrickson and members of the Health and Human Service Committee. My name is Scott Jones, spelled S-c-o-t-t J-o-n-e-s. I am a board-certified hearing instrument specialist, and I'm proud to have called this my profession for the last 23 years. I'm appearing today on behalf of the Nebraska Hearing Society. I'm speaking today in favor of LB154, which, as Senator Hardin explained, would allow licensed and appropriately trained hearing instrument specialists to perform cerumen removal in some instances and turn on tinnitus maskers and hearing aids with the assistance of the manufacturers. You may be asking what is cerumen? Simply put, cerumen is ear wax, which causes the ear canal to be acidic and inhibits bacterial and fungal growth. It also repels water from the ear, further protecting it from infection. A normal amount of earwax is good for people to have. Cerumen is produced by the sebaceous glands of the hair follicles on the outer half of the ear canal and it naturally flows outward along these hairs. Older adults are more susceptible to impaction due to the decrease in their cerumen-producing glands, resulting in drier and harder wax. So why are we told not to use Q-tips to clean our ears? One of the problems associated with Q-tips is they can push the wax inward, away from these hairs and against the eardrum, and the wax can stick and harden. Not only can Q-tips do this, but hearing aids can also impede the natural movement of wax out of the ear canal. Do many people need to have ear wax removed from their ears? The answer is yes, they do. Ear wax accumulation leads to 12 million patient visits and 8 million cerumen removal procedures annually in the United States. That's approximately 150,000 wax removals in the United States per week. Cerumen impaction is present in approximately 10% of children, 5% of healthy adults, 50% patients who are older in nursing homes, and 36% of patients suffering from intellectual or developmental disabilities. This bill will make the process of obtaining hearing aids more efficient and seamless for consumers, as well as less expensive. There are approximately 371,000 adults in Nebraska with hearing loss. When fitting hearing aids, hearing instrument specialists often have impacted wax removed from the outer ear to properly fit a hearing aid. Presently, many consumers have to unnecessarily be referred to a

physician to clean out the impaction, despite the hearing instrument specialist being able to do so in a safe and effective manner. This referral is costly, unnecessary, and time-consuming for patients. Some patients do not drive anymore and have to pay for transportation to their appointments, which is an additional expense that can be hard on some seniors on a limited budget or on family members who have to transport them, in addition to those who are hesitant about getting hearing aids and may give up completely because of the costs in having to see a second healthcare provider. Research confirms that hearing aids can help to delay and minimize falls, dementia, and depression in older adults. Basic noninvasive cerumen management, because it affects the efficacies of hearing aids, is within the scope of practice for hearing aid specialists. [INAUDIBLE]--

FREDRICKSON: I need you to finish up your testimony.

SCOTT JONES: OK. Just finish reading or--

FREDRICKSON: If you just have a little bit more, you can finish up.

SCOTT JONES: Yeah. Nebraska is a very rural state with a shortage of medical providers, as well as travel burdens and that. And so, we just want to thank Senator Hardin for bringing this forward.

FREDRICKSON: Thank you for your testimony. Any questions? Seeing none, thank you for being here. Next proponent for LB154.

MISTI CHMIEL: Hello, everyone.

FREDRICKSON: Good afternoon.

MISTI CHMIEL: Good afternoon, Vice Chair Fredrickson and members of the Health and Human Services Committee. My name is Misti Chmiel, spelled M-i-s-t-i C-h-m-i-e-l, and I am a board-certified hearing instrument specialist from Grand Island, where I own and operate a small hearing aid business that covers a large section of central Nebraska. I speak to you today on behalf of the Nebraska Hearing Society, as well as the outstate Nebraskans in the communities I serve. I am the current executive director for the Nebraska Hearing Society, a past president of that same society, and a past member of the Hearing Instrument Specialists Licensure Board, where I served for 2 terms and participated in all board positions during that time. The Nebraska Hearing Society and its professional members support LB154 that the proposed scope scope clarification of hearing instrument specialists include cerumen management, more commonly known as earwax

and the use of tuners maskers, which are already built with and many common hearing aids on the market today, or can be bought over the counter or accessed via a smartphone application. This legislation is the result of many years of work, research, engaging with other states about their statutes on the topic, and a 407 review. Our current scope definitions with language from 2004 list words like any parts of a hearing aid, which should cover built in tinnitus maskers, and the term by other means, when referring to hearing testing. We are hoping to better clarify those definitions with this bill. Cerumen management is a practice hearing instrument specialists use every day. It begins when we look in a patient's ear and determine if there is any need for a medical referral. Looking in a patient's ear with a well-lit, well-lit otoscope, or ear camera, tells us immediately if there is even any wax issue to be addressed or not. The revisions included in this bill mandate a professional be licensed for 2 years before sitting for the advanced cerumen removal class, which should garner them approximately 300 hours hands on of just looking in ear canals and observing before they even sit for the class or attempt earwax removal. The ear canal is basically like a circle. Think of it as a clock face. Sometimes the wax is minimal and not in an area that would affect the effectiveness of a hearing aid, say, 9:00 to 3:00. Sometimes, the smallest ball of wax in just the wrong area can continue to plug up a person's hearing aid until it is removed, approximately 4:00 to 8:00. Those are the cases where we would like to be able to remove wax, after finishing appropriate training classes as outlined in this bill. This is a service that both Wisconsin and South Dakota added to their hearing instrument specialists' scope in 2024, Tennessee added in 2021, and the longest established state offering this service, all without incident, I may add, is North Carolina, since 2013. Over the yearlong 407 process, the Nebraska Hearing Society made substantial changes to our application with the collaboration--

FREDRICKSON: If you could wrap up your testimony.

MISTI CHMIEL: --of Nebraska Medical Association and based on feedback from the Nebraska Speech Language Hearing Association and other doctors of audiology. Those changes include removing references to tympanometry and aural rehabilitation, clarifying that HIS only work with individuals over the age of 18, limiting cerumen management and, and removal to the outer one-third of the ear canal, the usage of tinnitus care is limited to preventing the audiologist working in hearing aid manufacturers' audiology departments, working with those devices remotely as that technologically ability exists, made updates

to the mandatory referral list, like Senator Hardin mentioned, meaning patients who have had any previous ear surgery would be referred out for cerumen management. At the end of the process, the director of public health gave us a--

FREDRICKSON: Your red light is on, so I'm going to have you wrap up your testimony, if you would.

MISTI CHMIEL: OK. We appreciate your support of this bill to remove barriers to care for individuals all over the state. And thank you sincerely for your time and consideration today. I would be happy to try and answer any questions.

FREDRICKSON: Any questions? Senator Riepe.

RIEPE: Thank you, Chairman. I guess I like to do things in the least restrictive way. I see this as a possible vehicle to try to get some state involvement, which then will make it ultimately go to insurance companies, which then makes the reimbursement. My own experience is one can go to the local school of cosmetology. And they can-- they do a candling which removes ear wax. I don't see it as real-- this is not heart surgery. I don't, I don't see it as that complicated and so I question then, the necessity for it.

MISTI CHMIEL: What we have found, Senator Riepe, is that-- and you are correct. That actually was a class that was taught at the university at one point in time, ear candling, and I don't believe it is any longer. What they have found through research is usually the wax inside of that candle is from the candle itself. And most of the audiologists and probably even the, the opposition that will speak would agree that they don't recommend that. But as innocuous as it seems to be, it sure had a lot of opposition. And you know, we feel that as licensed individuals, and some of us with many decades in the field, that it should be something clarified in our scope so that we know that it's OK for us to do that.

RIEPE: Thank you, Chairman.

FREDRICKSON: Other questions? Seeing none, thank you for being here.

MISTI CHMIEL: You're welcome. Thank you.

FREDRICKSON: Next proponent for LB154. Seeing no other proponents, we will move on to opponents of LB154. And while we wait for our first

opponent, we had online comments for LB154. We had 4 proponents, 10 opponents, and zero in the neutral capacity. Good afternoon.

CYNTHIA JOHNSON: Good afternoon. My name is Cynthia Johnson, C-y-n-t-h-i-a, last name J-o-h-n-s-o-n. I am an audiologist here in this-- in Nebraska. I've been practicing for 34 years. And full disclosure, I am also the District 1 representative for the Learning Community of Douglas and Sarpy County in Omaha. I am not here representing that group, however. I am here representing my profession of audiology. And specifically, you're getting a let-- you are receiving a letter from the Academy of Doctors of Audiology, of which I am also a member. And I am not going to read this letter to you. It will take me 8 minutes. I timed it, but I'd like to highlight some of the things that both our national and our state associations-- some of the things that we have issues with the bill as it is in its current form. We represent doctors of audiology in the state and the entire country, and we appreciate the opportunity. First of all, LB154 will unfairly restrict the audiology scope of practice. It, it does explic-- explicitly say that it does not. However, it will do exactly that because according to Nebraska Statute 38-512-- sale of instruments, audiologist, applicability of act-- any audiologist who engages in the sale of hearing instruments shall not be exempt from the Hearing Instrument Specialist Practices Act. Therefore, any amendments to their-- this act also directly significantly impacts audiology scope of practice. To conform the legislation with its stated intention not to affect impact or change audiology scope of practice, the repeal of Nebraska Statute 38-512 must be carried out in conjunction with the proposed amendments to-- and there's a list of them-- 38-511, 38-1501, 38-1502, 38-1504, 38-1505, 38-1506, 38-1508, 38-1510, 38-1511, and 38-1514. In addition, the ADA, the Academy of Doctors of Audiology, we do believe the intent of the legislation is to increase access. But this bill is going to have the opposite effect. One of the ADA's most significant concerns is that this, this bill contains significant new restrictions on the sale of hearing aids that, if enacted, will unfairly restrict access to hearing aid services via telehealth. These restrictions will undermine consumer choice, increase prices, and increase wait times for Nebraskans with hearing difficulties. This bill mandates face-to-face testing and imposes prescript-- prescript-- I can't talk-- prescriptive test batteries. And right now, we-- we've got rapid technological changes, as you all know, and we can do very effective remote and hybrid models of care via telehealth. These arbitrary provisions are contrary to LB154's stated objectives. Also, this does not-- the scope does-- is

not aligned with the provisions for their education and training for hearing instrument specialists. It is further amended that-- unless amended, this bill will inappropriately authorize instrument-- hearing instrument specialists to perform cerumen management services and tinnitus care without increasing the requirements in their education and licensing requirements. You've already heard a lot about cerumen management. There are a lot of complications that go along with that, including damage to the external auditory canal, including bleeding, [INAUDIBLE]--

FREDRICKSON: If you could wrap up your testimony.

CYNTHIA JOHNSON: So, I have colleagues that are going to be addressing other issues that we have with this bill. We certainly want to work with the hearing instrument spec-- specialists. They do have a place, but there's a big table and we, we should all have our own chairs. So thank you.

FREDRICKSON: Any questions for the testifier? I have one.

CYNTHIA JOHNSON: Yes.

FREDRICKSON: So you mentioned there's a couple-- a few of the concerns you enumerated, one being sort of the repeal of the statute necessary--

CYNTHIA JOHNSON: Yes.

FREDRICKSON: --for this. Did you-- were you engaged with the process of the drafting of the bill?

CYNTHIA JOHNSON: I was not--

FREDRICKSON: OK.

CYNTHIA JOHNSON: --specifically. Another of our testifiers would be able to answer that question. I do know, though, that in that 504 pro-- 504 or 405?

FREDRICKSON: 407.

CYNTHIA JOHNSON: 407 process. Sorry. See, I was not part of that. Part of that process was the Board of Health did, did vote, I believe, 10-1 on that, that, that they did not approve the-- what-- at that time what they were-- wanted to add. And almost all of that is included in

this bill. So the-- those are the concerns that we have, and just a little bit of scope creep. And we want people to be safe.

FREDRICKSON: Sure.

CYNTHIA JOHNSON: And not, not saying that they can't be, but there's, there's reference to a medical liaison, and that role is not very well defined. What does that mean? Who's the medical liaison? Is it a doctor? Is it a nurse? Is it another audiologist? It just doesn't-- there's just a lot of vagueness in the language that we'd like to see cleaned up.

FREDRICKSON: OK. Thank you.

CYNTHIA JOHNSON: So we're willing to work with the, the Nebraska Hearing Society and, and the International Hearing Society. We have offered to do that, and they're not taking us up on that offer.

FREDRICKSON: OK. Thank you. Any other questions?

CYNTHIA JOHNSON: Any other questions?

FREDRICKSON: Seeing none, thank you for your testimony.

CYNTHIA JOHNSON: Thanks.

FREDRICKSON: Next opponent to LB154.

LEISHA EITEN: Thank you, members of the Health and Human Services Committee, Thank you for the opportunity to speak with you today. My name is Leisha Eiten. It's L-e-i-s-h-a, my last name is E-i-t-e-n. I'm a clinical audiologist. I'm also the director of the Center for Audiology at Boys Town National Research Hospital. I am not representing Boys Town here at the table today. I hold a clinical doctorate in audiology, but I also hold a current specialty certificate in tinnitus management through the American Board of Audiology. I believe that I am able to speak today with some authority and talk to you a little bit about importance-- of the importance of tinnitus care in the state of Nebraska. Of particular concern we have with the is the proposed change of provisions relating to Section 7, subsection (11), which talks about tinnitus care, and Section 8, which defines tinnitus care as devices and maskers used in accordance with recommendations of the audiology department staff of the manufacturer of hearing devices or maskers. That is directly from the proposed bill. As a long-time specialty certified professional in tinnitus

evaluation and management, I do not feel that the above sections as defined are true tinnitus care. What they are talking about is activating a masking sound in a device. It doesn't address the significant safety and health concerns that are often encountered with patients who have bothersome tinnitus. And this is who we're talking about. Setting a device or a masker just based on some manufacturer's staff recommendation or direction, it doesn't address the complex needs of a person with bothersome tinnitus. Am I out of time already?

FREDRICKSON: I think the lights weren't reset, so please continue.

LEISHA EITEN: OK. Because I timed this baby down. They have very complex needs. They have sound tolerance issues. They have complex, severe anxiety and depression. Often, that comes along with it. They have complex pharmacologic and medical histories that all play into that bothersome tinnitus, and suicidal ideation is often of concern when dealing with this population. I also have an additional concern that if tinnitus care is being provided at the direction and the recommendation of a staff person from an out-of-state manufacturer, does that even pose a practice violation from an audiology scope or from the hearing instrument dispensers themselves? I strongly recommend that tinnitus care be removed from the proposed statute entirely. And I would recommend that bothersome tinnitus, however that is defined, would be included as a medical condition that requires a referral, first to an ENT physician and second, to an audiologist who has that appropriate tinnitus training and experience. This is a complex specialty area. For me, this is patient safety and the long-term health of somebody, and it's important. That's my overriding concern. So thank you.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you for being here. Next opponent for LB154. And while we wait for the opponent, I was reminded to state that those who submit online comments are not allowed to testify in person, per the Legislature's rules. Welcome.

KATHERINE GAMERL: Hello. Thank you for seeing me today. My name is Katherine Gamerl, K-a-t-h-e-r-i-n-e, Gamerl, G-a-m-e-r-l. I'm an audiologist from Norfolk, here to testify in opposition. My primary concern is that of the safety and health of Nebraskans. LB154 would expand the scope of practice for hearing instrument specialists with minimal or no additional training to the new areas. Likely, this is one of the primary reasons both the 407 committee and the Nebraska Board of Health recommended against this proposal last year. The

current requirements to become an HIS in Nebraska are age 21 years or older, a high school diploma or GED, 80 hours of clinical instruction, and a passing score on the international licensing examination and on the Nebraska practical examination. The current licensure requirements do not satisfy the health and safety of Nebraskans as the bill is currently written. The legislation expands the scope to include pediatrics, with exception to tinnitus and cerumen management, tinnitus, hyperacusis, psychoacoustics, cochlear implants, and auditory processing disorders, and pharmacology, but it does not expand the pre-- prerequisites of licensure. Audiologists have 8 years of didactic and clinical training in these areas and additional areas of hearing healthcare. Many of these expanded areas of scope require complex evaluations and a deep understanding of the auditory and human systems. LB154 does not include any additional educational requirements for an HIS to safely provide these expanded services. In addition, the current evaluations referenced for licensure do not include this content. Excuse me-- beyond the didactic training of the legislation is vague in regarding to the minimum number of clinical hours to gain experience. The 80-- the current 80-hour requirement is absurd for any healthcare provider to gain an adequate exposure to quality experiences. The HIS should be applauded for adding basic cerumen management training for the 407 and-- but it still lacks pharmacology and educational and supervision working with patients and not ear models. The Academy of Doctors of Audiology letter highlights the effects of cerumen management. Also in the final report, the credentialing review stated that North Carolina and Tennessee allow HIS to pursue-- perform cerumen management. However, the requirements to become an HIS in these states were omitted. North Carolina requires a 1-year apprenticeship and Tennessee requires a 2-year degree, as compared with Nebraskans' 8 hours of clinical instruction-- excuse me-- 80 hours of clinical instruction. Nebraska should strongly consider the implementation of a 2-year or more formal educational degree with appropriate clinical supervision. Thank you.

FREDRICKSON: Wrap up the-- thank you. Any questions from the committee? I have one. What, what changes would need to happen with LB154 to get it to a place where the aud-- audiologists could, could be-- could live with or could agree to?

KATHERINE GAMERL: Yeah. When, when they're talking about testing using an audiometer, in the past, the HIS role is to use that testing for the purposes of fitting hearing instruments. And right now, it's very open ended, which would lead it to be open for these other very specific and-- they're just very specific testing that you need to--

you really need a strong background in, in practical experience performing and you need a strong background clinically, to interpret the test results in order to appropriately come up with a treatment plan that is effective for the patient.

FREDRICKSON: OK. So, so the, the changes that you would like to have seen would be around the educational piece or--

KATHERINE GAMERL: I-- yes. If, if they want to include some of these things, I think we really need to elevate the basic training level--

FREDRICKSON: Sure.

KATHERINE GAMERL: --in which the educational requirements are currently at.

FREDRICKSON: Got it. Thank you.

KATHERINE GAMERL: OK.Thank you.

FREDRICKSON: Any other questions? Seeing none, thank you for being here.

KATHERINE GAMERL: Thank you.

FREDRICKSON: Next proponent for LB154-- or I'm sorry, opponent for LB154. Good afternoon.

NIKKI KOPETZKY: Hi. Good afternoon. Hey. Well, thank you all for the opportunity to testify. My name is Dr. Nikki Kopetzky, that is N-i-k-k-i K-o-p-e-t-z-k-y. I am the only dually licensed audiologist and hearing instrument specialist in the room, and I'm 1 of 3, I think, in the state, so I am uniquely qualified to answer questions on both sides of the coin. I'm also currently the vice president of legislative affairs for NSLHA, the Nebraska Speech Language and Hearing Association. I serve on the board for the Academy of Doctors of Audiology, and I'm also on the Nebraska Hearing Adjustment Specialists Board, although that board has not made an opinion on this legislation. So I am not able to answer any questions from that perspective today, but I did want to fully disclose. So I'm going to highlight some things, because I have also timed my testimony and I know it's longer than my 3 minutes. Basically, the statement of the intent is admirable, expanding the scope of practice to allow access for cerumen management and, and do other things, working with individuals that are over 18, we're in-- that's fine. But the problem

is the language of the bill is misaligned with the statement of the intent. So when you go into the actual language of the bill, we have several problems. Number one, for NSLHA and ADA, for audiologists, is that our scope of practice has that statute that states that any audiologist who engages in the sale of hearing instruments shall not be exempt from the Hearing Instrument Specialist Practice Act. So you're taking changes to this scope of practice and you're applying it to individuals who have doctorate degrees, when the base level of education for a hearing instrument specialist is a GED in the state of Nebraska. So you're actually going to reduce access by limiting what we, as audiologists, can do if you're not careful about separating those scopes. So if you wondered-- to know, Senator Riepe had asked you know, what-- it's just wax. If it was just wax, we wouldn't be here. It's not just wax. We are really talking about the care available to Nebraskans, and so we do need those scopes unlinked. Some other concerns. There's a lot of open and nonspecific language throughout that allows hearing instrument specialists the scope to be misconstrued far beyond cerumen and tinnitus care. The-- and in those spaces, the language does not ensure the proper education and training. Any time you allow someone to do something medically that doesn't have proper education and training, you are risking the health and safety of Nebraskans, which is the opposite of what this committee wants to do. So the education needs to be in place, the training needs to be in place. There needs to be a way to document that training and, and evaluate it to make sure it's correct before you let people loose on the public. Then the language that says that hearing instrument specialists should not work with patients over 18, that's, that's not consistent. That's only listed for tinnitus care and cerumen management. Right now, the way it's worded, you could do full diagnostics on pediatrics. And pediatrics are a special breed that require a lot of advanced training, and a GED education is not going to do it.

FREDRICKSON: That's your, your time, but if you have a few more thoughts [INAUDIBLE].

NIKKI KOPETZKY: I do have a few more thoughts. Thank you. Let's see. The, the-- right now, as it-- so a, a big goal of this legislation is to increase access. But as it's written, when you get into the really meat and nuts and bolts of the bill, there's language that restricts pathways for hearing instrument specialists' education and training. It restricts provider choice. It's requiring tests that are not medically necessary and do not follow any known best practices protocol, which fails to address these concerns and will unnecessarily

reduce provider availability by extending appointment times. And again, you're limiting the audiologists, which is a big problem. Last, and it's already been mentioned, but the State Board of Health voted this down 10-1 because of these reasons. There are so many health and safety risks. In your packet that I gave you, there is a summary here. It's kind of in an Excel format. And if you look at the last column and the reasoning, I bolded every one that's a health and safety risk. It-- it's a numerous amount. So these need to be cleaned up. We would love to be supportive of this legislation. We opened that door. We invited the NHS to come and talk to us and work it out. I said to Scott Jones, who testified earlier, him and I met and I said, hey, before you go to, to legislation with a bill, let us look at it. Let us comment. We would love to be on the same side testifying in favor, but here we are again, with nearly identical language that was shot down by the State Board of Health 10-1. Those are physicians. Charity Menefee, I, I respect her, but she's not a physician. And in a health matter, I think you do need to look at the physicians you've put in place to protect the health and safety of Nebraskans.

FREDRICKSON: Thank you. Any questions in the committee? Seeing none-- I, I, I had one. So you have information here, both from the NSLHA and the ADA. And as you mentioned--

NIKKI KOPETZKY: NSLHA. Yep. I'm, I'm on the board for all of those organizations.

FREDRICKSON: OK. And you-- you're dually licensed. So.

NIKKI KOPETZKY: I am. I had my HIS before I ever had my audiology license.

FREDRICKSON: OK. And I see-- the handouts, there, there are some suggested amendments that you've come forward with.

NIKKI KOPETZKY: Yes. Yeah.

FREDRICKSON: Do you, do you know why those weren't taken into consideration with the bill? Were you given feedback on that or--

NIKKI KOPETZKY: Well, I think it was a timing thing.

FREDRICKSON: OK.

NIKKI KOPETZKY: Because we, we did not know that this bill was going forward. I again had asked Scott Jones to give us a heads up. We

didn't find out until it was read into record on January 13, when our lobbyist informed us. And then the meeting-- the hearing got set. And so we did reach out to Senator Hardin's office. And, and there's been discussion, and I think he is definitely open to that, but we weren't able to get all of that done before this hearing. But we're, but we're very hopeful that that door will remain open so we can find language that would be agreeable to all parties.

FREDRICKSON: Great. Thank you.

NIKKI KOPETZKY: Yeah. Thank you.

FREDRICKSON: Thank you for being here. Other opponents to LB154. Seeing none, anyone here to testify in the neutral capacity for LB154? Seeing none, with that, Senator Hardin, you are-- Senator Hardin waives close. So that will close our hearing for LB154. Thank you.

HARDIN: Thank you. We will move on to LB274. Take us just a moment to shuffle things around. How many testifiers do we have here for LB274? Can I see hands? I see a hand. And it's Mitch's hand. Senator Hunt, when you are ready.

FREDRICKSON: We're ready for you. Yep.

HUNT: Oh, my gosh. I'm sorry. Nobody told me.

HARDIN: Welcome.

HUNT: I don't think my--

HARDIN: Did--

HUNT: I'd like to grab my testifiers--

HARDIN: We see Mitch back there. Do you have another one?

HUNT: --because they've been waiting to be seen, so let me go INAUDIBLE].

HARDIN: OK. How many of you are planning to testify, to skip ahead, for LB374 when that comes up? How many are planning to testify? OK. If there are people here who are not testifying at the mic for that, if we could have you leave from this room to 2022, that would be important for us to be able to bring those testifiers in when we get to that bill. Just a heads up. Also, my office is open, if anyone--

it's a, a far more comfortable room than this, I promise you. So it's 1402, and you're certainly welcome to use that office, too. Senator Hunt, were you able to find those folks?

HUNT: What's that?

HARDIN: Were you able to find the folks you needed?

HUNT: Yep. They're in here.

HARDIN: OK. Great. 2102. I'm told I got that wrong. I'm sorry. 2102 is overflow. My office is 1402, just down the hall, so. And Senator Hunt, welcome.

HUNT: Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. I'm Megan Hunt, M-e-g-a-n H-u-n-t, and I represent District 8 in the northern part of midtown Omaha. And I'm here to present LB274, a bill intended to strengthen liability insurance requirements for licensed childcares. Over the interim, a family that lives in my district reached out to me to share their story of a horrible accident that happened to their then infant child in daycare. When their 6-month-old was at daycare, he was dropped by a staff person and suffered a fractured jaw and a severe concussion. Their little boy, Callaway, has suffered severe medical issues as a result, ever since that unfortunate incident. The Johnsons hired a lawyer, Matt Lathrup, who wasn't able to join us today, but I'm passing out his letter in support. He's been helpful in suggesting some possible improvements to the bill, as well. When the Johnsons and Mr. Lathrop proceeded with their case against the provider, they learned that the childcare had left their liability insurance lapse many, many months before the incident. That resulted in no insurance payout for all of the pain and suffering baby Callaway endured, enormous medical expenses for the family, and the pain, suffering, and stress that his mother and father had to endure in wake of the accident. The Johnson family is here with us today, and I will let them speak to their own story, but that's just a summary as far as how the bill came to me. When I heard from Mr. Johnson about this, we dug into the statutes, thinking we would find something that would have prevented this provider from letting their policy lapse. We found it in our Child Care Licensing Act, applicants for childcare licensure are required to provide proof of liability coverage, and that failure to maintain the required minimum coverage constitutes noncompliance with the act. So at first, we thought, OK, we're already requiring providers to have coverage, so this provider was out of compliance,

right? But discussing more with the Johnsons and their attorney, Matt Lathrop, it became clear that there's nothing beyond the check at the initial licensure to verify that the provider has continued to maintain their insurance coverage. LB274 provides that in addition to the proof for licensure-- excuse me, the proof of insurance to receive licensure, that DHHS shall also check and verify that the provider's liability insurance policies are valid and current. That check can be carried out when they conduct periodic unannounced inspections or investigations of providers that statute already requires. So when they're already going in there to do their inspections, that's when they can make sure that their liability insurance is still updated. LB274 gives a grace period of 3 business days to provide proof that providers have renewed their liability coverage. If the childcare provider shares their proof of coverage within the grace period, they're fine. No problem. Business as usual. If they don't, then the department will temporarily suspend the provider's license. The provider can then have their license restored at any time as soon as they provide proof of coverage to the department. The bill also increases the minimum amount of coverage required, from $100,000 per occurrence to $200,000. This was something that the Johnsons advocated for, saying that after what they experienced, $100,000 is too low. Their son, Callaway, after his fall, had multiple ER visits, back surgery, scans, not to mention the Johnsons' time away from work and having to find childcare for their other child, because Callaway is a twin. So just the back surgery alone for Callaway was over $120,000, so that would not have even been covered by liability insurance had the provider had it. Since the bill's introduction, I've learned a lot more about the challenges facing providers, as well. I know that there's a lot of issues with the insurance market that some providers think that $200,000 of coverage is too onerous, and that's something that I welcome a discussion with the committee about, as we decide how to move forward with this legislation. And finally, I appreciate the DHHS's emailed comments to the committee taking a neutral stance on the bill and relaying that their current practice is the same as what is stated in the bill. Unfortunately, in the Johnsons' case, after finding out that Callaway would be getting nothing due to their childcare provider not having liability insurance, the DHHS licensing department had no idea that this provider was operating without insurance. So this bill would help make sure that they're at least getting these checks to make sure that the insurance is current. I do have another amendment that I wanted to let the committee consider separately that has to do solely with the required coverage amount. That amendment, AM143, was informed by suggestions from the Johnsons'

attorney, Matt Lathrop. First, it adds a requirement for the insurer to notify DHHS within one business day if a childcare provider has had their policy lapse. I didn't put that in the initial draft because I thought it would be burdensome for the department and for insurers to say, you know, if it's been lapsed for one day, you have to notify the department. But Mr. Lathrup pointed out that that's actually not that weird. That's not that out of the ordinary, because there are already requirements in statute for insurers to notify the state-- different state entities if other policies lapse, like worker's comp or car insurance or homeowner's insurance. So that's something to consider in the amendment. Second, the amendment provides that if the provider's license is suspended for failure to prove that they have insurance, they need to post a notice on the building that's readable and obvious so that parents who are sending their kids there can be informed about the situation that they don't have a current liability policy. I brought this bill at the request of a family in my district who has gone through something horrible and who's trying to use this experience to make sure that doesn't happen to anybody else again in Nebraska. I know that childcare providers in Nebraska do their work for the love of children, and they take every step they can to make sure that the children in their care are safe and cared for. I know that providers are dedicated and caring people who would be genuinely heartbroken if anything happened to a child in their care. But-- I won't say but, I'll say and. And at the end of the day, childcare is a business. We cannot lessen or let slide safety requirements because the insurance market is challenging, just as we would for any other state-licensed provider that has a vulnerable population in their care. In reality, running a daycare is a huge responsibility and insurers know it. That's why insurance is so expensive, because it's a risky occupation. This is a business that has to be done right 100% of the time or else bad things can happen. If a company installed fire sprinklers in a daycare and the system didn't work and kids were injured or worse, we wouldn't care if the sprinkler business was being run out of a home or a big industrial warehouse or a corporation or what. All we would care is that people were injured. So I get the problem. You know, daycare is hard to find. Daycare is expensive, but we have to put kids' safety first. So I welcome any questions from the committee. And thank you very much.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. And thank you for being here, Senator Hunt. My question would be and it's a little bit looking back, did the

owner of the childcare center have to file bankruptcy then or was it shielded through some other subcorporation?

HUNT: I don't know. But maybe someone behind me who has experience with that specific case can let you know.

RIEPE: OK. Thank you.

HARDIN: Other questions? Seeing none, will you be with us for close?

HUNT: I think so, yeah.

HARDIN: OK, thank you.

HUNT: Thanks.

HARDIN: Proponents, LB274. Welcome.

JARED JOHNSON: Good afternoon. Good afternoon, Chairperson and members of the committee. My name is Jared Johnson, J-a-r-e-d J-o-h-n-s-o-n, and I am here before you today as a father who has faced an unimaginable challenge. I am here to ask for your support for LB274, an essential measure to ensure greater accountability in Nebraska's childcare system. My son Callaway suffered severe injuries at a licensed daycare facility in Omaha when a worker dropped him onto a hard tile floor. What followed was months of hospital visits, difficult medical procedures, and an uncertain road ahead. To make matters worse, we discovered that the daycare had no liability insurance to help cover the overwhelming costs of his care. No parent should ever have to face such a devastating reality. LB274 is a necessary step to protect children and families. First, there must be immediate mandatory reporting when a daycare's insurance lapsed or is dropped. Parents trust these facilities with their most precious loved ones and deserve full transparency. If a daycare is uninsured, they must be informed without delay. Second, any daycare operating without liability insurance should have its license suspended immediately. Licensed providers have a, have a responsibility to be prepared for emergencies. If they cannot meet this fundamental requirement, they should not be entrusted with the care of children. Third, clear and visible notes must be posted in all daycare facilities when insurance coverage is missing or has lapsed. Parents should have-- should never have to wonder if their child's daycare is adequately insured. A simple, prominently displayed notice can make all the difference in ensuring families make informed choices. This is not just policy. It is personal. My family is dealing with medical bills exceeding

$175,000, with costs continuing to rise. My son is facing lifelong medical challenges, brain injury, a fractured jaw, a vertebral wedge fracture, hearing loss, and development-- developmental delays. The current law, with its $100,000 minimum coverage, is simply not enough to support families in a situation like ours. LB274 is not just a piece of legislation. It is an opportunity to prevent this from happening to another child and another family. We need stronger protections, clearer enforcement, and real accountability. We can't wait until another child, your child, or your grandchild is injured or even killed to act. LB274 ensures that no parent is blindsided when the worst happens. I urge you to take action, strengthen, and support LB274 to ensure that no Nebraska family has to endure what mine has. Thank you for your time and consideration. I'm happy to answer any questions.

HARDIN: Sorry for the challenge.

JARED JOHNSON: Thank you.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you. Thank you for being here and for sharing your dreadful story. Do you happen to know off hand when the $100,000 limit was set? Has that been 5, 10 years ago, or-- do you happen to know or is a question for someone else?

JARED JOHNSON: I think that was set back in 2017.

RIEPE: '17?

JARED JOHNSON: Yeah.

RIEPE: Not way, way back. OK. But today's healthcare costs, that doesn't go very far.

JARED JOHNSON: No.

RIEPE: Again, thank you very much, sir.

JARED JOHNSON: You're welcome.

HARDIN: Other questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for, for being here and, and sharing your story. I'm, I'm very sorry that that, that happened to your family.

JARED JOHNSON: Thank you.

FREDRICKSON: You know, I think as, as a parent of a young child myself, you just assume your childcare facility is, is covered. I would never even imagine that it, that it wouldn't be so-- yeah. Thank you for being here and your--

JARED JOHNSON: Thank you.

FREDRICKSON: --willingness to share your story.

JARED JOHNSON: Thank you.

HARDIN: We just looked. It was since 2013.

RIEPE: '13?

HARDIN: 2013.

RIEPE: OK. So 17 years [INAUDIBLE].

HARDIN: Senator Quick.

QUICK: Thank you, Chairman Hardin. So were you able to recoup any at all? Anything from the daycare center to help with the expenses or from anywhere else or--

JARED JOHNSON: With the help of our lawyer, Matt Lathrop, we went to mediation and we got a little bit, but not enough.

QUICK: Yeah. OK. All right. Thank you.

HARDIN: Other questions? Seeing none, thank you.

JARED JOHNSON: Thank you.

HARDIN: Other proponents, LB274. Welcome.

KAELA JOHNSON: Thank you. Good afternoon, Chairperson, members of the committee. My name is Kaela Johnson, K-a-e-l-a, and then Johnson, J-o-h-n-s-o-n, and I'm here today to urge your support for LB274, a critical measure to strengthen accountability in Nebraska's childcare

system. My son Callaway suffered catastrophic injuries at a licensed daycare facility in Omaha when a worker dropped him onto a hard tile floor. He was only 6 months old. What followed was every parent's nightmare: months of hospital visits, painful medical procedures and an uncertain future. And to make matters worse, we discover that the daycare had no liability insurance to help cover the enormous costs of his care. LB274 must include strict enforcement measures to prevent other families from enduring this kind of financial and emotional devastation. First, we must require immediate mandatory reporting when a daycare's insurance lapse or it's dropped. A childcare facility should not be able to continue operating in the dark, hiding the fact that it has no financial protection in place for children in its care. If a daycare is uninsured, parents deserve to know immediately. Second, any daycare that does not maintain liability insurance should have its license suspended without delay. Operating without insurance is not just irresponsible, it's reckless. Families trust licensed daycare providers to be prepared for accidents. And if a provider cannot maintain the basic requirement of insurance, they should not be entrusted with the care of vulnerable children. Third, we need clear and prominent notices posted in all daycare facilities where insurance coverage is missing or has lapsed. Parents have a right to know if they're placing their child in an uninsured facility before tragedy strikes. A simple sign at the entrance can make the difference between an informed decision and a financial disaster. The consequences of these failures are not theoretical. My family is living proof of what happens when a daycare is allowed to operate without accountability. My son's medical bills have already surpassed $175,000 and contin-- and continue to accrue. His injuries, including a brain injury, a fractured jaw, a wedged vertebrae, hearing loss, and developmental delays will require a lifetime of medical care. The $100,000 minimum coverage required by current law is grossly inadequate, even in cases far less severe than ours. This is not about convenience for providers. This is about protecting children and their families from financial ruin. LB274 is a step in the right direction, but it must have teeth. Immediate reporting, automatic suspension, mandatory parent notifications are essential to ensuring that no other Nebraska family suffers the way that mine has. I urge you to strengthen and pass this bill to protect children and hold daycare providers accountable. I hope Callaway's story can be a catalyst of change for the childcare system. Thank you for your time and consideration. I'm happy to answer any questions.

HARDIN: Thanks for being here.

KAELA JOHNSON: You're welcome.

HARDIN: Questions? Senator Quick.

QUICK: Thank you Chairman Hardin. And I just wanted to apologize because I, I didn't express my, my sincere-- it had to be devastating for you. And I, I apologize to him, too, because it's-- you know, we had children who went to daycare and we have grandchildren that go there. And we want the best care we can for them to make sure they're safe.

KAELA JOHNSON: Yeah. It's the hardest decision you have to make is who's going to take care of your children when you're not there. So-- but we hope that in the future we can help other children, so that way they're safe and this isn't an issue for anybody else because this is a nightmare. And I don't want anybody else to ever have to experience this.

HARDIN: Questions? Thank you.

KAELA JOHNSON: Thank you.

HARDIN: Proponents, LB274. Proponents. Hello, Mr. Lindsey.

JOHN LINDSAY: Good afternoon. Not moving as fast as I used to.

HARDIN: You are moving as fast as it matters.

JOHN LINDSAY: Senator Hardin, members of the committee. My name is John Lindsay, L-i-n-d-s-a-y. I'm appearing as a registered lobbyist on behalf of the Nebraska Association of Trial Attorneys. I should start out saying this. We did not bring this bill to Senator Hunt. This bill came from exactly as she described it, from the Johnsons, her constituents coming forward. We, we, of course, saw the bill and support it because it's right up our alley. But I'm glad you all got a chance to, to hear from the Johnsons. I just got a chance to meet them before the hearing. And that is when we-- well, you've seen me come up here before. And when, when we testify. I know it seems to be it's about NATA. It's about the lawyers. And it's not. It's about the Johnsons. It's about people over at the tort reform hearing in Judiciary Committee. And it's about people who've been hurt through no fault of their own. For the Johnsons, they, they-- from what I heard they're-- you can, you can imagine the pain of a hurt child. And then the medical bills start coming. And whether it's covered by your health insurance or not and I don't know if theirs is, you still got

co-pays, deductibles. This committee hears that stuff all the time. And you hear all the time about childcare facilities because it's in your jurisdiction. And I think it's important in this particular bill, the requirement of, of having liability insurance is the, the-- the good, good side of liability insurance is that the insurance company is at risk. And if the insurance company is at risk, they are going to do what's in their best interest, which is try to lower the liability. They, they may look at that facility and say, hey, we can suggest these improvements to your, to your protocols to improve safety of, of children. They have experience in it and provide that advantage. Ideally, any accidents of this type are prevented. That's what we would hope. But in any event, our association supports this legislation. It's important to maintain auto liability insurance. You don't just do it when you register. You need to have it all the time. That's all-- I think that's all that Senator Hunt is asking for here is just have it all the time, not just when you get your license. And then, of course, it's up to you to determine the amount of insurance. And I guarantee you see a lot more medical bills in this committee than, than I would in whatever I do. And, you know, though, that $100,000 [INAUDIBLE]--

HARDIN: [INAUDIBLE] up to the red, so.

JOHN LINDSAY: Thank you.

HARDIN: Yes, thank you. Any questions? Seeing none-- Senator Riepe.

RIEPE: Thank you. I had my trusty staff take a look at-- based on $100,000 in 2013, that would be-- at 6% inflation, and healthcare has been higher than that. It would -- on a quarterly basis it would be $192,500. And annually, it would be about-- so the $200,000 would be the same as in 2013. So then the question remains, is that still enough? I don't know. I just thought I'd want to get it into the record.

HARDIN: My understanding it's $1 million in Colorado.

RIEPE: It wouldn't probably fall below that much in Nebraska, over a lifetime.

HARDIN: Yeah. Seeing no other questions. Thank you, sir.

JOHN LINDSAY: Thank you.

HARDIN: Any other proponents, LB274? Proponents. Opponents, LB274. Opponents,LB274. Those in the neutral for LB274. Mr. Clark.

MITCHELL CLARK: Chairman Hardin.

HARDIN: Welcome.

MITCHELL CLARK: Thank you. Chairman Harmon-- Hardin and members of the Health and Human Services Committee, my name is Mitchell Clark, M-i-t-c-h-e-l-l C-l-a-r-k. I am a policy advisor for First Five Nebraska, a statewide public policy organization committed to the early care, education, and development of our youngest children. I am here to testify in the neutral capacity on LB274. I would like to start by thanking Senator Hunt for her responsiveness to childcare providers on the issues they face with finding and maintaining liability insurance. I would also like to express my deepest sympathies for the Johnson family for what they went through. Liability insurance is a crucial protection for children and the providers that care for them. Recognizing this, as you've all heard today, the state currently requires licensed providers to maintain liability insurance of at least $100,000 per occurrence. The most common insurance policies in Nebraska for family childcare homes are $100,000 per occurrence, $300,000 aggregate. For childcare centers, the most common policies are $1 million per occurrence, $3 million aggregate. I will note that specific coverage amounts depends on a variety of factors, such as license type, capacity, age of the facility, et cetera. In the past couple of years, childcare providers in Nebraska have reported a spike in premiums far beyond generally sustained increases. They have also reported more stringent underwriting requirements, leading to an uptick in denials and nonrenewals. This is part of a national trend in the childcare industry, even for those that haven't submitted any claims. Last year, First Five Nebraska worked with Senator Hardin to introduce LR429, and I have also distributed a brief on that study-- an interim study that examined the availability and affordability of liability insurance for childcare providers. Although we were unable to uncover data on premium increases, we received reports from numerous providers across the state. The National Association for the Education of Young Children also conducted a nationwide survey last year, in which 80% of respondents reported a market increase in premiums, with one-third of respondents reporting denials or nonrenewal due to insurance carriers dropping out of the market. Childcare, as you heard today, is a high-risk industry. The majority of providers take the utmost care to provide safe, high-quality environments. However, when these tragic

incidents occur, as, as happened to the Johnson family, those, those incidents demonstrate a need for ensuring coverage. However, raising the preoccurrence requirement from $100,000 to $200,000 would have an impact on the affordability of insurance coverage, particularly for licensed family childcare homes, at a time when affordability continues to be a barrier, a barrier. I would again like to extend gratitude to Senator Hunt for her responsiveness to providers on this issue and being open to their discussion. Thank you for the opportunity to testify. I would welcome any questions you may have.

HARDIN: Thank you. Questions? And we will continue to endeavor in those LR activities, won't we?

MITCHELL CLARK: Indeed. We appreciate it very well.

HARDIN: Thank you. Appreciate you being here.

MITCHELL CLARK: Thank you.

HARDIN: Anyone else in the neutral? Seeing none, Senator Hunt. Welcome back.

HUNT: Thank you, sir. Thank you to the gentleman of the committee. I think you guys pretty much get the gist. It, it makes no sense that we require daycares or any business that's required to have liability insurance to get their license to never, ever, ever, ever go back and check that they have the insurance. You know, I, I own a couple businesses. We have to have $2 million in, in insurance to rent the spaces that my businesses are in. And if that lapses, my landlord knows about it. And so-- I'm not even caring for a bunch of infants every day. So I think that we just need to hold childcare providers to the same standards that we hold other businesses. Because at the end of the day, it is a business and they are caring for some of the most vulnerable people in our state. And we see when something goes wrong, you know, it's not like shoplifting or vandalism. It can be something devastating. It can be something that shatters the world of an entire family. So I would be happy to take any other questions, and can always talk more on the floor, as well, about this. So thank you.

HARDIN: Thank you. Questions? Seeing none, thank you.

HUNT: Thank you, guys.

HARDIN: This ends the LB274 testimony and hearing for the day. Next up, LB248, Senator Sanders. Oh, I'm sorry. Online comments, we had, for LB274, 4 proponents, 4 opponents, zero in the neutral. Welcome.

SANDERS: Thank you very much. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. I am Rita Sanders, R-i-t-a S-a-n-d-e-r-s, and I represent District 45, which encompasses much of Bellevue and the Offutt community. LB140 [SIC] addresses the intersection of childcare regulations and federal programs for military families. The Child Care Licensing Act has long ensured high standards of care for children in Nebraska. However, it's time we recognize that Department of Defense, DOD, childcare standards are not only comparable to Nebraska's, they are most-- more often stringent-- stin-- strin-gu-ent [PHONETIC]--

FREDRICKSON: Stringent.

SANDERS: Say it, after me. For military families, childcare programs on federal properties are already held in rigorous DOD requirements. To avoid unnecessary duplication, this bill will exempt certain federal childcare programs from Nebraska's licensing requirements while still ensuring the highest standards of care. This change will reduce burdens on military families and providers who already are meeting the comprehensive federal regulations. This bill doesn't affect childcare programs outside the military. It is simply-- streamlines regulations where federal standards are already-- already apply, making life more efficient for our families, service members and their families, ensuring military families have the streamlined, high-quality care they deserve while maintaining our state's commitment to childcare excellence. Following me is a representative from Offutt Air Force Base, my one invited guest, who will speak on this bill. Thank you very much. And I invite Lieutenant Colonel Andersen.

HARDIN: Thank you. Questions? Seeing none.

SANDERS: Thank you.

HARDIN: Proponents, LB248. I bet you are Colonel Andersen.

JOSEPH ANDERSEN: I don't know what gave it away. Thank you for having me today. Good afternoon. My name is Lieutenant Colonel Joseph Andersen, J-o-s-e-p-h A-n-d-e-r-s-e-n, and I am proud to serve as the commander of the 55th Force Support Squadron at Offutt Air Force Base.

As the commander of the 55th Force Support Squadron, I've seen firsthand the challenges that military families face in accessing quality childcare, and that's why I'm here to provide testimony for LB248. As the commander of the Force Support Squadron, I'm responsible for the team that cares for the human capital of the 55th Wing, U.S. Strategic Command, the 95th Wing, the 557th Wing, and numerous tenant units on Offutt Air Force Base. This includes human resources, education training, manpower and organization, morale, welfare, recreation, the honor guard, casualty assistance, and traveling youth programs. At the core, my mission is to take care of people so the installation can execute its mission on time and on target. One of the programs that falls under my child and youth programs portfolio is the Family Child Care program. This Department of Defense accredited program expands childcare opportunities for airmen, soldiers, sailors, Marines, guardians, and their families, while providing a source of income for military spouses who frequently move. Family childcare providers are able to serve the community, care for their children while caring for others, work from home, and be part of a network of peers, provide coaching, mentoring and on-the-job training for the United States Air Force. I've seen the impact of this program firsthand. At my previous assignment at Minot Air Force Base, North Dakota, we had over 25 family childcare providers operating on base and in the surrounding community. These providers were a force multiplier for the installation and the families, providing care where there are gaps. They offered childcare for exceptional family member respite care, permanent change of station care, after duty care, and smaller classroom ratios that better suited some children's needs. Unfortunately, Offutt Air Force Base doesn't have as robust of an in-home care network. This is in part due to the state of Nebraska's requirement that family childcare providers hold a state license in addition to their Department of Defense certification. This additional requirement has driven family members to drop out of the Department of Defense certification process, as it requires them to operate in 2 realms. They have to meet the criteria for Nebraska while also meeting the Department of Defense criteria, complete 2 inspections, and accomplish 2 applications and 2 trainings to achieve the same goal. LB248 is a critical step toward addressing this challenge. By removing the dual licensing requirement, we can increase the number of family childcare providers and expand childcare opportunities for military families. This will help Offutt Air Force Base tackle the growing childcare availability crisis and ensure their airmen, soldiers, sailors, Marines and guardians have access to quality care for their children. In my experience, family childcare providers are some of the

best childcare providers I ever met. Build programs they're proud of and invest in the children are key components of the community mission. LB248 will allow us to grow our childcare workforce and provide service members more options for childcare amongst their peer families. Thank you for your time and consideration.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you, Colonel, for being here.

JOSEPH ANDERSEN: Yes, sir.

RIEPE: I, I think you talked it-- correct me where I'm wrong here. You talked about removal of dual application processes?

JOSEPH ANDERSEN: Yes, sir.

RIEPE: Does that also-- then the standards are also duplicated?

JOSEPH ANDERSEN: Yes, sir. There's different standards for the state of Nebraska and the Department of Defense. The standards for the Department of Defense are usually more strict.

RIEPE: Which ones are stricter?

JOSEPH ANDERSEN: The Department of Defense.

RIEPE: OK.

JOSEPH ANDERSEN: So, for example, our trainings are more comprehensive. Our liability-- our minimum liability insurance is 5 times as large as Nebraska. Our initial training is 4 hours, compared to Nebraska's 12 hours. We do monthly unannounced inspections on the homes, whereas Nebraska does them annually. We do health, safety, fire, multi-disciplinary, and higher headquarters, my boss's boss's boss's boss, they come to Nebraska once a year and they will inspect the homes, also. We have smaller ratios, whereas Nebraska allows more kids inside the home. So we have much stricter requirements on our end.

RIEPE: It sounds like you're running a little boot camp.

JOSEPH ANDERSEN: No, sir.

RIEPE: OK. Thank you. Thank you, Chairman.

HARDIN: Other questions? Seeing none, thank you for being here.

JOSEPH ANDERSEN: Thank you for your time.

HARDIN: Yes. Other proponents, LB248. Proponents? Any opponents, LB248? Any in the neutral, LB248? Seeing none, Senator Sanders. Online, we had 2 proponents, zero opponents, and zero in the neutral. And she waives. Thank you. We are up to LB374 and Senator Hansen. Welcome.

HANSEN: Thank you, Chairman Hardin and members of the HHS Committee. Before I even begin-- gentlemen, you know that a lot of the bills that I bring in front of the HHS committee sometimes questions your notion of what is normal. This is going to be the easiest one for you of all the bills I've brought. My name is Ben Hansen. That's B-e-n H-a-n-s-e-n. I represent District 16, and I want to thank you for the time this afternoon. As you can tell, the bill I'm presenting today is a popular topic, not only for the people in my district but in yours, as well. LB374 creates licensure for certified professional midwives, a profession recognized by 37 other states. These midwives practice around the country in birth centers and homes, providing quality care in-- to women and babies. I brought AM152 to clarify that we are discussing professional midwives. I also didn't want to mandate coverage by insurance companies, so AM152 addresses this. I also want to mention that I'm working with the Nebraska Hospital Association to clear up some language that may address any liability issues and to clarify that professional midwives don't claim authority in the hospitals. I've been hearing from people all over the state in support of LB374. The support has come from parents, mothers, doctors, NICU nurses, EMT responders, professionals, professional attorneys, social workers, and many more. One NICU nurse said she has been working in the hospitals for 36 years, but she had all 4 of her kids at home. Some of the greatest support comes from Nebraska's certified nurse midwives, these midwives that are already trusted and licensed in Nebraska working in our hospitals. They also recognize the qualifications of their fellow midwives who are certified professional midwives. You will hear from certified professional midwives today, but something you should keep in mind is that this is not a new concept. This is not an experiment. Medical communities, governments, HHS departments, cultures, religions, and lawmakers all across the country find what we will be discussing today as normal. Planned home births have increased by 60% over the past 7 years in the United States. According to the Journal of Pediatric Medicine, the number of home births reached 46,918 in 2023, the highest in 3 decades. LB374 is

modeled after our neighboring state, Iowa. They created licensure for certified professional midwives in 2023, and are finding great success. These midwives are trained, skilled, and certified through nationally-credentialed entities. With 74 Nebraska would become the 39th state recognizing certified professional midwives as knowledgeable and skilled maternity care providers. CPMs receive certification from the National Commission on Certifying Agencies with standards that are consistent with the standards for educational and psychological testing. These same standards are applicable to all professions and industries, including nurses. Their certification options are respected nationally and recognized by the State Department of Education. So not only is this common in the United States, it is educated. Students demonstrate knowledge in clinical or didactic settings for over 800 topics related to birth: skills exam, a 7-hour written exam, over 100 prenatal exams, 55 births, 40 newborn exams, 40 postpartum exams, under the supervision and evaluation of a qualified preceptor. Most importantly, identifying risks throughout their pregnancy is a large part of their studies. I know that's kind of a concern, a lot that I've been hearing from the opposition is that they don't have the ability to, to recognize when something is outside of their scope and how to refer them. But identifying risks throughout their pregnancy is a large part of the studies. Currently, with more than 2,857 active credentials, 1 in 5 midwives in the United States is a CPM. National Library of Medicine Studies aligned with the National Academy of Medicine to find that planned home births have outcomes comparable to birth center deliveries for low-risk birth. Professional midwives not only nurture normal birth processes, but are trained in risk assessment. Every CPM must have an informed consent document that details her relationship with referral physicians. Home births are legal in Nebraska, with close to 100 births a year. In 2016, the state even had a proclamation stating that home births are a parent's right and that they are a safe option. In the opposition, you'll hear concerns. You will hear medical personnel saying that professional midwives aren't trained, that they aren't responsible, that Nebraska should be concerned. But I would point, I would point you to the handout that I provided you earlier. You'll notice that more states have licensed professional midwives over the years, not less. You will also find that the training is nationally accepted as reputable, and the education required in LB374 is consistent with other states. In most of the other states, home birth and licensed professional midwives are influential and respected in the birthing communities. Medical personnel work with professional midwives, not against them. Professional midwives work with the doctors, sending clients to them

in cases of high risk. It is time Nebraska catches up. There will be people following me who are more knowledgeable about professional midwives. I have worked with the National Association of Certified Professional Midwives, North American Registry of Midwives, and the Nebraska Affiliates of the American College of Nurse Midwives to craft this bill. I will answer any questions to the best of my ability, but the professional midwives following me might have more insight. With that, I thank you for your time and I ask for your support of LB374. Thank you.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you, Senator Hansen, for being here and for your bill. Can you help just educate the committee a little bit? I know there's 2 separate bills that you're bringing related to-- I want to say it right-- mid-- midwifery, I think is the correct word.

HANSEN: Your favorite term that you've learned, yeah.

FREDRICKSON: Midwifery, yeah.

HANSEN: Midwifery.

FREDRICKSON: So I-- there's-- I know this bill, as I understand it, is with CPM, certified professional midwives. There's also a second bill, as I understand, for--

HANSEN: Certified nurse midwives.

FREDRICKSON: --nurse midwives. Can you differentiate those two for the committee a little bit or educate us a bit on the difference between the two?

HANSEN: In a nutshell, and some people behind me might be able to explain it better. Certified nurse midwives are the ones that work in or with the hospital and birthing centers. Certified professional midwives will be more with home delivery.

FREDRICKSON: Got it. OK. And are you able to speak more to the training requirements for a CPM?

HANSEN: Yeah, like the CPMs?

FREDRICKSON: Yeah.

HANSEN: In general?

FREDRICKSON: This one, yeah.

HANSEN: The handout has actually some better-- it's right there in that green section on the left, on-- yeah, on the left part. That explains a lot of the, the training right there for you.

FREDRICKSON: OK. OK.

HARDIN: Any other questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you, Senator Hansen, for being here. You had said 60% increase in-- was that home deliveries?

HANSEN: Yes.

RIEPE: When you were starting. Do you know what percentage of all deliveries-- do you know this-- are home deliveries? Say in a given year, like 20-- any 12-month period of time?

HANSEN: I do have that information.

RIEPE: You have a big notebook there.

HANSEN: Yes. I like to have as much as I can. What percentage?

RIEPE: I was just, I was just trying to get some feel for the magnitude of it, whether it's-- I'm also concerned with is it trend-- obviously, it, it appears it's trending somewhat because of the number of states that are involved.

HANSEN: Yes.

RIEPE: But I'm just--

HANSEN: If not, I'll get there in my closing, or I can get it to you afterwards, one of the two.

RIEPE: OK. I'm just concerned whether it's 5%, or 10 or 8 or whatever. Thank you. Thank you, Chairman. Thank you.

HANSEN: Thank you.

HARDIN: Other questions? Senator Ballard.

BALLARD: Thank you, Chair. You cr-- the proposed bill creates a board under midwife-- midwifery.

HANSEN: Midwifery.

BALLARD: Midwifery. What is the board responsible for?

HANSEN: Similar to what other kind of boards, like the Board of Dentistry, the Board of, you know, Cosmetology. You know, all the different kinds of boards that we have, it's kind of the oversight and current rules and regulations, training when it comes to mid-- midwifery, the certified professional midwives, for instance, and more of a kind of an oversight approach.

BALLARD: OK. So it will still be regulated by the department. It's not a--

HANSEN: That's my understanding, yes.

BALLARD: OK.

HANSEN: Just like-- it's, it's still in the Uniform Credentialing Act.

BALLARD: Yes.

HANSEN: So just like all those other ones that are in there.

BALLARD: Yeah, of course, of course. OK. And then can-- if-- I have one more question, if I may. So if, if an individual opts not to give birth in a hospital, is there other avenues besides-- or is it hospital-- because I know Lincoln had a birthing center. So the-- would this be your only other option, this home birth, besides a hospital?

HANSEN: Home birth, yeah, birthing centers. I mean, one of the goals is to-- I think that might be more to the certified nurse midwives bill that we have coming up here.

BALLARD: OK.

HANSEN: Probably-- I don't know when we have it scheduled, but sometime soon here. [INAUDIBLE] we discuss that a little bit more about birthing centers, their affiliation with hospitals, certified nurse midwives. I think that's kind of a direction we would like to increase, as well.

BALLARD: OK. Thank you.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair. Thank you for pointing me out to the handout I, I saw in there a little bit-- so my understanding from the handout is that part of the training is the requirement of, of attending or observing 55 births. Is that your understanding, as well?

HANSEN: Yes.

FREDRICKSON: OK.

HANSEN: A writ-- 7-hour written exam, 100 prenatal exams, 55 births, 40 newborn exams, 40 postpartum exams--

FREDRICKSON: OK.

HANSEN: --under the supervision and evaluation of a qualified preceptor.

FREDRICKSON: OK. So, so one concern I might have is your typical OB-GYN, by the time they're done with their training, typically deliver around 1,000 babies. There seems to be a really big discrepancy between the two there. Do you have any thoughts on that?

HANSEN: I think a lot of it is in the scope of practice, as well, of what an OB-GYN can do and a, and a midwife cannot do. And that's where a lot of that training comes into, you know, effect, especially when it comes to more emergency management--

FREDRICKSON: Sure.

HANSEN: --which is what we're hoping-- the whole goal is to have, which I think we do already, but in writing, CPMs now are qualified, regulated, licensed to recognize those kind of instances and send them then, to the appropriate healthcare professional to address those emergency management situations in which they're trained in.

FREDRICKSON: Sure.

HANSEN: Right? Midwives, midwives aren't trained to deal with-- do C-sections. Right.

FREDRICKSON: Sure.

HANSEN: They need to recognize when that needs to happen and send them to the appropriate person--

FREDRICKSON: OK.

HANSEN: --which is what all their training is about.

FREDRICKSON: OK. And I also see here that there's the-- with the CPM, 6 weeks postbirth care. Can you tell me more about that?

HANSEN: Let's see. It's-- that, that-- we have that in the bill here. It's just their ability then, to kind of follow up with the child, make sure that they're healthy and happy, all that kind of stuff. Again, recognizing issues that are not within their scope, saying, hey, look, there might be concern that I have with this child. I would refer them to go see their pediatrician. All right.

FREDRICKSON: OK.

HANSEN: Where a parent might have questions about that-- I think that just creates another avenue, especially in kind of rural parts of Nebraska--

FREDRICKSON: Sure.

HANSEN: --where they may not have those avenues.

FREDRICKSON: Sure.

HANSEN: They can recognize this kind of stuff and then direct them where they need to go.

FREDRICKSON: So that's more of like a consultation, in tandem with like a pediatric type of setting or--

HANSEN: Yes.

FREDRICKSON: --so it would be-- OK. My last question is, I see in the bill, too, authorization to administer various drugs, including misoprostol. I know we have a bill in here next week that's looking to strongly regulate that drug.

HANSEN: You might be thinking of mis-- mifepristone--mifepristol-- mif-- mifepristone.

FREDRICKSON: No, I'm thinking-- there's, I think, both, mifepristone and--

HANSEN: Misopristol?

FREDRICKSON: --misopristol, yeah.

HANSEN: Yeah. From my understanding-- again, somebody after me might be able to answer these questions better. But this is more the-- I-- they're not able to prescribe them, but they're able to use them in an emergency setting if they need to.

FREDRICKSON: OK. So--

HANSEN: If they're in rural Nebraska and you have somebody hemorrhaging, and your next pediatrician is an hour away--

FREDRICKSON: Right.

HANSEN: I mean, they need to have some kind of ability to handle the situation. Again, somebody behind me will be able to answer that a little bit better.

FREDRICKSON: OK. So on-- so with that assumption-- so would you agree it would be safe-- that misoprostol is a, is a safe drug to utilize?

HANSEN: Depending on the situation.

FREDRICKSON: OK. But we're saying someone who has not been board-certified could administer this.

HANSEN: I would have to know the administration of it--

FREDRICKSON: OK.

HANSEN: --to answer that question better.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Riepe.

RIEPE: You're able to see out of the corner of your eye.

HARDIN: I raised children, too.

RIEPE: Thank you, Mr. Chairman. I don't want to wordsmith too much, but in the documents, it refers here, it says, according to the "appropriate" standard of care. I would, I would like to see stronger language there that says "established" standard of care. "Appropriate" seems to me maybe more judgmental, and I think that's dangerous in the healthcare business.

HANSEN: Yeah. And just like working with the Hospital Association to clean up liability language, I'm willing to work with anybody to see what kind of language we need to clean up-- to improve the bill. So I'm not, I'm not against that at all.

RIEPE: And I know the providers are wanting to provide the best care they can, too. There's, there's no malpractice interest here. Thank you very much. Thank you, Chairman.

HARDIN: Senator Quick.

QUICK: Thank you, Chairman Hardin. So one of my concerns is, I guess-- of course, my wife, Alice, was a labor and delivery nurse for 44 years, so she saw a lot of deliveries. I think she was in on maybe 40-50,000 deliveries throughout her career. So-- and one of the things that-- when I've talked to her about maybe this type of bill, she understands that maybe women want to have their births at home. But when there's-- she's seen a-- she's seen, seen a lot of situations where things go wrong, you know, and it's not something that you can preassess before the delivery happens. So one of my concerns is it's not just the care for the mother, but after the baby is born, sometimes they have to go right to-- have a, have a nurse there, just to care for the baby. And then you have the nurse that's caring for the mother. You might have two nurses caring for the mother and one for the baby. So did they-- is there-- did that-- are they going to have that ability to make sure that they can take care of both? Because at some point, they may have to be trying to care for both.

HANSEN: That might be a better question for somebody after me. And I have the statistics on the difference between home birthing and births in a hospital, which I can allude to later, but that might be a better question for somebody after me.

QUICK: OK. All right. Thank you.

HARDIN: Other questions? Will you stick around for closing?

HANSEN: Definitely. Yes.

HARDIN: Thanks. Proponents, LB374. Just a reminder, folks, that if you testified online, you don't get to do a double dip. No double dipping here, no skinny dipping, none of that kind of dipping is allowed here at HHS. So thank you for coming.

HEATHER SWANSON: Hello, Chairperson Hardin and committee members. My name is Heather Swanson, H-e-a-t-h-e-r S-w-a-n-s-o-n. I'm here to testify on my own behalf in support of this bill. I've been a certified nurse midwife for 23 years. In addition to Nebraska, I have worked clinic-- clinically in Texas, Colorado, and South Dakota. Other than Nebraska, those states licensed the type of midwife this bill addresses. While in Texas, I attended out-of-hospital births in a birth center, as well as planned home births. I'm here to speak regarding 3 items: the different types of midwives, the international defin-- definition of midwifery in U.S. MERA, and the 2 407 reviews about the type of midwife LB374 addresses. I have provided you with 3 documents regarding these topics. There are essentially 2 types of midwives in the U.S., those trained in midwifery and those trained in nursing and midwifery. I am one that's been trained in nursing and midwifery and hold the CNM credential. I became an RN, went to graduate nursing school, sat for the national credentialing exam, and am recognized as one of the 4 types of advanced practice registered nurses. CNMs primarily work in clinics and attend births in hospitals, though around 10% of CNMs in the U.S. attend births out of hospital. That combination of nursing and midwifery was adopted from the English model, which is not the international norm. Internationally, midwifery is usually an autonomous profession, performing some skills similar to other professions, but through the lens of the midwifery model of care. Those trained only in midwifery are often called direct entry midwives, or DEMs. In the U.S., they primarily attend births out of hospital, though internationally often attend births in hospitals. DEMs might be trained through an apprenticeship or their training may be more formalized by completing a midwifery education program. Those programs may be accredited or nonaccredited. These midwives can go on to sit for an accredited board exam and become a certified professional midwife. There's also a category of lay midwifery, which are midwives without formal training. This bill would not be licensing lay midwives, rather midwives with the C-- CPM credential. I served a term on the National ACNM board of directors. During that time, the International Confederation of Midwives strengthened their definition of midwife to include formal training. U.S. ICM membership organizations and midwifery stakeholders in the U.S. gathered to process how these new standards would be implemented in the U.S. This

group was called the U.S. MERA, Midwifery Education, Regulation and Association. The decision was that direct entry midwives would become CPMs and that those midwives would complete an accredited education program or complete something called The Bridge. There have been 2 407 reviews regarding nonnurse midwives. The first 407, conducted in '93 and '94, recommended against licensing lay midwives, though the final report noted that as accredited programs and standardized exams become available, it might be appropriate to revisit licensing. Despite formalization of mid-- of the midwifery profession and provisions in the proposal consisted with the later developed ICM definition and U.S. MERA recommendations, licensing of DEMs in subsequent legislative efforts have not yet, have not yet to get out of committee. Per the request of the then Health Human Services Committee chairman, it went back to 407 in90-- in '05 and '06. I was the applicants--

HARDIN: Ms. Swanson, if I can encourage you to wrap up your last thought.

HEATHER SWANSON: Yeah. So I'll wrap up this point on 407 and that will be it. That 407 review, I sat on the technical review committee. Despite adherence to national standards, licensing of DEMs, and utilizing the CPM credential, it was not supported through the existing 407 process. It is my opinion that the then and current 407 process, in particular the questions that are asked and voted on, do not allow for fair consideration of this profession. The decisions, of course, have, have not kept Nebraskans from offering home birth and midwifery services or becoming CPMs. Thank you for your-- I urge your support of this bill.

HARDIN: Thanks. Questions? Senator Ballard.

BALLARD: Thank you, Chair. Senator Hansen and you highlight it, but what is a training requirement to become a CPM? You highlight--

HEATHER SWANSON: Yeah. So CPMs, that credential is issued from the North American Registry of Midwives. There's 3 pathways to be eligible to sit for that exam. One pathway is a apprenticeship-trained pathway, and they have to demonstrate certain competencies to be eligible to sit for the exam, or they can complete a accredited or nonaccredited program to sit for that exam, and then they're issued that CPM credential. There's also other things they have to maintain to maintain that credential. If I'm correct, it's NRP, BLS, and if they did The Bridge, there's also continuing competency related to that.

BALLARD: OK. So you can become a CPM today in Nebraska?

HEATHER SWANSON: Yeah, anybody-- yeah, they could.

BALLARD: You could? I--

HEATHER SWANSON: You have to have a certain number of births. Like even-- I mean, I'm an advanced practice nurse. I prescribe. I work in clinic. I would be eligible to sit for the NARM exam because I have out-of-hospital birth experience, but it would be-- I wouldn't have that breadth of scope I have as an APRN.

BALLARD: OK.

HEATHER SWANSON: But midwives could if they have [INAUDIBLE].

BALLARD: OK. And what are you allowed to do today as a CPM?

HEATHER SWANSON: As a CPM-- well, I'm not a CPM. I'm a certified nurse midwife.

BALLARD: Or you're-- or not you but just like, in general.

HEATHER SWANSON: Well, there's no licensing right now, so it's--

BALLARD: OK. So noth-- OK.

HEATHER SWANSON: Yeah.

BALLARD: So that's what the bill's trying to address. OK. Thank you.

HEATHER SWANSON: Yeah.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and your testimony. So you, you, yourself are a certified nurse--

HEATHER SWANSON: Correct.

FREDRICKSON: --midwife. Correct? OK. So-- I asked this of the introducer, can you tease that out a little bit more? So what can you, what can you do that a CPM can or can't do, or is the goal to have both be able to do the same, same things in the scope of practice?

HEATHER SWANSON: So there are some things that overlap. We attend births, we provide prenatal care, we provide postpartum care. Some CPMs are also trained-- they do some, some basic GYN-related care. They do Paps. So there's a lot of things that overlap. Similarly--.

FREDRICKSON: Sure.

HEATHER SWANSON: --like with our physician colleagues, there's a lot of care that we provide that does overlap in what's delivered. I think that's one of the issues that came up with the 407 review on those questions that get asked, because there are other professions that provide similar services.

FREDRICKSON: Right.

HEATHER SWANSON: So as a APRN, I'm a graduate-trained nurse, and I go to graduate school. I see women across the lifespan. I do a lot of primary care, I do a lot of GYN care along with prenatal care. So it's a difference-- it's probably a, a little bit more kind of traditional medical sort of model, even though I'd say provide nursing-- you know, advanced practice nursing care. But nurse midwives probably see a higher volume, just because usually we are--people are coming to us in clinic and oftentimes in the hospital, versus us, you know, providing care at a hospital, and usually our volume is a little bit higher, but it depends. I know some very busy CPMs, as well, in states.

FREDRICKSON: OK. And are there any educational requirements for the CPM?

HEATHER SWANSON: So there's-- if they're going to be able to become a CPM to sit for that NARM exam, as mentioned, they either have to demonstrate an apprenticeship model-- and there's some midwives here-- some CPMs here today that could speak a little bit better to that.

FREDRICKSON: OK.

HEATHER SWANSON: But either they have to meet several criteria for that apprenticeship process that they have to demonstrate [INAUDIBLE] to, or go to a program, which there are-- it's-- either it's associates or bachelors. There's also doctorates midwifery programs in the U.S., so either an accredited or nonaccredited program.

FREDRICKSON: OK. Thank you.

HEATHER SWANSON: Yeah.

HARDIN: Senator Riepe, did you have a question?

RIEPE: No.

HARDIN: OK. Senator Quick.

RIEPE: Thank you.

QUICK: Thank you, Chairman Hardin. So-- and I know you probably heard me ask Senator Hansen, you know-- address some of my concerns, but-- so, you know, like in the hospital setting, you might have a, a nurse from the nursery, a pediatric nurse there, as well as a-- in case the baby is in distress and the mother is still needing to have that care. So how does that work, like, if, if, if you're in that situation and it's an emergency, maybe the mother is-- maybe she had an abruption and the baby's went through a lot of stress, you've, you've actually delivered the baby, but now you've got 2 patients. Then how do you care for both at the same time?

HEATHER SWANSON: Yeah. Good question. Because I think, you know, safety is always a concern. And regardless of where people deliver at, because things-- bad outcomes can happen in, in any setting. So for births, like a CPN-- as a nurse midwife attending home births, I wouldn't attend a home birth alone. Ideally, I would have other people there with me to be able to provide NRP, neonatal resuscitation, which CPMs are credentialed to do-- there's-- they do BLS, basic life support, and then they also do our NRP. NRP does require that there's at least one person present at the delivery whose sole responsibility is that baby's, so the expectation would be there would be at least two people there. Different midwives might, might choose to have additional people there. When I attend home births, I like to have two additional people. I'm usually training somebody and then I'd have a couple of nurses there, so I usually have a bit more people. But the standard is usually two people, so a primary midwife, and then a birth assistant, and then somebody that can-- the sole responsibility is the baby's. And then also to be certain that we are risking out appropriately, so we do know that if we're assessing risk throughout pregnancy, at the onset of labor, throughout labor, and transferring women appropriately, that the, the rate of obstetric disasters like an abruption are, are reduced and that population ends up staying at home. So it doesn't mean those things can't happen. And so that's where the responsibility goes on the, the patient of, you know, there are some risks if you don't have an OR down the hallway. But we know people are, are choosing that. And our birth certificate data now

doesn't-- does gather intended home births. And so we know that people are making very purposeful decisions for this. And so, the expectation would be that midwives would talk to families about here's what could happen, here's the plan if this happens, and be [INAUDIBLE] that informed consent is there. So-- and I've been a part of, of deliveries where-- in a birth center, where we did have to transfer babies. And sometimes, they'd have to transfer moms, thankfully without a hospital birth. And the research that's out there demonstrates that most transfers from, from home to hospital are non-emergents. So thankfully, that's the case. Usually there's those red flags that come up and you're like, OK, we're you know, here's what's going on. My recommendation, get to the hospital. And then the hope is that there would be a seamless process, where somebody would feel like they could share, here's what happened at home, here's what's going on, rather than just having somebody show up in the ER or labor and delivery unit without that background. So hopefully, this bill would-- well, the expectation is this bill would very clearly improve that process because home births are happening. They aren't-- they haven't not happened just because this hasn't been licensed. But what we're missing is that, that smooth transition to a higher level of care if need be, if risks are, are appropriate.

QUICK: I have another question, if it's all right?

HARDIN: Yes.

QUICK: Are-- so on your practice, you're probably able to start IVs. Are they-- will this also be able to like, start-- I know you say there's a, a test-- you know, I talked, talked about group B strep, so-- and that's important to be able to administer antibiotics in-- for the safety of the baby.

HEATHER SWANSON: Yeah. So CPMs maintain this-- the recommended standard is-- standard of care that the CDC recommends and other health organizations like ACOG or just simply their, their professional organization, the National Association of CPMs. There are standards of care for what's done in regards to screening prenatally and then treatment. So these-- those things are maintained. Honestly, between CPM care and a CNM providing care at a hospital, people probably wouldn't notice a difference when it comes to what's on the prenatal record for labs, because those things are pretty consistent. I will say there's also that informed consent. Like, when I do labs on somebody, I, I let them know what we're doing. And there's some of them I really want them to do, but I'm not going to hold-- I'm not

going to force somebody to get labs done if they don't choose to, but I want to be certain they have good informed consent. And most CPMs and nurse midwives are providing those same sort of labs that somebody would have traditionally in the hospital. IVs, you asked about that. So CPMs are trained to start IVs. Not all-- I mean, it's difficult-- it'd be very difficult for a CPM in Nebraska right now to get access to IV supplies, because they'd have to purchase those. Usually there's some restriction on that. So that's one big-- I have serious safety concerns right now, about what's happening, because we have people attending births, people with the right credentials, but with credentials that aren't allowing them, because of licensing, they can't-- if there-- if it was Iowa, they could do a lot more and be able to have some those emergency things ready, or if somebody had group B strep, they could go ahead and start an IV, administer whatever antibiotic was being used-- Amoxicillin or penicillin or Clindamycin, and do that during labor and maintain those same sort of standards that we see for GBS treatments at home as what we see in the hospital.

QUICK: So how do they do that, get the lab test if it's in the home-- in-home del-- because you might test-- you might not test for that until they're actually delivering. So how does that happen?

HEATHER SWANSON: Well, so you-- there-- you can do rapid group B strips, but usually those done at 36 weeks, so that would be done at a prenatal visit that a CPM would do. So that's-- usually, we do that around-- you know, maybe even 35 weeks if somebody is delivering early, so that would be done earlier. People that practice at a hospital, just like in the clinic, we collect labs in clinic and those are, are sent to a lab to, to run those labs. So like, I worked at a birth center and I ran a birth center, so we contracted with Labcorp, and there was another lab that we used. So we would collect those labs. Sometimes, we would do some home visits and would collect labs at home, or we did the heel sticks on newborns at home. And then we would take those-- well, the heel sticks, we would send to the states. But for other labs, then, would send those to the lab like traditional people do, so very similar to what like home health providers would do or if somebody is doing a home visit on somebody, they would contract and, and work with a lab to run those.

QUICK: And then my other, my other-- my last question would be like, so when you're-- so if something serious has happened in the delivery and you're trying to get that person to the hospital, you-- you know, is it just an emergency situa-- emergency room situation, or is-- or

are you going to be able to contact an OB-G-- GYN to be there to, to, to help with-- and a pediatrics doctor to help with the situation or how does that work?

HEATHER SWANSON: So when I attended births-- out-of-hospital births, if we had a transfer need, we would contact-- we had a consulting provider would contact. And there was a couple in town that we, we worked relatively closely with and that said, hey, yeah, if-- you know, call me-- there-- whoever's on call with my practice, will, you know, we'll help you out. That doesn't always happen. But usually-- like, there are sometimes when people might have a practice that they might not have that established relationship with somebody. Then usually what happens then, is either people would call that-- usually there's like a one-call number for facilities. And you would say, you know, what you're calling about, who you need to consult with. And it depends on the area. It might be that the process is going to be that they go directly to the, to the ER and through the ER. But ideally, it would be good to talk with somebody that's on call for OB or a maternal fetal medicine doctor or if it's with a baby, whoever's on call for pediatrics about that transfer. And it might be that, you know, maybe time isn't going to allow for that conversation on the phone while you're waiting for it. If it's urgent, you're going to call 911, transfer that patient in, so it might be something that happens on the EMS side of things. But the hope is that provider is going to be able to be there to share here's the records, here's what went on, and to share kind of what they were doing. And if they happen to be providing like NRP to a baby, if they're resuscitating a baby, if additional assistance was needed-- whether or not that CPM could ride in an ambulance and could continue to provide those services would be really up to that local EMS service. Like, would they allow that person to, to go with them, which is one of the things that's an error in jurisdictions in states that license CPMs. Usually there's that process that's already developed. Like, an out-of-hospital birth is going to chat with their local fire department or EMS, they're going visit with the local hospitals-- you know, we're practicing out here. If something comes up, we would like to be able to have, you know, a relationship where we can have these communications and allow for a more seamless, smooth transfer to optimize care.

QUICK: Thank you.

HEATHER SWANSON: Really varies based on the area where they're at.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. That got me thinking a bit more. So with, with, with, with training process, [INAUDIBLE] it's sort of the 55 births. Are you required to independently deliver under supervision or just observe the 55 births?

HEATHER SWANSON: So the 55 births have to be the ones that they caught themselves, but there-- there's going to be somebody precepting them and supervising them.

FREDRICKSON: Got it. So independently delivering--

HEATHER SWANSON: Yeah.

FREDRICKSON: --the, the birth.

HEATHER SWANSON: Yeah. I mean, they wouldn't be--

FREDRICKSON: And then, [INAUDIBLE] under supervision.

HEATHER SWANSON: They'd want-- their preceptor is going to be there. And if they're billing, it's probably-- the bill is going to be under the preceptor. So it wouldn't be considered independent, but they would be the one-- like, a student C-- if I was precepting a student CPM, if I was practicing in that hospital right now, just like with a nurse midwife, they would be the primary one. As a preceptor, I would try to give as much autonomy to them as I could to help them develop their skills, and then if need be, step in and intervene with the--

FREDRICKSON: OK. You also mentioned that in the births that you've been involved with, you've had a consulting OB-GYN or a provider for those times. Is your understanding that this bill will-- would waive that requirement or is that something that would still be required?

HEATHER SWANSON: Now, somebody else might be able to speak better to this-- is my recollection of looking at the bill is that there isn't like a written agreement that's required.

FREDRICKSON: OK.

HEATHER SWANSON: Midwives, CPMs are generally recognized to be autonomous, independent practitioners, which is what nurse midwives are trying to go for. And that hearing, hearing will be later. So there's no formalized process there. I mean, if that was required, I think we, we would have a lot of people attending-- or having babies at home without anybody there. Because I, I think it would be unlikely

for people to find very many physicians willing to, to say, I'll supervise them, when, when that's-- when they aren't themselves accustomed or experienced or trained in nonhospital birth.

FREDRICKSON: Thank you.

HEATHER SWANSON: Yeah.

HARDIN: Other questions? Seeing none, thank you.

HEATHER SWANSON: Yeah. Thank you.

HARDIN: Proponents, LB374. Welcome.

CHANDRA STEWART: Thank you for having us here today. My name is Chandra Stewart. C-h-a-n-d-r-a. S-t-e-w-a-r-t. I am a certified professional midwife, and I'm here today to ask you to pass LB374 out of committee. 38 other states currently have licensure for certified professional midwives, and several other states allow CPMs to practice freely despite lack of licensure. Nebraska is one of the few states in which a certified professional midwife like myself risks being criminally charged for practicing within their scope. Professional midwives are charged with acting as nurse midwives without a license. Last September, the Nebraska Supreme Court ruled that anyone practicing as a midwife must be licensed by the state of Nebraska. However, a license does not currently exist for my type of midwife. I truly believe that the state does not understand that there are different types of midwives. Though CPMs are experts in out, out-of-hospital birth and are well-trained to assess risk and handle complications that may arise during birth, the state does not recognize our profession. CPMs are not untrained or lay midwives. CPMs must prove their competency in midwifery to receive their certification. CPMs may receive their education through an accredited school, self-study, online courses, or in-person workshops. All routes of education must verify the same knowledge and skills. They must be certified in neonatal resuscitation and CPR and must recertify every 3 years. CPMs must document the competent performance of over 800 individual skills, pass a hands-on skills assessment and a 7-hour written exam, and complete a clinical preceptorship lasting at least 2 years. I completed the majority of my own preceptorship with an experienced midwife who is well well-respected in the home birth community but treated like a criminal by the state of Nebraska. I also spent the better part of 2 months training with a midwife in Pennsylvania, and the differences between the 2 states were

astounding. In Pennsylvania, I could administer Rhogam and Pitocin, perform the newborn screening test and hearing test, order labs, and file birth certificates. When we had a home birth client who needed to be transferred to the hospital, we were able to call ahead of time and speak openly with the hospital staff, explaining the situation and faxing them our client's chart. We were able to work safely, openly, and without fear, without fear of repercussion from the state for simply doing our jobs. If I were to cross any one of Nebraska's borders into a neighboring state, I would be able to practice with that same type of freedom. Why can't I do the same in my own state? We, the certified professional midwives, are asking Nebraska to recognize our type of midwife and offer us a license. We will gladly take the regulation that comes with that license and be held accountable to the state and to the families we want to serve. It is important to note that home births are happening in Nebraska already. They're just happening without the benefit of a trained professional there to assist. LB374 would allow CPMs to carry medicines and equipment that are within the CPM scope, including Pitocin, antibiotics, neonatal-- nee-- neonatal resuscitation equipment, and oxygen. It would allow CPMs to collaborate with the healthcare system, refer clients who need a higher level of care, and perform the newborn screening test. Licensing CPMs would simply make home birth safer for the families of Nebraska who choose to give birth outside of a hospital. Respectfully, I ask that you pass LB374 out of committee. Thank you so much for taking the time to understand this important issue.

HANSEN: Thank you. Questions? Senator Quick.

QUICK: Yeah. Thank you. Chairman Hardin. So one of my-- you, you mentioned-- one of the drugs that you mentioned, I think it's to induce labor, right? so--

CHANDRA STEWART: Pitocin?

QUICK: Yes. Yes.

CHANDRA STEWART: It's used in the hospitals to induce labor. It's never used at a home birth. No. It would be used for postpartum hemorrhage.

QUICK: OK. OK. And then do you have any drugs that-- in case-- that needed to be to stop labor, so that you could get that--

CHANDRA STEWART: We do not. No. If-- that would be outside the, the realm of normal birth, if someone was-- I assume you're talking about a pre-term labor. That, that would be a case that would be sent in to the hospital.

QUICK: OK. Thank you.

HARDIN: Other questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair. Thank you for being here and your willingness to testify. You, you spoke a little bit about some of the training involved. And I know I spoke with the previous testifier, who was a certified nurse midwife. You're a certified professional midwife.

CHANDRA STEWART: Correct.

FREDRICKSON: Correct? OK, perfect. Can, can you share a little bit more about the training involved with kind of recognizing and managing, whether that's pregnancy complications or what that looks like?

CHANDRA STEWART: Yes.

FREDRICKSON: Thank you.

CHANDRA STEWART: So CPMs have a rigorous educational and training process. It requires at least 2 years. Typically, it takes 3-5 years for a student CPM to complete that training. They have a clinical assessment that eval-- evaluates both the knowledge and the competency in performing over 800 individual skills. There's a hands-on clinical component, where you have to work one-on-one with a preceptor-- an approved preceptor. That's the at least 2 years part. It has to be an apprenticeship of at least 2 years. There's a minimum of 55 supervised births, which has been discussed. The majority of those must take place outside the hospital. It's actually the only midwifery credential that requires out-of-hospital birth experience. And then you have to complete and pass a 7-hour written exam. You have to be certified in neonatal resuscitation, you have to be certified in CPR, and you have to recertify for those things, every 2 years for those. And then, for your certificate in general, every 3 years.

FREDRICKSON: Got it. And you know, obviously, your goal is obviously a safe and healthy birth.

CHANDRA STEWART: Of course.

FREDRICKSON: I think everyone wants that. You, you, you mentioned this a little bit earlier. I'm kind of curious what, what might-- what would happen if there was, you know, postbirth hemorrhaging that occurred at-- with a home birth? Like what, what that-- might that look like? Could you--

CHANDRA STEWART: Yeah. That's one of the things that CPMs are trained to handle. The first thing we would do is, is uterine massage, and that's the first thing they're probably going to do at the hospital, too. We would like licensure so that we can carry Pitocin. That's the standard of care for postpartum hemorrhage. We would like access to that so that we can use that at home in a case like that.

FREDRICKSON: OK. So, so currently, without the licensure, you're-- that-- what would happen?

CHANDRA STEWART: Currently, midwives are using uterine massage. They're using herbs. Yeah.

FREDRICKSON: OK. Thank you.

HARDIN: Other questions? Seeing none, thank you.

CHANDRA STEWART: Thank you.

HARDIN: Proponents, LB374. Welcome.

DANIEL MEINKE: Good afternoon, Senator Hardin, members of the committee, I come to you today not as a midwife or midman, but I am a board certified family nurse practitioner. As a physician practicing medicine in the state of Nebraska, I run a regener--

HARDIN: Sir, can I have your, your name-- first name, last name spelled, please?

DANIEL MEINKE: My name is Daniel Meinke, spelled D-a-n-i-e-l M-e-i-n-k-e.

HARDIN: Thank you.

DANIEL MEINKE: As a physician practicing medicine in the state of Nebraska, I run a regenerative medicine clinic, where my spec-- specialty is repairing sports injuries, arthritis, and pain, which I'm

trained in. I've also delivered 3 of my own children, which was only possible with the support of both professional midwives sitting behind me and OB-GYNs, as midwifery is not my specialty. Professional midwives will perform best with continued oversight from the state of Nebraska. With LB374 refining the legislation of certified professional midwives, physicians like myself and others will have peace of mind, with trained professional midwives being yet another-- I'll emphasize the word-- another resource available in supporting our OB patients. I think previous bills we heard today, the committee members would agree that we need to look to find more avenues, of ways that we can take care of our unborn and recently born children, not less avenues. So while I practice in my specialty area of regenerative medicine, I implore you to refine legislation for midwifery, which is their specialty. Thank you.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: I'm trying to get some clarification here. It says in your letter, it says, as a physician practicing medicine. And I think in your comments, you refer to yourself as a physician. And yet in your signature, it says board-certified family nurse practitioner. Which are you?

DANIEL MEINKE: Correct. Board-certified family nurse practitioner, where a general terminology, a physician would be called someone who practices medicine or in the United States, commonly, as prescribing medicine. So in the state of Nebraska, nurse practitioners that are certified are able to prescribe medication, diagnose, treat illnesses. There are nurse practitioners that are in cardiology and treating A-fib, in surgery, in orthopedics. I myself have my own medical clinic, so I think maybe your confusion is the definition of physician versus medical doctor.

RIEPE: I spent 40 years in the hospital business, so I don't think I'm confused. You either are a physician or you're a nurse practitioner. Which are you? You're a nurse practitioner.

DANIEL MEINKE: I call myself both. Thank you.

RIEPE: You're not a physician. Thank you, Chairman.

HARDIN: Other questions? Thank you.

DANIEL MEINKE: Thank you.

HARDIN: Proponents, LB374.

SCOTT THOMAS: Good afternoon. HHS Committee, Chair Hardin, my name is Scott Thomas, S-c-o-t-t T-h-o-m-a-s. I'm the regional director for U.S. Institute of Diplomacy and Human Rights and the director for Village in Progress. Nebraskans have a variety of beliefs and values, and we believe that this addresses that by keeping options open to accommodate that. I didn't have my children at home. Both of my children were born in a hospital, but my son was born here in Omaha at Methodist-- Women's Methodist, and my daughter was born in Fort Worth, Texas, at Harris Methodist downtown. And we had a midwife for her birth and the, the costs were quite less substantial. So we just want to support Senator Hansen's bill and keeping options open for Nebraskans. And that's all I have, be willing to take any questions. And thanks, Senator Hansen, for making Nebraska great again.

HARDIN: Thank you. Questions? Seeing none, thank you.

SCOTT THOMAS: Thank you very much.

HARDIN: Proponents, LB374. Welcome.

BETHANY VAN DER HART: Hello, my name is Bethany Van Der Hart, B-e-t-h-a-n-y V-a-n D-e-r H-a-r-t. Thank you for seeing us today. I am a certified professional midwife. I have an associate's degree in direct entry midwifery from Southwest Wisconsin Technical College. I did 3 years of hands-on training with 5 midwives in both Wisconsin and Indiana. Both of these states offer their residents easy access to different midwifery options. I have worked in these states, both at home and in freestanding birth centers, and if I continued to live there, I would be able to get a license to practice freely with the credentials I have, which is why I ask you to pass LB 374. I am currently in the position to need midwifery options myself. I could legally do it at home alone, with myself and my husband, but personally don't believe that is a safe option for me. Whereas if I lived just 10 miles to the east, I could have a homebirth freely attended by a midwife. Why is Nebraska withholding from me a trained, qualified provider? But there is a way. A CPM is exclusively trained in out-of-hospital birth. She carries equipment needed to safely handle minor complications, has the knowledge to know when a safe, low-risk birth stops being so and needs additional care. When that CPM is given the freedom to practice within her scope, she can also help to facilitate a safe transfer to the hospital. A large prospective study published in 2005 by Kenneth Johnson and Betty-Ann Davis looked

at over 5,000 women and found that planned home births for low-risk women using CPMs were associated with lower rates of medical interventions and had similar intrapartum and neonatal mortality to that of low-risk hospital births. A large part of the CPM's training requires risk assessment. And with this bill, we look forward to the chance to be able to consult with doctors, OB-GYNs or MFMs when a client is presenting prenatally with the potential to risk out of home birth. While I strongly believe that the majority of birth is a normal physiologic process, there is need for higher care sometimes. Licensure would enable the safe standards for competency-based CPMs to be upheld and gives prospective clients a way to verify the midwife they choose for their care. I started out mentioning Wisconsin and Indiana. Wisconsin passed licensure in 2010 and Indiana did in 2013. By quick Google search, both capital cities have over ten different midwifery options, both CPM and CNM. Nebraska has none. Hospital with CNMs, yes, but no birth centers and no home birth options. Our state seal boasts equality before the law. Where is my equal protection and where are the parents' equal opportunities? Thank you.

HARDIN: Thank you. Questions? Senator Fredrickson.

FREDRICKSON: Thank you Chair Hardin. Thank you for being here and your willingness to testify. Can you elaborate a little bit more? I asked this a bit earlier from a testifier about the 6-week kind of postbirth care that a CPM might be able to provide or might be able to assist with.

BETHANY VAN DER HART: So the postpartum period would be the first 6 weeks after birth. And at that time, a lot of the assessment would be to assess the mother's bleeding, making sure it's continuing to be-- going down. We would be talking about breastfeeding, making sure that has been established and that that's going well, able to take blood pressures, may be able to diagnose if something's going to happen in the postpartum period that then we could transfer into care. We are able to offer the mothers who choose midwives a safe place to ask questions and get support, and know whether or not what they're experiencing is normal or whether it needs maybe additional care.

FREDRICKSON: Sure. So is the care at that point primarily for, for the mother or is that for the, for the baby as well, or--

BETHANY VAN DER HART: Both.

FREDRICKSON: For both, as well. OK.

BETHANY VAN DER HART: Yeah. So it does not take place of a pediatrician.

FREDRICKSON: OK.

BETHANY VAN DER HART: But for low-risk mothers and babies, it's just more of assessment, making sure-- and also weighing the baby, making sure that the growth is happening within that time period. And at birth, there is a newborn exam that is done by midwives usually, and that assesses whether or not all the functions are working the way they should, weight, and looking at, you know, bowel sounds and heart tones and res-- respirations, looking over the skin and everything. And if anything happens at that time where you would assess that this baby needs additional looking into, then that's something that we can look for the parents onto a higher level of pediatrics.

FREDRICKSON: Sure. Sure. My other question would be during, during, during an actual birth process, is there a way to monitor, for example, fetal heart rate or, you know-- I'm thinking of cases that I know, in my own life, of friends who've had very healthy pregnancies, and then come to labor time, you know, an umbilical cord was maybe wrapped around the infant's neck or situations like that. Can you walk me through that a little bit?

BETHANY VAN DER HART: Yeah. The midwife will carry a handheld Doppler. And prenatal care is usually about an hour long for home birth midwives. They assess mothers' blood pressure and diet and her health, and they're checking out baby as well, using fundal measures and making sure the baby's growing according to the weeks that she should, and then checking fetal heart tones. And with the Doppler, being able to listen for about 60 seconds is able to determine whether or not that heart rate falls within normal standards, and if there's anything that sounds out of the ordinary or it's not reassuring. And that's something where we would encourage the parents to go in, maybe get an ultrasound or something, to figure out why. And the same is true with labor. So the midwife comes when the client calls and also carries the same device. We check blood pressure, make sure everything is stable at the beginning of labor and make sure baby is continuing to do well. You mentioned, you know, cord around the neck. That is common, but it is actually not a common cause of death. The-- about 10-29% of all babies are born with a nuchal cord, and most are not associated with perinatal mortality.

FREDRICKSON: OK.

BETHANY VAN DER HART: It is-- like, to reiterate, not a common cause of fetal demise. And a midwife, you know, at birth, is able to, you know, train to recognize the signs of that and help to facilitate the baby. If it does compromise the baby, then that's where she would use her NRP training to be able to help resuscitate while, you know, figuring out what the next level of care would be.

FREDRICKSON: OK. Thank you.

HARDIN: Senator Quick.

QUICK: Thank you, Chairman Hardin. So-- and, and talking about like the fetal, you know, the heart monitoring. I know in the hospital setting-- my wife-- I know they have a monitoring strip so they're, they're always monitoring. How do you monitor all the time? I mean, because you, you probably have to hold that on there, right?

BETHANY VAN DER HART: Mm-hmm, mm-hmm. Yeah.

QUICK: So how does that work? So you're-- you know that--

BETHANY VAN DER HART: In a low-risk birth, there does not appear to be-- the studies that show that continuous fetal monitoring is necessary. I'm not speaking today for high-risk women, but for low-risk women. It seems that intermittent auscultation is enough to be able to figure out whether or not the baby is continuing to do well. It's a longer period of time in between checks in early labor. By the time labor has gotten to the period where we are in second stage, it is about every other contraction that we're listening in.

QUICK: OK. And then in the, in the case of a, of a shoulder dystocia, where the head is, is out-- I know my wife has talked about-- they've, they've had several nurses in there to help reposition that baby to have a, to have a safe delivery or get that baby out, and that's still difficult. So what do you do when it's only you and you need other people to help position that mom so you can get that baby repositioned?

BETHANY VAN DER HART: Right. So as Heather had mentioned-- sorry, I just blanked. Most midwives work with an assistant, and we work with someone who can help us. The other person in the room is the dad. They can also help. The benefit of having an out-of-hospital birth is that women are not confined to a bed and they are not under epidural medications. There is free movement and when there is free movement, then the mother can change positions and that can change the hip

angles and that can help work out the baby, or a midwife is trained, if that doesn't work, to move her into a position that would-- to extract the posterior arm, to go into a lithotomy position if necessary, to use [INAUDIBLE] pressure, things like that.

QUICK: OK. And then my last question would be on the postpartum. So, you know, some, some mothers go-- have postpartum depression. So do you also treat that, or what do you do?

BETHANY VAN DER HART: That is the benefit of postpartum care. Because we are able to come into their homes when they are recuperating, as an outside person looking at their life, and able to see whether or not that they are doing well. We ask questions about how are they doing, how is their mood, what are their emotion levels like? And if it's just a minor case, you know, we can talk through that. Sometimes, all it needs is just talking to someone else to help with some of the, you know, postpartum hormone changes. And other thing is, is nutrition is, you know, benefit to the mental state of people. And so if it is not-- and I know some midwives also will go through a postpartum depression checklist. And they'll kind of use that as a screening tool on their patients and decide whether or not then, they would need to go see a, you know, therapist or someone else who's trained more specifically in for that.

QUICK: And you can refer them to that, then?

BETHANY VAN DER HART: Personally refer them, you know. At the place where I have worked, I have not had any of the ability to, you know, like I said, sign anything over. But it would be the same that they would, you know, call up a, you know, a person and request to be, you know, seen by them.

QUICK: OK. Thank you.

FREDRICKSON: Other questions? Seeing none, thank you for being here. Next proponent for LB374. Good afternoon.

ABIGAIL CADA: Good afternoon. My name is Abigail Cada, A-b-i-g-a-i-l C-a-d-a. Thank you for taking the time to hear my testimony today. I am a native-born Nebraskan, mother of 6, and certified professional midwife. I hold a bachelor's degree in intercultural studies and an associate's degree in midwifery from the National College of Midwifery. My interest in midwifery originally began with a desire to serve mothers in low-resource countries. After the birth of my first

child, I applied for a college which offered both the theoretical and clinical training I would need to serve mothers through the evidence-based art of midwifery. The college I attended is accredited through the Midwifery Education Accreditation Council. My apprenticeship was carried out at a busy birth center in one of the Philippines' largest cities. There, I was taught under very experienced and skilled Filipina and American midwives. This clinic filled in the gaps in the maternity care system and provided excellent care for an average of 1,000 mothers every year, irrespective of socioeconomic status. I assisted in providing prenatal labor, birth, postpartum, and newborn care. We were able to transfer to the hospital, consult with OB-GYNs and pediatricians, refer for ultrasound, perform newborn metabolic screening, read labs, fill out birth certificates, and offer well-woman care. After I completed 2.5 years at this clinic and attended over 150 births, the CPM credential required that I attend additional home births in the U.S. I worked under an experienced CPM in Washington state and saw an excellent example of women being served by a healthcare system that allowed for them to give birth safely at home with a skilled birth attendant. Unfortunately, our maternal healthcare is at a tipping point in the U.S. We are ranked 55th in the world for maternal mortality, behind every other developed nation. Furthermore, the March of Dimes has given the state of Nebraska a D grade in maternal and infant health. The only state to receive an A was Vermont, where 1 in 4 babies are delivered by either a CNM or CPM. And 3% of babies are born at home, the highest home birth rate in the U.S. The Commonwealth Fund, the World Health Organization, and the March of Dimes have all stated that integration of midwives into the healthcare system is key in reducing maternal mortality and preventing adverse outcomes for newborns. Midwives provide excellent prenatal and postpartum care and are trained to be vigilant to screen for any problems which may occur during the perinatal period. Because midwives focus on personalized care, informed decision-making, and continuous hands-on assistance, women are less likely to experience interventions in the birthing process. And they report higher rates of satisfaction with their care. When midwifery care is combined with an ability to collaborate with other healthcare professionals such as OB-GYNs and pediatricians, mothers and babies win. Birth is a normal physiological process that is safe for low-risk women. The greatest risk that we can take is keeping skilled birth attendants from Nebraska's mothers and babies. That is why I ask that you would pass LB374 through the committee and license certified professional midwives. Thank you for your time and consideration.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you.

ABIGAIL CADA: Thank you.

FREDRICKSON: Next proponent.

KATHRINA FOX: Good afternoon.

FREDRICKSON: Good afternoon.

KATHRINA FOX: Hello. My name is Kathrina Fox, K-a-t-h-r-i-n-a, last name Fox. I have been a certified Bradley childbirth educator in several states for 26 years. My journey with midwifery and home birth began in 1996 in Colorado. By that time, Colorado law had provided for midwives to practice and deliver babies at home already, for 4 years. When I became pregnant, I diligently researched all of my birth options, and my husband and I chose to have a home birth. We took responsibility for our care and put forth serious effort to remain low risk. We were thrilled to get such skilled professional care from our professional midwife. She had extensive training and experience. Shortly after this, I began the process of becoming a certified Bradley childbirth educator and began teaching couples the skills needed to have a natural birth, whether that was in the hospital or at home. I help families have the best birth possible wherever it is that they choose. Our family then moved to Washington state in 1998. Washington was even more advanced in their midwifery care, having an abundance of options available. Again, after doing my research, I chose a home birth with a certified professional midwife. When we came to Nebraska in 1999, I was confident that we had moved to a state with even more freedom of choice. So I was shocked to find out that Nebraska allowed parents to birth at home, but that they did not allow a highly-educated and well-trained healthcare provider to be there. I was devastated. I had had 2 wonderful and safe home births and could not imagine having to be in a hospital setting to receive the excellent care that I had been used to in my own home. So when I became pregnant with my third child in 2024, I was able to find an experienced-- sorry, 20-- 2004. I was able to find an experienced midwife who was willing to attend my birth. But by the time I was pregnant with my fourth in 2006, there were no home birth options available to me. Like every other time, I considered a hospital birth but I was not willing to trade the amazing, personalized, home-based care that I had always had. So to find safe care that I wanted, I had to travel to Des Moines, Iowa for all of my prenatal appointments, and

I had to deliver my baby at a friend's guest house in Council Bluffs. I could not believe that I could not have a professional midwife attend me in my own home in Nebraska. It is time for Nebraska to catch up with the rest of the country. Nebraska parents should not have to engage in healthcare tourism to be able to have skilled professionals attend their births at home. Before I close, I'd like to leave you with a brief quote from a September 2009 article in the Canadian Medical Association Journal. Quote, planned home birth attended by a registered midwife was associated with very low and comparable rates of perinatal death and reduced rates of obstetric interventions and other adverse perinatal outcomes compared with planned hospital birth attended by a midwife or a physician, end quote. I've cited this and another journal article for you to read at your convenience. I urge you to advance LB374. Thank you so much for your time.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you for being here.

KATHRINA FOX: Thank you.

FREDRICKSON: Next proponent. Good afternoon.

NOVELYN SCHIPMAN: Good afternoon. Good afternoon, Chairman Hardin, who's not in here, and members of the Health and Human Services Committee. My name is Novelyn Schipman, N-o-v-e-l-y-n S-c-h-i-p-m-a-n. It's good to see you all again. I was here last week for the first time, asking that you trust me as a parent. And it was then that I realized how unique of an opportunity this is. For regular people like me to have the ability to express my concerns or support a bill that impacts my family is something I am grateful for. I'm here in support of LB374 and home birth. I would hate to focus on the negatives of the day my daughter was born because there were so many blessings. For one, I met her, but the process and the treatment I received getting to that point causes me to look for other options for the future. One thing that the doctor told me once labor had begun was that studies show that having birth as a woman of color was significantly more dangerous. From that moment on, I felt like I was treated as if I was a risk for failure even before I started. There was a study done by the National Institute of Nursing Research and the National Institute of Health, and it found that 11.5% of women like me feel safest giving birth in an out-of-hospital setting. And I can see why. If you were told by your provider in the midst of making decisions and dealing with birth that even though you're healthy, there are risk, it causes tension in a place that should be calm. I, like many others, started

to feel forced. I had desires and opinions of how I wanted my birth to go, yet I was not heard. I had to fight for my voice. Here I was in labor, during the most beautiful and powerful experience, but I had to defend my body and my choices. The medical process was more important than my body and my baby. I know that home birth is legal in Nebraska. The state governor even gave a proclamation in 2016, proclaiming that May 5th of 2016 was International Midwives Day. In that proclamation, it says that women have the right to choose where and with whom to give birth. It included home birth specifically, calling it a safe experience. If you have a baby at home, you can put-- you can get a birth certificate and put home as the location. Like many others in similar circumstances, I intend to pursue a home birth. LB374 would enhance this right that I have and give me access to professional midwives without fear from the state. Thank you for your time and I hope you support LB374.

FREDRICKSON: Thank you for being here. Any questions from the committee? Seeing, none, thank you.

NOVELYN SCHIPMAN: Thank you.

FREDRICKSON: Next proponent. Welcome.

PATRICK PRIOR: Hello, Senators, members of the Health and Human Services Committee. Thank you for the opportunity to speak today. My name is Patrick Prior, P-a-t-r-i-c-k P-r-i-o-r, and I'm here as a husband, a father, and a strong proponent of LB374. My family has personally experienced incredible benefits and midwifery care, and I believe this bill is essential to improving maternal and infant health in Nebraska. When we were expecting our first child, my wife described feeling dismissed and unheard at her first doctor's appointment, she said she felt herded like cattle through the medical system, without anyone listening long enough to address the concerns and questions she'd had as a first-time mother. She cried during that appointment. During childbirth, women have fewer complications and have a smoother experience when they're relaxed and free from unnecessary stress factors. For many women, including my wife, this means hiring a midwife and birthing at home, where they're most comfortable. For us, this was a decision made with great care, one rooted in research, personal conviction, and the desire for a birth experience that felt safe, supportive, and natural. But we quickly realized that midwifery in Nebraska exists in a gray area where highly-trained midwives operate without clear legal recognition. This creates unnecessary challenges not only for families like ours, but for the midwives

themselves. Like many Nebraskan families looking to hire a midwife, we had a great deal of trouble finding one. Many are afraid to practice in Nebraska for fear of running afoul of the law. Even though home birth and midwifery are legal in Nebraska, the lack of licensure and regulation has made these options difficult to navigate for us and for other families we know. LB374 addresses these problems by formally recognizing and regulating certified professional midwives, or CPMs. Providers who specialize in out-of-hospital births, these midwives are not untrained or reckless. They are professionals with rigorous education, hands-on experience, and a deep understanding of physiological birth. By licensing them, Nebraska will ensure that they meet consistent safety standards, have legal clarity in their practice, and can better integrate with other healthcare providers when needed. We were finally able to find a midwife, but she lived several hours away from us, out of state. Nevertheless, I can personally attest to the expertise and care our midwife provided. She monitored my wife and baby throughout the pregnancy, educated us on every step of the process, and ensured that we had a solid plan in place for any possible emergency. LB374 doesn't force anyone to choose home birth, but it does ensure that those who do have access to qualified, legally recognized providers. I urge you to support LB374. Thank you for your time and I welcome any questions.

FREDRICKSON: That was some solid speed reading towards the end there. Any questions from the committee? Seeing none, thank you for being here.

PATRICK PRIOR: Thank you.

FREDRICKSON: Next proponent. Welcome.

JOSIE CLARK: Hello. Thank you. Good afternoon. My name is Josie Clark, J-o-s-i-e C-l-a-r-k. I am a certified physician assistant who is here today in support of bill-- LB374, from District 19. I'm here today speaking as a member of the medical community and a mother of 4 beautiful children. I've had the privilege to work with certified professional midwives on a personal and professional level, helping myself and other women achieve their birthing goals in a safe manner. I am in complete support of these certified professional midwives being able to practice to the full extent of their training alongside other medical providers, as has been demonstrated by many other states. With my experience in emergency medicine and family practice, I have seen the gap between certified professional midwives and the rest of the medical community, as they attempt to serve their patients

with the safest, most up-to-date practices and the medical community not completely understanding what the role of a certified professional midwife is or how they could be a large asset to a community by giving women the choice to birth safely where they feel the most comfortable, in their homes, and have the proper support while doing it. Medicine is about teamwork, and each individual profession brings a different skill set to the table, allowing us to best serve our patients toward their specific goals and needs. In this manner, certified professional midwives should be given a seat at this table to work alongside the family medicine providers, obstetricians, and all other medical professionals involved in patient care so that everyone's strengths can be supported and the patients can be given care that aligns with their health/birth goals. This will allow all the providers involved to have clear lines of communication, which in turn will make home births even more safe, as the certified professional midwives have full support and resources of their colleagues at the hospital at their disposal as needed. As a medical provider, I'm always striving to give my patients a choice with all the necessary knowledge for informed consent, a choice that fits their own personal beliefs and values, that gives them the opportunity to birth at home or in a birth center or in a hospital with a provider of their choice. In conclusion, I'm here in support of all the certified professional midwives who serve the women of Nebraska to be empowered and given the freedom to practice their passion. Thank you so much for your time and consideration today, and I welcome any questions.

FREDRICKSON: Thank you for your testimony. Any questions from the committee? Seeing none, thank you for being here.

JOSIE CLARK: Thank you.

FREDRICKSON: Next, proponents. Welcome.

JAMIE MILLER: Thank you. Good afternoon, Chairman Hardin and members of the Health and Human Services Committee. My name is Jamie Miller, J-a-m-i-e, M-i-l-l-e-r. My involvement in home birth is multifaceted. I'm a home birth mother. I attend home births as both a photographer and a doula. I also co-lead the Omaha Birth Circle, a home birth centered women's circle with over 100 total members, all who have had a home birth, are planning one, or want to learn about it. These various roles give me a great pulse on the current needs regarding home birth in Nebraska, because I'm able to freely advertise my home birth photography services on my website, which midwives cannot do. I receive dozens of emails each year from women who are seeking a

midwife or any direction on how to have a home birth in Nebraska. In the last year, I received multiple emails from women who were either considering moving to Nebraska and wanted to know the first step to planning a home birth here, or had already moved here and were shocked to find out how difficult it is to find any information on home birth in Nebraska. One mother wrote, I'm preparing for my fourth birth. I've had 3 unmedicated vaginal births, 2 of them at home, and I do not want to go to a hospital for this birth. I'm not comfortable with an unassisted birth, though, and I can't find any home birth providers. Can you help me? This is sadly becoming an increasingly familiar tune. The lack of access to midwives is forcing many women to birth in the hospital or at home without the trained professionals that they want to be there. There is a dire need for midwives to be able to openly practice in Nebraska. LB374 is the first step to breaking down the barriers that force women to birth in a place they don't want to or without the support they desire. Birth is inherently safe, and it is made even safer when a woman feels safe, including at home. Home birth is largely undisturbed and allows God's good design of birth to freely unfold. If help is needed, CPMs have the skills to identify any arising complications before they become emergent and they know when to seek a higher level of care. In my work as a birth photographer and doula, I have witnessed firsthand the competency and skill of CPMs at home births. These midwives are experts in their field. They are educated, experienced, thorough, and always prioritize the well-being of the mother and the baby. The number of families who are seeking home birth in Nebraska is ever-increasing. The right response to this is not to continue to restrict midwives and leave families without options. It is in the best interest of Nebraska families to recognize CPMs and allow them to freely practice. I urge you to vote yes to LB374. Thank you very much for your time.

FREDRICKSON: Thank you for your testimony. Any questions? Seeing none, thank you for being here.

JAMIE MILLER: Thank you.

FREDRICKSON: Next proponent. Welcome.

PEGGY BEHRENS: Welcome. Thank you. Hi. I am Peggy Behrens. That's P-e-g-g-y B-e-h-r-e-n-s. And I want to thank you for taking time to listen to the voice of your community. Like I stated previously, my name is Dr. Peggy Behrens. I'm an APRN clinical nurse specialist specializing in women's health, and I have my doctorate in nursing practice. I'm not a physician. I am 1 of 5 nurse APRNs in the state of

Nebraska that are specializing in women's health. There's very few of us. I've also been certified in high-risk obstetrics since 1995. I was a labor and delivery nurse and a clinical nurse specialist for 19 years, and I now have the opportunity to be a professor of nursing at one of our local colleges here in Lincoln, educating on maternal childcare. And I'm here in support of LB374. Healthcare disparities and access to healthcare across the country have caused a rise in both infant and maternal morbidity and mortality in America. In the state of Nebraska, we have many of these undeserved [SIC] regions that could com-- that could compromise both infant and maternal health. This includes access to hospitals that could provide labor services, as well as APRN certified nurse midwives. The fact that these regions are underserves pushes many to choose home births. Women and families in undeserved regions should have access to those that can provide natural atraumatic care. This is where both midwives and home births come into play. Research has shown that the presence of a midwife in the labor and birth process can not only aid in identifying potential complications, but it also can mitigate those complications by immediate actions. There's also an established trusting relationship between the patient and this midwife, which allows the patient to be treated at their most vulnerable time. This is why I cert-- I support the certified professional midwives. These are trained and certified professional midwives who have the knowledge to assess, intervene for both in-- for both the natural labor processes, as well as complications that may arise. By allowing and passing these bills, it allows them to practice in collaboration with other healthcare providers. It allows them to access medications to protect both moms and babies. I can address-- Senator Quick, I can address some of those concerns that you brought up earlier. It, it provides a safer option for women in the delivery of their children. I wouldn't recommend this or support this bill if I didn't feel passionate about it. We must provide women an educated, prepared birth option that aligns with their values. I would ask that you please support LB374 for certified professional midwives and home births. Thank you.

HARDIN: Thank you. Questions? Seeing none, thank you.

PEGGY BEHRENS: OK. Thank you.

HARDIN: Proponents, LB374. Welcome.

MARIA OLLIS: Thank you. Gentlemen of the committee, I'm grateful to be here from Senator Ballard's district. I'm Maria Ollis, M-a-r-i-a O-l-l-i-s. Hi. I'm here with my 6-day-old, Avila, born at home last

week. I'm a transplant to Nebraska since 5 years ago. And in that time, I've birthed our 4 children at home. We were excited to move here for my husband's dream job, and we were expecting our first child after initial infertility. For years, I worked very intentionally on my own health and even underwent endometriosis, endometriosis removal surgery here in Nebraska with a great doctor. One of my biggest dreams was to be a mom, but with PCOS and endo, I knew that it would-- I would have trouble conceiving. I share this to convey our absolute gratitude and appreciation and reverence for the eventual gift of our 4 children. We do not take our family's health and well-being for granted. When we moved here, I was at the end of my pregnancy and we entered the spring of 2020, with the shut downs. We had planned to deliver at the hospital, but policies changed by the day. Eventually, I could only bring one person in the hospital with me, which was either my husband or our doula that we had already hired. In New York at that time, no one was allowed to enter the hospital or accompany a birthing woman. In other places in the country, some women were forced-- separated from their baby until they got a negative COVID test result. Tests at that time took a week since it was before the rapid tests. We immediately looked for other options. The birth center had the same restrictions as the hospital, so we found and hired a, a midwife. We were surprised by the level of intentionality and care. My appointments were a whole hour long instead of just the standard 15 minutes. She went above and beyond to evaluate my nutrition and supplements, as well as my mental and emotional health, not just reading the baby's heart rate. My birth was smooth, peaceful, and incredibly healing after the infertility, and I was on cloud 9 after the birth, until my midwife informed me that I had tore and I would have to go to urgent care for stitches. She was unable to stitch me, lest she be charged with practicing surgical procedure, so we headed in. Due to the legal ambiguity surrounding midwives, I was not able to be forthright with the hospital staff about the circumstances of the birth. This led to 4 hours of questioning for domestic abuse or neglect, I presume. Meanwhile, my husband and baby were waiting in the car. I was sure they'd call the police or CPS. And finally, I got a very aggressive physical exam and my 3 stitches. My midwife was so gentle and respectful, and I truly didn't hurt until after the doctor examined and stitched me. What if I'd been able to remain at home and have my midwife stitch me in bed and recover? What if my midwife collected the newborn screening sample instead of having to leave again another day, which was a very-- another challenging experience. So to wrap up, our midwives deserve better. Please let choo--them be able to continue to serve Nebraska families and provide the type and

quality of care for those of us that are qualified and do choose that option. Thank you for letting me share my experience on home birth and I would welcome any questions that the committee has. Thank you.

HARDIN: Questions? Senator Ballard.

BALLARD: Thank you, Chairman. Thank you for being here. It's good to see you.

MARIA OLLIS: Thank you.

BALLARD: So, so can you outline-- so you had your home birth and then were transferred to the hospital.

MARIA OLLIS: Correct.

BALLARD: OK. For-- and that was just--

MARIA OLLIS: At that point-- yes. At that point, we had finished all of the, the postpartum care, the wrap up, assessing baby, everything, assessing me. And part of that was assessing that I needed stitches. And so, my midwife and her multiple assistants and my doula departed and then my husband and child and I went to the hospital.

BALLARD: OK. So it was just the stitches and then kind of that legal ambiguity by the midwife.

MARIA OLLIS: Yes. So I was aware that if I mentioned my midwife's name or the fact that I had a midwife or any sort of care team, they might come under legal difficulty because of that. And that had happened in the past, even if nothing bad happened. Obviously, needing stitches is not a fun thing, but it's a normal part of many births is needing stitches.

BALLARD: OK. Thank you for being here. It's good to see you.

MARIA OLLIS: Thank you.

HARDIN: Any other questions? Thanks.

MARIA OLLIS: And if I could also add, if that's OK--

BALLARD: Yes. Please.

MARIA OLLIS: --to the part of your question. I believe that part of the reason that I had had somebody questioning is because all I said

was my husband and I-- or my husband caught the baby. And because of that, I was asked multiple questions by multiple rounds of people. Are you sure you feel safe at home? Are you sure this was on purpose? And they kept sending people in, and it just-- I think it was completely unnecessary. And also, it felt so gross that they couldn't be honest with them and say, I did have professional care. I did-- you know, we did make this as an informed decision, not just, you know, some idiots they need to call CPS on. So.

BALLARD: Thank you.

MARIA OLLIS: Thank you.

HARDIN: Thanks. Proponents, LB374.

AMALIA MAGNER: Hello. I'm Amalia Magner, A-m-a-l-i-a M-a-g-n-e-r. I'm here as a mother in support of LB374 to tell my daughter's birth story and how my experience shows that access to home midwifery care is needed in Nebraska. After having a traumatic first birth 2 years ago, this summer I prepared to give birth to my second daughter, again at St. Elizabeth's Hospital, in order to have midwifery care. During my pregnancy, I was sent to the hospital to have ultrasounds and just walking inside made me anxious, remembering how I almost had to have an emergency hysterectomy there. In June, a week before my due date, my labor began. I labored at home until contractions were every 3-5 minutes apart, then we drove to the hospital. But as I checked in, my labor slowed and stalled. I grew anxious and my body shut labor down. After laboring on and off all night long, I was sent home exhausted. A week later, my labor began again. I contacted my doula and midwife and labored at home again-- until again, my contractions were 3-5 minutes apart. They were steadily progressing and we prepared to go to Lincoln. My husband got our toddler ready and put towels down in the back of the van just in case, thinking we'd never need them. As soon as we were on the interstate, beginning our hour-long commute to the hospital, my body began pushing. My husband called our doula and asked her to start driving to us, saying we might need to detour to the Seward Hospital. She told me to feel for the baby's head, and I did. My baby was already crowning. My husband pulled over, and running to the back of the van, he opened the trunk to see that baby's head was already halfway out. Within 5 minutes of him parking, My husband was in the back of the van with me, and had just caught our baby as her big sister cheered, go, Mama, go. It only took 10 minutes. My doula took notes of the time everything happened, less than 10 minutes from when my body began pushing involuntarily to my baby being born,

something I couldn't have imagined after my first birth. We didn't immediately detour to the York hospital, partially because I had pushed for 2.5 hours with my first, and so I had no idea my body would begin pushing so quickly after being sent home from the hospital just the week before. But more importantly, I chose the midwives to be my birth team. I had a relationship with them, I trusted them, and I wanted them to attend my birth. I knew that the midwives would help me to have an undisturbed natural birth. My baby was caught in the back of her van by her daddy. It was an incredible experience, and she and I were perfectly healthy and in no danger. My 9-pound baby was happy, healthy, pink, and she cried immediately. The only danger was from the traffic flying past our van on the side of the Interstate. But I wish I'd been able to simply give birth to my daughter at home in my own bed instead of having to get in a car, no matter if the drive had been 5 minutes instead of an hour. Home is where many women, myself included, feel safest and most comfortable. If we had stayed home that day, we wouldn't have this unique story. But if I had been attended by a midwife in the safety of my own home, it would have been much more comfortable than either a hospital bed or the back of a car. Thank you.

HARDIN: Thank you. Questions? Thanks for being here. I'm going to give you a, a 10-minute warning, folks, that we're going to move over to opponents in, in another 10 minutes, and we're going to give them a shot for a while. So this is still proponents, LB374. Welcome.

GABRIELLA OTTO: Hello. My name is Gabriella Otto, G-a-b-r-i-e-l-l-a. I appreciate you taking the time to hear me out today.

HARDIN: And last name is O-t-t-o?

GABRIELLA OTTO: O-t-t-o, yes.

HARDIN: OK. Thanks.

GABRIELLA OTTO: I am asking for your support of LB374 and helping mothers like myself have the option for birth in a place that is safest for us. First, I'd like to draw attention to the fact that we are not talking about some medical phenomenon. Birth is normal, so normal that every one of us has experienced it in some way or another. Birth also happens every day. It isn't rare. And finally, birth is cultural, for me, especially. During my first pregnancy, at my very first appointment with a OB, my OB would hardly look my way, a legal adult, instead turning all of my questions to my mother. I was

frequently asked to run extra tests during this pregnancy just in case, be-- since you're of color, there are extra risks. One time, she went as far as suggesting I schedule an abortion due to my inconclusive test. No other testing was done at this time. We later found out towards the end of my pregnancy that those-- all those testings were within normal ranges and it was a lab error. When I did bring up fears or questions, they were regularly dismissed and/or ignored. My whole experience during that time, including my labor and delivery, I had no real choice in providers or any questions being asked. I was made to feel ashamed and on edge, ready for my body to fail me at any moment because of my skin color. Since then, I have realized that I am not alone. It doesn't take much research to know that black women in the United States have higher risks of maternal mortality. The CDC says black women are 2.6 times more likely to have higher risks of mater-- oh, sorry-- of-- more likely to die in a hospital giving birth than any white woman. In fact, when a mother of color has a birth in a hospital, they are told this statistic. I appreciate the care given in our hospitals, but in birth, sometimes we are looking for something else. Through my experiences, I decided I would become an educated doula and work to support women during birth. It comes at no surprise that according to recent data, the rate of home births among black women has significantly increased. I saw a CNN, CNN report that says studies have jumped to-- sorry-- studies that show a jump of over 30% in recent years, indicating a growing trend of black women choosing to deliver at home instead of a hospital setting. As a birth worker, I can say that black mothers have a desire for more control over their birthing experiences, and the home birth option is working for us. People all around the country are finding the care we need. If you look around at the policies in other states that not only allow but encourage for home birth, it would suggest that home birth is normal. It happens every day and is culturally acceptable everywhere but Nebraska. My second birth was at home. I was respected. I was not told that my color was an issue. I was told I was powerful and capable. I took responsibility. This is how we should approach birth. I'm asking for professional midwives to be respected as qualified birth workers in Nebraska. Please support LB374. Thank you.

HARDIN: Questions. Seeing none, thank you.

GABRIELLA OTTO: Thank you.

HARDIN: Another proponent for LB374. Again, about 4:30, we're going to hear the other side for a while. Thanks for being here.

ALY McCLAIN: Good afternoon. My name is Ali McClain, A-l-y M-c-C-l-a-i-n. Thank you for the opportunity to speak today. I stand in strong support of LB7-- or LB374. As a registered nurse with nearly a decade in women's health, a doula, and as a mother who has birthed 3 of 4 of my children at home, I urge you to consider this issue objectively. I co-lead a group of over 100 Nebraska women searching for how to have a home birth here in this state. Many, including myself, will choose home birth, regardless of if this bill passes or not, because birth, we believe, is not a medical event. It is a divinely designed process that works when left undisturbed. By voting no, you are not preventing home births from happening. You are restricting women's access to care when they need it the most. Nebraska values families and the right of parents to make informed healthcare decisions, yet we remain one of the few states where access to midwifery care is unnecessarily restricted. After a traumatic C-section with my first baby, I was told future surgeries were for my safety because my pelvis was too small to birth a baby. Hospital policies risked me out of care and I couldn't go to the birth center because I was high-risk, leaving home birth as my only option. I refused to return to the place where I experienced trauma the first time. And instead, I had 3 safe, empowering, and redemptive homebirth with babies all 1 pound bigger than my first. In 2022, a Nebraska judge declared during a ruling that home birth is a constitutional right. Parents have the right to choose where, how, and with whom they give birth. LB374 simply aligns Nebraska with the 38 other states that license CPMs, ensuring women have the access to skilled, accountable professionals. Some may question home birth safety, but the evidence is clear. The 2021 Washington Birth Studies Outcome-- Outcomes Study found that planned home births with trained midwives lead to fewer interventions, infections, and complications. A 2019 meta-analysis confirmed neonatal mortality rates are comparable to a hospital and home births when skilled midwives are presenting-- present. So Senators, if a home birth is just as safe as hospital birth, why deny women access to the same quality of care at home? Passing LB374 is about protecting families. It's about trusting women to make informed choices. And for many, it's about religious freedom, deeply held beliefs guiding where and with whom they give birth. This bill of informs their-- affirms their constitutional right to safe, supported birth, wherever they choose. I urge you to vote yes on LB374 and stand for family rights, maternal health, and the safety of Nebraska mothers and babies. Thank you for your time.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I, I guess I would question, are you claiming your constitutional right under the religious freedom?

ALY McCLAIN: That came from the ruling that happened in 2022 with a judge during a home birth, a home birth ruling. And so he declared during that time-- it was not his ruling. It was his comment that it is a family's constitutional right to birth at home.

RIEPE: Well, I don't think one judge can call it constitutional right. That's why I asked you if you were claiming it under religious freedom, since you can.

ALY McCLAIN: That, too, Senator. Yes.

RIEPE: I was just curious.

ALY McCLAIN: Yes. That, too, Senator. I could go more into that if you'd like.

RIEPE: OK. Thank you. Thank you, Chairman.

HARDIN: Other questions? Seeing none, thank you.

ALY McCLAIN: Yes. Thank you.

HARDIN: Another proponent, LB374. Welcome.

CORTNEY STEFFENSMEIER: Thank you. My name is Cortney Steffensmeier, C-o-r-t-n-e-y S-t-e-f-f-e-n-s-m-e-i-e-r. I'm here in support of bill, LB, LB374, District 19. I'm here today as an IBCLC, internationally board certified lactation consultant. As both a mother and 3-- as both a mother to 3 children and a medical professional, I want to address the cascade of interventions during childbirth and its implications on breastfeeding. The cascade of intervention refers to a series of medical procedures or interventions that can occur during labor, sometimes leading to a birth experience that feels far removed from a family's original plan. One of the consequences of this cascade is its impact on breastfeeding, which I frequently see in my practice. Research shows that women who experience fewer interventions are more likely to successfully breastfeed. For example, a study in the Journal of Midwifery and Women's Health found that 86% of home birth newborns were exclusively breastfeeding at 6 weeks of age, versus hospital birth babies that are only exclusively breastfeeding by 50-55%. For many women, home birth is appealing due to the fact that we can achieve a more personal and controlled birth environment. I can

personally speak to this. The comfort of being in your own home and curating a peaceful environment, reclaiming birth as our own through radical responsibility, slowing and respecting birth, fostering an immediate connection with our baby through skin to skin, and promoting early breastfeeding. This nurturing environment is enhanced by skilled professionals such as CPMs. Now, of course, home birth is a deeply personal decision, but what we must acknowledge is that home birth goes far beyond location, right? Home birth is about supporting a woman's autonomy and providing her with tools that she needs. We do this by making quality midwifery care more accessible to families across the state. Just as Jesus was born into humble surroundings without intervention, home births highlight the natural raw process of life's beginnings. This aligns with the idea that birth is sacred, intimate, and profound, where simplicity met divine purpose. Thank you for your time. And thank you, Senator Ben Hansen, for your support.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I'm trying to learn here. You're a lactation consultant?

CORTNEY STEFFENSMEIER: Correct.

RIEPE: Are, are you in private practice or do you work for an organization?

CORTNEY STEFFENSMEIER: I have a private practice.

RIEPE: You do?

CORTNEY STEFFENSMEIER: Yes.

RIEPE: What is your, your service area?

CORTNEY STEFFENSMEIER: I live--

RIEPE: How, how, how, how far do you have to go to get enough business?

CORTNEY STEFFENSMEIER: I live in Norfolk, Nebraska.

RIEPE: OK.

CORTNEY STEFFENSMEIER: And since we live in a rural area, it doesn't take much to have a lot of families come to my practice because we're very limited for lactation care.

RIEPE: OK. Thank you. I was just curious. Thank you. Thank you, Chairman.

CORTNEY STEFFENSMEIER: Yeah. Thank you for asking.

HARDIN: Other questions? Seeing none, thank you.

CORTNEY STEFFENSMEIER: Thank you.

HARDIN: We're going to do one more proponent for LB374. We'll switch it over to the opponents next. And I'll just say that how many opponents do I have out here? Opponents? So I've got a few. Otherwise, I was going to order some from the other room. Just so you all know, there's a room bigger than you down the hall and they have challenged you to an arm wrestling match later. So anyway, take it away.

BENJAMIN STACHURA: I'll have to stay for that. My name is Ben Stachura, Benjamin Stachura, B-e-n-j-a-m-i-n S-t-a-c-h-u-r-a. I'm not a midwife. I'm coming to you from the perspective of a husband and a father. I care deeply for the safety of my family. I've never thought of having a home birth until I actually married my wife. I never considered it. But it is the dream of my wife that she would have her birth, her births at home. And since then, it has become my desire to. Support My wife In having a safe home birth, And my desire to have a home birth. Just under a year ago-- 2 years ago, my wife gave birth to our firstborn. It was her desire and plan to have a home birth, with our midwife who is here today. As my midwife-- as my wife's pregnancy continued but just a few days before the due date, due to signs our midwife observed, she directed us to have a hospital birth, with concerns that it would be-- wouldn't be safe for my wife to have a home birth-- that she had observed. Where-- so we decided to go to the hospital, where we later had our baby. We trusted our midwife, and midwives can be trusted. Looking back, we were very thankful for our midwife and for the direction that she had given us to go to the hospital. LB374 supports our desire in giving freedom to midwives in practicing in Nebraska. Our desire is to have a safe home birth, if it's the Lord's will. We owe it to our midwives and mothers to provide clarity in our law, and that is what LB374 provides. As Senator Hansen mentioned, home births are nothing new. It's even mentioned in the Bible, as we see that Jesus Christ, the Son of God, was born of what

we would consider a home birth, naturally. And that gives us a pretty good depiction of what we-- what God, in his stance, would be on birth. Life, liberty, and the pursuit of happiness is a well-known phrase that the United States Declaration of Independence uses. This phrase gives an example of unalien-- unalienable rights, which the Declaration says have been given to humans by their Creator, and which governments are created to protect. Having children in the comfort of your home is the foundation of life, liberty, and the pursuit of happiness. Thank you for listening, and I would urge you to support this bill, LB374. Thank you, Senator Hansen, for bringing it forward. That is it.

HARDIN: Thank you for being here.

BENJAMIN STACHURA: Yeah.

HARDIN: Questions? Seeing none, thank you.

BENJAMIN STACHURA: Welcome.

HARDIN: We're going to have a change of pace. Let's move over to opponents, LB374. Other proponents, we'll come back to you in-- we gave the first group an hour and a half. We're going to switch back in an hour and a half if we have that many opponents. And so, here we go.

MAGGIE KUHLMANN: Yes. Thank you, Senator Hardin and other members of the committee for hearing my testimony. My name is Maggie Kuhlmann, M-a-g-g-i-e K-u-h-l-m-a-n-n, and I am a maternal medicine physician, M.D., at the University of Nebraska, though I'm not representing them in that capacity, and I am here to voice strong opposition to this bill. I have a lot of issues with it actually, but I will hit on 3 points, the biggest of which is the idea of preventable harm. There's been a very dangerous hand-waving argument that has been proposed here that complications of birth occur in any setting. While that is technically true, it is also wildly misleading. Common complications of birth, including postpartum hemorrhage, infection, hypertensive disease of pregnancy, and birth trauma look a lot different in out of hospital births versus those in hospitals, with resources, highly-trained professionals, and numbers. Right. You've alluded to that point, OK. There's also the idea of-- I keep coming back to comparing my own training and my own requirements for licensing in the state of Nebraska versus those that are proposed in this bill. And although the idea of regulation has been put out there, it's extraordinarily vague. And a lot of the safety measures that my

profession goes through to ensure safety to my patients, like continuing medical education, are not addressed at all in this bill. Another idea I would like to turn to is the idea of misuse and abuse of the wide scope of practice that is actually granted by this bill. A lot of people here have testified and I've talked to a lot of people who have told me, you know, they don't like to think of birth as a medical event. There's even a section in this bill, Section 20, that posits that certified professional midwives are not engaged in the process-- in the practice of nursing or medicine. If that is true, I don't know what placing IVs and giving medications is supposed to be. That's the way that I practice medicine. Nurses spend a lot of time not only hitting a vein in a practice setting, but learning how to deal with complications, learning how to recognize them. And Senator Quick, as your wife can probably attest to, it's a lot harder to hit a vein after someone has lost 4 liters of blood and is actively hemorrhaging than to do it in a practice setting. The medications that are specified in this bill-- methylergonovine? That is medication that you cannot give to someone who is hypertensive. If you're not doing serial blood pressure monitoring, how do you detect preeclampsia, a common complication even in low-risk women. OK. So I, I can't support this bill. I don't think it is in the best interests of women and babies in the state of Nebraska. And, you know, I practice not only in Omaha, but in outstate Nebraska. I was in Grand Island yesterday. And although I do not doubt that there are physicians who may be enthusiastic collaborators for out-of-hospital births, I have yet to meet one. That's it.

HARDIN: Thanks for being here. I have a question. Help me understand. 37 states do allow this, and what are they thinking? From your perspective, can you comment on that for me?

MAGGIE KUHLMANN: Honestly, I can't. I don't understand it.

HARDIN: OK. OK. It seems absurd to you. You've seen it all.

MAGGIE KUHLMANN: Yes, I have. I've seen complications of out-of-hospital births, not only here in Nebraska, but I actually did my training in the state of Texas, where direct entry midwifery is legal and allowable. And throughout my 7 years there, I saw a lot of bad complications, including maternal and neonatal mortality.

HARDIN: OK. Other questions? Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and your testimony. Do you-- so you talk about direct entry midwifery. Do you have any thoughts on the certified nurse midwife-- midwifery?

MAGGIE KUHLMANN: Yeah. I work with certified nurse midwives in my practice. I have, from my training to-- actually I was with CHI before I went to the University of Nebraska. And that's another thing. You know, peop-- I've seen people who are very happy with working with certified nurse midwives. I, I understand that people seek different models of care and I support people in doing so. But the problem with birth is that things go wrong even in low-risk women, and resources need to be on hand.

FREDRICKSON: Thank you.

HARDIN: Other questions? Senator Quick.

QUICK: Yeah. Thank you. Chairman Harmon-- har-- har-- Hardin, sorry. So, you know, I know you've heard some of the questions asked previously about, you know-- any delivery, you know, you may not know until that baby's actually coming that some of these problems are going to-- you know, some, some of the risks that are involved. So let's just say like an abruption. I mean, how much time would they have to get to a hospital? Because you're not-- I mean, it's, it's a short amount of time, right?

MAGGIE KUHLMANN: It depends. Abruptions can be, you know-- occur slowly, or they can occur massively and all at once and cause fetal demise.

QUICK: OK. OK. And then, you know, I know you've had years of training, right? So compared to the training that they would receive compared to what you've had and what-- like my wife. She went through-- she was a diploma RN. She went back to the Med Center, got her, her bachelor's degree. And then hers-- she had to get all of her certifications to be a registered-- or a, a, a delivery nurse. And then also, I think they had to do some for taking care of babies, as well. So-- and then her continuing education. So.

MAGGIE KUHLMANN: Right.

QUICK: So can you address like the, the training that they're getting, versus what you've had and like my wife? I mean, it's a lot less, right?

MAGGIE KUHLMANN: I mean, I think in obstetrics, like with most things, you have to be there to see things and to get training. So the more experience you have, the more structured education you have, the more continuing education you have to stay up to date on what evidence-based practice tell us are the best and safest things to do, the more qualified you are to do that.

QUICK: OK. All right. Thank you.

MAGGIE KUHLMANN: I don't know if I answered your question. Sorry.

FREDRICKSON: Other questions from the committee? Seeing none, thank you for being here.

MAGGIE KUHLMANN: Thank you.

FREDRICKSON: Next opponent for LB374. Welcome.

MOLLY JOHNSON: Thank you. Good afternoon, members of the Health and Human Services Committee. I'm Dr. Molly Johnson, M-o-l-l-y J-o-h-n-s-o-n. I am a board certified OB-GYN in Grand Island, where I've practiced since 2007. I am testifying on behalf of the Nebraska Medical Association in opposition to LB374. I would like to emphasize that I have also been asked to represent the Nebraska Nurse Practitioners with this opposition. Thank you for the opportunity to speak today. I'm here to express my strong concerns and reservations regarding the Licensed Midwives Practice Act. This bill has many concerning aspects related to maternal healthcare, especially the allowance for home births by certified professional midwives. Unlike hospital-based deliveries, the home birth setting, especially when attended by inadequately trained providers, lacks the necessary resources to manage obstetric emergencies. Conditions such as postpartum hemorrhage, shoulder dystocia, and fetal distress and labor are not uncommon. Most of these scenarios occur in what has previously been a normal pregnancy or a normal labor. These can become life-threatening emergencies in just seconds. A substantial body of medical literature establishes that home births carry higher risks compared to hospital births. The statistic that I want you to remember from the Journal of Obstetrics and Gynecology in 2002, is that neonatal mortality is twice as high for planned home births compared to hospital births. I would like to-- I'm going to give my testimony with a couple of examples, just to kind of illustrate just how quickly normal becomes not normal. First example is going to be kind of a hypothetical from my group, kind of a conglomeration of things that

have happened in my practice, you know, throughout time. So a patient with a normal pregnancy, normal labor, everything's going totally fine. And at the time of the delivery, baby's head comes out and the shoulder is stuck. That's called a shoulder dystocia. And in the hospital setting, what we can do, we can push a button and a team comes in, and maneuvers are done and the patient's placed in different positions, help is readily available to relieve the shoulder dystocia. But in this hypothetical scenario, it took over 2 minutes to relieve the shoulder dystocia, so it took almost 2 minutes for the baby to be born after the head had been born. When the baby was finally delivered, the baby did not have a pulse. But, again, because everyone was available in the hospital, the neonatal nurse practitioner, other nurses were available to resuscitate that baby, the baby went home. The baby's doing fine. I guarantee that if that baby would have had the significant shoulder dystocia that it had at home, with a inexperienced, maybe not as well trained, you know, a certified professional midwife, that baby may not be alive today. I would like to contrast the example that happened in the hospital that had a good outcome with one that was earlier in my practice several years ago. I was on call. I was called into the hospital for, you know, an emergency to the ER-- the pregnant patient needs your help. When I got there, I found a mom that had delivered the legs and torso of a baby. The head and shoulders were stuck. That baby had died, unfortunately.

HARDIN: Dr. Johnson, sorry to interrupt you.

MOLLY JOHNSON: Yeah.

HARDIN: We are on red. I'd like you to finish your story.

MOLLY JOHNSON: OK. Can I finish that story?

HARDIN: You bet.

MOLLY JOHNSON: OK. That baby had delivered at home. But yes, the baby came to the emergency when something was recognized to be abnormal. But because of delaying care, that baby died. And this family that should have been able to take home a healthy newborn baby, had to mourn their newborn's loss. This proposed law is creating the potential for more and more unsafe and potentially tragic situations to occur. Please oppose LB374 and do not advance this bill from committee. Thank you.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Thank you very much for being here and for traveling in to, to be with us today. I'm an urban senator. I was an urban hospital administrator, but I still have a serious concern about a mom in a blizzard in February in the middle of somewhere. And being halfway between one point and halfway to the other is the worst place to be. How do we address this? Because we hear so much about the maternal infant desert, the pharmacy desert, the emergen-- everything, everything seems to be in rural healthcare. And I-- it's, it's a, it's a major problem and it's not getting any better I-- as I see it.

MOLLY JOHNSON: I agree. And I think this has been proposed as a way to maybe address, you know, rural maternal health deserts. But I personally feel like this is actually making the situation worse. You know, I'm originally from Ainsworth, which is in north central Nebraska, kind of middle of nowhere. And so, women that live in the country outside of Ainsworth may have to, you know, travel an hour and 45 minutes to a hospital that delivers maternity care. So if they believe that they're having a safe delivery at home with a home-based midwife, but then something goes wrong, not only are they at home and not at a hospital, but it's going to take them an hour and 40 minutes to get to an hospital. Do we think that this is going to be an out-- good outcome for that mom and that baby? No.

RIEPE: Do you, do you ever have any mothers, maybe parents that would come, say, to Grand Island 2 months before the delivery, just to be close?

MOLLY JOHNSON: I mean, if there's, if there's bad weather, sometimes I'll say like, you know, come stay for the weekend or something. I mean, I do have patients that drive quite a ways. And we, we work around, you know, that situation so they're in town, so they can be at the hospital more quickly. Mm-hmm.

RIEPE: I know the majority of babies come not easily. Being a man, I'm never going to say it's easy. But it's that one exception that creates a real concern.

MOLLY JOHNSON: Yeah, absolutely. Most normal-- most labors are normal. Most, you know, pregnancies are normal, absolutely. But then when they're not, they're not.

RIEPE: Yeah.

MOLLY JOHNSON: And it is-- you know, it can be very bad.

RIEPE: I appreciate you coming. Thank you, Chairman.

HARDIN: Senator Fredrickson.

FREDRICKSON: Thank you, Chair Hardin. Thank you for being here and your testimony. I'm just looking at-- you, you have a couple of handouts that you put out here.

MOLLY JOHNSON: Yes.

FREDRICKSON: One was kind of regarding the CPM educational and training requirements. I, I was curious. Can, can you elaborate a little bit more on your perspective of what's outlined in this bill and your thoughts on that?

MOLLY JOHNSON: Yeah. So this, so this-- the handouts you will see are talking about CPM, then also certified nurse midwife, and then, you know, OB-GYN-trained physicians. And so, you will see the difference. I mean, I am really quite concerned about the requirements for a certified professional midwife, in terms of the experience level needed to-- I mean, it sounds like some of the midwives that have testified had-- have had excellent training. But what is outlined here seems like bare minimum. And if you only have to be or at or observe 55 deliveries, you are not going to see many shoulder dystocias. You are not going to see very many, you know, hemorrhages. You are not going to see the bad things, and so that's concerning. So you could have a high school, you know, diploma, observe a few things, take an online class, and-- you know, to me, it's, it's concerning, the level of education. Certified nurse midwives obviously have more robust training and the advantage to the certified nurse midwife model as it now is in Nebraska, it's a collaborative model. So they're collaborating with a physician at all times. I feel like the testimony that has been presented today is that the certified professional midwives would have a professional relationship with physicians, but that's not really I think what happens in surrounding states, just kind of based on what I've heard. And so, it's more like-- kind of like what happened to me. Like, OK, come to the emergency room, we have something going on, or you know, the patient that testified, oh, she just went to urgent care. I mean, that is not ideal for patients. That's not great. But if it's in a certified nurse midwife model where there's an ongoing collaboration as the pregnancy goes, that's, I feel like a much better team approach.

FREDRICKSON: Thank you.

HARDIN: Additional questions? Yes, Senator Quick.

QUICK: Chair Hardin. Thank you for being here. You know-- and you're talking about the, the, the training. And then, you know, we also mentioned the-- like the IV. And I know there were certain nurses that could probably get the IV in very well. I think maybe my wife was one of them.

MOLLY JOHNSON: Absolutely, she was. Yeah.

QUICK: She could absolutely find-- even on the, on the baby. She could--.

MOLLY JOHNSON: Yep.

QUICK: --happen to find that vein. So-- but the training for them to actually do that or even administer some of the drugs that they, that they are going to be able to administer and knowing the right dose, can you address that?

MOLLY JOHNSON: Well, I feel like that is concerning because I feel like the background knowledge for giving these medications, kind of like Dr. Kuhlmann alluded to as well, these are kind of high risk medications. You can only give them over certain timeframes. They all have different, you know, contraindications. So I feel like, you know, having kind of that minimal level of education, then, to be able to give these dangerous medications, I-- it's concerning to me.

QUICK: OK. Thank you.

HARDIN: Other questions? Seeing none, thank you.

MOLLY JOHNSON: OK. Thank you.

HARDIN: On that note, everyone, I was just going to share with you-- it was just shared with me. Local streets are a little bit slick, highways are good. So, just an update. In opposition, LB374. Welcome.

NICK TOWNLEY: Thank you. Chair Hardman [SIC] and members of the Health and Human Services Committee. I'm Dr. Nick Townley, N-i-c-k T-o-w-n-l-e-y. I am a neonatologist and a faculty member of University of Nebraska Med Center. Creighton University, Children's Nebraska. However, I'm not speaking as a representative of the universities today or any clinical site where I practice, I'm here speaking on behalf of my-- my half, as a concerned neonatologist and on behalf of

the Nebraska Medical Association in opposition to LB374. As a neonatologist, my practice takes care of the most fragile babies in the state with exceptional outcomes. We go to work every day, night, weekend, holiday to take care of the smallest and the sickest children. Some of the most tragic cases we see are the ones that could have been prevented. It's devastating when we have to care for these infants who experience a serious or fatal event in their attempt to have a home delivery with a lay midwife. One of these recent Nebraska home delivery cases, the midwife failed to recognize the mother was pregnant with twins. An hour after the first baby was born, the mother was still in pain, still laboring. An ambulance brought the baby from home to a delivery hospital, where the twin pregnancy was quickly diagnosed. The term infant was delivered by our trained obstetrical staff, but the infant died after prolonged resuscitation. In another case, the mother presented to the hospital after laboring at home with a midwife for 72 hours. An emergency C-section was done to the neonatal's low heart rate. Forceps marks were noted on the scalp from the home environment. Forceps were used at home. This infant was unable to be resuscitated and died in the OR. These are recent Nebraska cases. These tragic outcomes were preventable. LB374 provides to give midwives, like these responsible for these devastating cases, a state, a state-issued credential to perform these unsafe practices on the most vulnerable patients in Nebraska. While home birth is associated with, with risks and worse outcomes for mother, I would like to focus attention on the risks for the infant. Planned home births attended by midwives that have been associated with drastically higher neonatal mortality rates compared to hospital births. The neonatal mortality rate for planned home births attended by direct only midwives-- entry midwives is 2 to 3 times higher than the neonatal mortality rate for hospital birth. Planned home births also have a 3 times higher incidence of neonatal seizures, one of the signs that the brain was injured during the deliv -- delivery process. These babies do not have a voice in deciding where they're born or what type of care they receive. By licensing lay midwives to attend home births, Nebraska would be telling Nebraska families our state, this is acceptable. In addition to attending home births, it allows lay midwives to provide care for that newborn infant following birth for 6 weeks after birth. This is egregious to think it's appropriate or safe. The first 6 weeks of an infant's life are stressful for families and full of risks. These newborns are immunocompromised, they're at risk for failure to thrive, hypoglycemia, hyperbilirubinemia. These, when they're not treated, they cause long-term neurologic defects. These 6 weeks are tremendously important for brain growth-- was why--

and that is who they're going to be as an adults. None of the provisions of the bill come close to ensuring these midwives have-- to entrust them with a critical time in the newborn development. There will be--

HARDIN: Doctor, if I can encourage you to, to move out of the red zone. Thank you.

NICK TOWNLEY: Out of the red zone, into the end zone. OK. This will be-- in conclusion, every baby deserves a safe and appropriate medical care. Please oppose this dangerous bill.

HARDIN: I'm sorry if I missed it earlier. You said home births 2 to 3 times higher and I missed-- is that complications, fatalities? What's spec-- is specifically--

NICK TOWNLEY: Mortality.

HARDIN: Mortality, so it was fatalities. Senator Riepe.

RIEPE: Thank you, Chairman. Thank you, Dr. Townley, for being here. On the case of the lost twins, was that a result of failed prenatal care, or was that specifically because of a home delivery?

NICK TOWNLEY: I think the incompetence of not knowing it was a twin pregnancy.

RIEPE: So a missed diagnosis--

NICK TOWNLEY: Missed diagnosis.

RIEPE: --if you will. OK.

HARDIN: Senator Ballard.

BALLARD: Thank you, Chair. Thank you for being here, Doctor. Help me understand, what would you do if a mother came to you and said I-- I'm just more comfortable at home. Would you just tell her no? Would you say you have to be in the hospital? Would there be-- if they-- if she didn't want a midwife, would you, would you be able to give birth at home?

NICK TOWNLEY: Yeah. So we, we work really-- we work-- have good collaboration with nurse midwives in the hospital and birth centers. I would talk to-- if the mom was asking me for personal advice, I would

talk to her about what I've seen. And unfortunately, I do see the sickest and the worst outcomes. That's who they come to, at the neonatal ICU. So I would talk to her about what I've seen. These are healthy pregnancies, big babies. They should have done well. They should be alive. They should be ready to go to kindergarten. Those are-- that's what I would talk to them about.

HARDIN: I have a strange question for you that you may not know. So I have worked in the health insurance world. Is there such a thing as global billing? Because cost is a consideration. Certainly not the only consideration, but is there a way to make a hospital birth less expensive? Even in a world of the Affordable Care Act and so on and so forth, out-of-pockets can still be enormous. And so are you aware of either the hospital where you serve or others that are essentially working to help make that process more affordable? Sometimes they like cash.

NICK TOWNLEY: Yeah.

HARDIN: I'm just saying that out loud. So can you kind of comment on that?

NICK TOWNLEY: I don't think that's a strange question. I think it's something that we deal with separately to this, you know, things that we try to cut down-- medication use. We really focus on trying to get the length of hospital stay down, things like that, that, that help families not have resource board-- burden. You talked about global payment. Bundled care is sometimes the word you'll hear.

HARDIN: OK. And so that's available?

NICK TOWNLEY: It's, it's available. And, and we, we do talk about and do worry about it.

HARDIN: OK. Very well. Other questions? Senator Quick.

QUICK: Thank you, Chairman Hardin. And then just to kind of go off of that, I know, like at CHI sometimes, if a patient doesn't have insurance, they can apply for assistance or for-- and I don't know if, if that works that way at your hospital, as well. And I know sometimes, that also drives up the costs for others, because now you have someone not paying. And so, that-- can you talk about that?

NICK TOWNLEY: In-- no, in the hospitals I work at, we have case managers who meet with families pretty early on in their admission, to

go through that process. Because babies inherently don't have their insurance immediately, and they'll work through that in that paperwork.

QUICK: OK. And then just one other question. You know, you talked about the forceps. Is that something-- and I guess I, I don't-- I didn't even think about that. But is that something that they can do now or do you know that, that nurse midwives can use the forceps?

NICK TOWNLEY: No, I would have to leave that's-- I can't imagine they're trained to do that. Some of the more senior obst-- obstetricians that I know, you know, even shy away from it, just because we know how-- the risks involved. There are very skilled obstetricians at forceps, but they are a lot older and a lot-- and have done it for a long, long time. But, you know, to your questions earlier, talked about kind of the infant resuscitation, and some of the things were brought up that they're trained at NRP. During those comments, I looked through the NRP item checklist and there was 12 things on what supplies you need for NRP that you can't have at home, that you're not going to have at home. So those kind of statements are-- worry me.

QUICK: Yeah. Well, and then also being able take care for 2 patients at once. And you have someone else there, but are they able-- are they trained to actually take care of one of the patients?

NICK TOWNLEY: In NRP, you're going to need 2 or 3 people in itself for just NRP.

QUICK: OK. All right. All right. Thank you.

HARDIN: Other questions? Seeing none, thank you.

NICK TOWNLEY: Thank you.

HARDIN: Opposition to LB374. Welcome.

AMY PINKALL: Hello. Thank you for your continued patience, Senator Hardin and committee. My name is Amy Pinkall, A-m-y P-i-n-k-a-l-l, and I'm a physician testifying on behalf of the Nebraska chapter of the American Academy of Pediatrics. As a pediatric hospitalist physician, I provide medical care for newborns in the hospital setting. My testimony will focus on the bill's impact on newborns. However, provisions of this bill do not ensure safe and appropriate care for newborns nor their mothers. Certified professional midwives, also

known as direct entry midwives, lack adequate training to safely handle the unexpected risks and complications of managing labor and delivery and the care of newborn infants. The American Academy of Pediatrics, the AAP, does not recommend planned home birth, which has been associated with, as we just heard, a twofold to threefold increase in infant mortality in the United States. Rates of mortality for infants delivered at home by lay midwives is even higher. Mortality for infants delivered at home by lay midwives is up to fourfold higher than those delivered in the hospital. AAP policy dictates that 2 care providers should be present at each delivery. And I think other, other testifiers have touched on this. And at least one of these providers should have the primary responsibility of taking care of the newborn. And they need to have the appropriate training, skills, and equipment to perform a full resuscitation of the infant, according to the Neonatal Resuscitation Program. Approximately 10% of deliveries of full-term infants require some degree of resuscitation. So having trained skilled providers that are able to assess infants and intervene immediately when necessary is of the utmost importance. This bill does not ensure the CPM would have the necessary skill set to resuscitate a newborn. This bill would allow direct entry midwives to care for-- provide care for the newborn immediately following birth and for up to 6 weeks after birth without any medical training or degree. It is a critical time in a baby's life. They're at risk for a multitude of conditions such as hypoglycemia, low blood sugar, hyperbilirubinemia or jaundice, sepsis, and congenital heart disease. This bill does not ensure the CPMs have the medical knowledge, skills, or training to recognize and promptly treat these conditions. This bill is unsafe and puts at risk the lives of our smallest and most vulnerable newborns. Thank you.

HARDIN: Thank you.

AMY PINKALL: Any questions?

HARDIN: Questions? Senator Quick.

QUICK: Thank you, Chairman Hardin. So I know you heard me talk a little bit about like, the, you know, the baby care.

AMY PINKALL: Yeah.

QUICK: And so I know like, usually in a hospital setting, you would have a pediatric nurse, a labor nurse. Then you would have-- also have that pediatric doctor and, and a doctor for the, the mother

themselves. So-- I know sometimes, there's a family practice doctor that can do both. But that training to take care of both of those is, I think, vital. So I don't know if you can talk a little bit about the training.

AMY PINKALL: Right. So-- and I think it's important that it needs to be more than one person that has that capability for for taking care of mom and baby. You can't have one person who's capable of both, because sometimes they're both needing care at the same time. So in the hospital setting, we have sort of, you know, different levels of attendance at deliveries based on risk of moms. But there's always someone there whose only job is that baby and to be able to resuscitate that baby. If there are problems, then, of course, they call, and a whole team of people comes to assist. But they have, you know, a checklist of equipment that they look at before delivery to make sure that they're able to intervene in any way necessary immediately after that baby's born.

QUICK: Yeah. Thank you.

HARDIN: I know I'm asking you to speculate a bit. How many times does that doctor of the baby need to rush that baby off because there's a complication that is quite disconcerting or disconcerting-- requiring special care of some kind that would not be safe if the baby was born at home. How many--?

AMY PINKALL: Well--

HARDIN: --times out of 10 might that happen?

AMY PINKALL: I mean, 10% of deliveries require some intervention.

HARDIN: OK.

AMY PINKALL: And sometimes, it's pretty minimal intervention.

HARDIN: OK.

AMY PINKALL: And I don't know the specifics. I think it's closer to 1% for significant intervention, you know, CPR-type things.

HARDIN: OK. That's helpful. Thank you.

AMY PINKALL: That's what, what the Neonatal Resuscitation Program quotes, I believe, is 1%.

HARDIN: OK. Other questions? Seeing none, thank you. Opposition to LB374. Welcome.

ROBERT WERGIN: Good afternoon, Senator Hardin and members of the committee. My name is Dr. Robert Wergin, R-o-b-e-r-t W-e-r-g-i-n. I'm speaking on behalf of the Nebraska Academy of Family Physicians. It's a family physician association that has over 1,200 members across the state. I'm speaking in opposition of LB374. I'm a family physician who has practiced obstetrics in a rural Nebraska setting for over 30 years in Seward, Nebraska. I've delivered over 1,000 babies in my career and, and probably 100 cesarean sections when needed. I served as national president of the American Academy of Family Physicians, which represented 130,000 physicians at the time I was president. After serving in that capacity, I was a member of the American Board of Family Physicians. The American Board of Family Physicians determines the standards for family physicians' criteria to be competent in OB delivery and C-sections. The standards that are set by the American Board of Family Physicians are high for family physicians. They are high for a reason. Childbirth is one of the most dangerous parts of a woman's life. We have become accustomed to good outcomes. Many fail to recall the tremendous risk associated with childbirth, unless they practice obstetrics and have first-hand knowledge of the complications that can accompany childbirth. The point I'd like to stress to this committee is when these situations start going wrong with childbirth, it usually happens extremely quickly. Physicians have mere seconds to intervene before adverse outcomes start to set in. This could be a child who is not breathing, an umbilical cord event, a mother that is hemorrhaging, these scenarios happen frequently with pregnancies that have already been normal throughout the entire pregnancy and kind of unpredictable until the moment of delivery. The amount of coordination during adverse situations like these is critical to the child and mother survival. The amount of training, preparing, and resources for emergencies matters as well. This is especially true in rural settings. Many times, my volunteer ambulance service have a slower response time for transportation to a higher level of care. When a mother is hemorrhaging or a newborn is not breathing, the ability to access advanced resuscitation, transfusions, or emergency C-section can mean the difference between life and death. I urge you to prioritize the safety of Nebraska mothers and newborn-- borns and oppose LB374. Thank you for your time and I'd be happy to answer any questions as a rural family physician that does obstetrics.

HARDIN: Thank you. Dr. Wergin. Questions? Senator Riepe.

RIEPE: Doctor\, thank you for being here. Good to see you again.

ROBERT WERGIN: Good to see you.

RIEPE: My question is, this may be a, a not accepted question. Is the standards, are they exact or is there some latitude, if you will, given the situation of-- or do the standards have to be firm standards? Exact?

ROBERT WERGIN: It's a good question. On the American Board of Family Medicine, they've gone to [INAUDIBLE] based evaluations. In other words, you can't predict all the situations, but you instill anticipatory learning and, and knowing how to handle emergency situations. This is probably even more critical in rural situations. The best way to get out of trouble is not to get in trouble. And, and you're trained highly in assessing those patients. Abruptions was mentioned. It's a scary proposition. And we've had patients in Seward-- we've had to do crash C-sections that weren't our patients. They showed up in the ER, bleeding. The baby's heart tones were down, and we just had to do it. And, and it was unpredictable. They-- but they couldn't drive the other 35 miles on to-- here, to see their OB-GYN, so. It, it-- having, having done it in a rural setting, it's your anticipatory guidance. You're always anticipating what may happen and, and get help from my colleagues and Lincoln perinatologists.

RIEPE: Do you continue to deliver babies?

ROBERT WERGIN: What's that?

RIEPE: Do you continue to deliver babies at this time in your career?

ROBERT WERGIN: I, I just turned 70. I stopped obstetrics here last January. I did deliver someone that I had delivered. I thought maybe that means that it's time for me to--

RIEPE: Sort of a legacy?

ROBERT WERGIN: I guess so. I-- she wondered why I was crying when I was delivering the baby. I remember delivering her.

RIEPE: Wow. Do you take OB-GYN call at the local emergency hospital?

ROBERT WERGIN: When you're on call-- yeah, when you're on call in the emergency room, you, you don't turn anyone away. You take all comers. My son is a family doctor in Fairbury, Nebraska, a rural community.

And they stopped OB because of cost and that. And I told him, you do the worst kind of OB because when they come in, they're not your patients. They're an abruption or bleeding. And he's had to deal with that. People from Hebron and surrounding areas were trying to get to Beatrice and pulled off the road there. So, yes, in an emergency setting, in a rural setting, you take all comers and-- I've delivered babies in the emergency room.

RIEPE: Do you see another generation of physicians that are willing to do deliveries?

ROBERT WERGIN: It-- that was a really-- you always come up with very good questions. It's getting a little more difficult because the demands placed on you being on call in rural settings and that, but--

RIEPE: And the liability.

ROBERT WERGIN: Well, it's a--

RIEPE: The liability premium.

ROBERT WERGIN: It is. And that's why in rural settings, you mentioned OB deserts-- southern Georgia is one-- that, that it, it becomes difficult for hospitals, when they look at their balance sheet, to say gee, should we be doing OB? We don't do enough. The, the question is this: what is your mission for-- other areas? Is it to make a positive bottom line or serve the individuals in your community? I'd say it's to meet the services needs of your community and then figure out how to get it paid for it, because low volume, high cost is not a good business formula, and that's rural Nebraska.

RIEPE: Have you been featured in the Wall Street Journal lately?

ROBERT WERGIN: Not, not lately. I was on the front page.

RIEPE: I know you were.

HARDIN: Other questions? Senator Quick.

QUICK: Thank you, Chairman Hardin. One of my questions was about the administration of drugs. You know, when they would-- you know, what drugs they could actually-- given. So I know, like in the hospital setting, I thought my wife would have to call the doctor to make sure we can start this drug or give this drug and make sure that the doctor approved all that. So can you talk a little bit about that? So.

ROBERT WERGIN: Well, it is a team sport. And, and many of the meds-- and it's surprising how often it comes up, even post-partum hemorrhage or during the course of a, a pregnancy. And it-- often the, the nursing staff and I work closely, the labor and delivery nurses work closely together. And it's surprising how many times, even after delivery of the baby, you know, they call me bleeding and you have to assess it. And perhaps, medications in those instances-- and, and there are medications that-- again, I don't do the volume of some of my OB colleagues, so it's not drugs I use every day, but I'm familiar with them and doing them. I, I can't imagine given them in a home setting, just for my thinking. I, I wouldn't want to do that.

QUICK: Well, and I think about the dosages. How do you know what dose to give for a certain-- and then maybe some drugs have to be used intravenous-- with, with that-- I can't even say the word-- intravenously?

ROBERT WERGIN: Yes.

QUICK: And also, some could be given through maybe a, a shot, but.

ROBERT WERGIN: Many of them are intravenous and, and the dosing you have-- you go over in your head and, and that. And you're, you're, you're sure. Before you go in, you anticipate and that, and the nurses and you working together, and there-- and you do those things. And it, it comes up more often than you think.

QUICK: All right. All right. Thank you.

HARDIN: Additional questions? Seeing none, thank you. Opposition to LB374. Welcome.

JOHN MASSEY: Mr. Chairman, members of the committee, my name is John Massey, J-o-h-n M-a-s-s-e-y. I'm testifying as a physician and as a member of the Board of Medicine and for the Board of Medicine. Many of my colleagues, when we were talking about this, we typically stay out of the political issues, but they were all regretting not being able to be here. We're very concerned about this bill for a number of reasons. As a practicing anesthesiologist, I've been familiar with the situation that was described for a very long time, where we're having a very warm, comfortable, expected labor course, and all of a sudden things instantly turn terrifying, with life-threatening conditions that have to be changed and have to be fixed immediately, without-- otherwise, we'll have very poor outcomes for the, for the patient.

That's disconcerting to family members when they don't understand what's going on and certainly reduces their comfort level. But the thing I would emphasize in that is what makes this a safe thing is the team that's provided and the training that's provided of the members on that team. As a member of the Board of Medicine, one of the, one of the most challenging aspects of what we do is we have to review cases where individuals have received care with catastrophic outcomes-- trained individuals, and things haven't gone well and there's been a devastating or life-altering outcome. There are a lot of features about those kinds of situations that stand out. Very typically, it's an individual who has been operating just outside of their expertise and training, where they've maybe had minimal training. Very often, individuals who are not collaborating with a team in an advanced way prior to an, an event occurring, and also, people who fail to anticipate that because of the lack of numbers of training and, and the experience that's coming with that. In other words, they're not reflexively acting when emergent situations happen. And this-- you can tell from the testimony that, that certified nurse practitioners in this situation would be very vulnerable to that kind of a situation in a home birth environment. That's why we believe this is not a turf issue. You, you very often hear physicians talking in, in a different way from nurses, from advanced practice nurses. But I remind the committee that the Advanced Practice Nursing Association, the Nursing Association, and the Physician Association, as well as the Hospital Association, all stand united in opposition to this, because of the potential for untow-- untoward events. For those reasons-- we're also concerned that this will actually limit access to care rather than improving it. The individuals who deliver at home don't have access to liability insurance if an untoward event occurs. Those individuals will go to the emergency room urgently-- emergently, like you heard testified earlier. And now, as soon as they interact with the healthcare system, now the liability of the healthcare system is activated and those are going to be where the deep pockets are. So we have a, we have a concern that this is going to make liability worse in the state, and possibly threaten that environment as well.

HARDIN: Questions? Senator Riepe.

RIEPE: Thank you, Chairman. I know in the delivery business you're an anesthesiologist. Either too much oxygen or not enough oxygen is a real problem. And I don't know how-- you know, I don't know how someone in a rural-- or a midwife home delivery can address-- or identify and address that issue. And I'm not sure how-- I assume it

doesn't happen often, but it only has to happen once, and you've got a real problem.

JOHN MASSEY: Well, well, reflect back on the testimony that you heard, not just oxygen and fluids, right? Individuals-- too much fluid and too little fluid is bad, as well. These individuals, moms, as well as babies, can very easily get-- what did we-- 5% of, of delivering mothers hemorrhage and need resuscitation with that. If you give IV fluids without training of some sort or another that's adequate, you can easily put a mom into pulmonary edema. I do not believe anyone testified that they would be able to diagnose breath sounds. Certainly, they don't have access to the equipment needed to determine if pulmonary edema is occurring or hypovolemic shock is occurring. Those kinds of things happen urgently and lead to mortality and morbidity that can't be recognized out in, out in an environment without medical resources, which is why the American College of-- ACOG states that the safest environment for delivery is within the healthcare system.

RIEPE: Does-- I'm, I'm, I'm just curious, does anyone have a number of how many either babies or mothers have been lost because they weren't able to get to-- some form of delivery in some place across-- probably in rural Nebraska?

JOHN MASSEY: Well--

RIEPE: I don't know, I don't know whether that number even exists.

JOHN MASSEY: Depending on which statistic you look at, either 1.5 or 2.5 times more likely to occur.

RIEPE: Is that right?

JOHN MASSEY: There were 12,000 babies delivered in the state of Nebraska. Multiply that number. And right now, you know, we talk about less than 1% are delivered at home. But there-- again, we're not, we're not opposed to midwives. We should be respectful of the environment that mothers want to have and their families want to have. But it's impossible for people to understand the risks that they're in-- incurring without the, the appropriate training.

RIEPE: OK. Thank you very much for being here.

HARDIN: An uncomfortable question, sir. Can I ask one of those?

JOHN MASSEY: I've been through oral boards. Sure.

HARDIN: Well, I'm asking you to speculate a bit.

JOHN MASSEY: All right.

HARDIN: Not all hospitals are perhaps created equal. And so, I'm asking you to speculate. What's it like to go to a rural hospital versus oh, I don't know, somewhere in a bigger city where they're very well-equipped. I'm asking you to differentiate on that continuum.

JOHN MASSEY: I, I don't have to speculate for that.

HARDIN: OK.

JOHN MASSEY: I practiced in Oshkosh and out in the Panhandle, very small communities as well as metropolitan areas. Unquestionably, it's more challenging with reduced resources. You heard Dr. Wergin talk about how you have to think about that. But what you have to do is you have to think about it in advance and you have to be a member of a team. With today's technology, telemedicine, flight, you know, ambulances, the ability to coordinate, if you have a team, then you're going to be able to do a much better job, no matter where you are geographically. And this, this kind of quasi-licensing, you know, the, the fact that there's going to be a board of, of individuals that are all certified, you know, CPMs, and people who have been advocates who are going to serve on that board. They're kind of setting themselves apart from the rest of the healthcare team, aren't they? You can, you can see that resistance, or when they talk about, you know, very few moms die because of-- or babies die because of the cord being wrapped around. Right. Well, that, that, that number is 10-30%. Right. And if you're not able to recognize that up front, you're not going to be able to do something about that. So you can be in a geographically isolated location. What you have to have is a willingness to be part of a team and collaborate and get the training necessary to do what, what you purport to do.

HARDIN: Thank you. Any other questions? Seeing none--

JOHN MASSEY: Thank you.

HARDIN: Thank you. The next person in opposition to LB374. Opposition, LB374. Can I ask this question? How many are in the neutral to LB374? The neutral. Very well. What I'm going to do is-- Page, can I ask for your help? Let's, let's see how many human beings are in the other

room over there, and encourage them to begin to fill in these chairs. It's getting chilly in here, and we'd like it to warm up a little bit. So we're going to now go back to the proponents for LB374. Who would like to speak to us next? We're back to the proponents for LB374. If someone who's in opposition, we will eventually flip back here. We probably won't necessarily go an hour and a half. We might make our intervals a bit shorter, hour, or whatever it needs to be, but welcome.

SALLY HUFSTADER: Thank you for your time, you guys.

HARDIN: And I just want to say you are in rare company, because you are now sitting-- well, one of them's about to get up and leave it looks like-- the, the, the 3 last chairs of Health and Human Services are sitting here, right now.

SALLY HUFSTADER: We're going to make it. We're going to do it.

HARDIN: So this has, this has never happened before in the history of Nebraska, so I just wanted to give you that opportunity.

SALLY HUFSTADER: I appreciate your time, you guys. I am Sally Hufstader, S-a-l-l-y H-u-f-s-t-a-d-e-r. I am a doctor of chiropractic and I have had 5 children born under midwife care at home. Procedures cost money, and the hospital is where you would find those costs rise quickly. According to an analysis by Healthnews team, the average home birth fee in the United States is $5,396. In contrast, a vaginal birth in a hospital costs more than twice as much, at approximately $13,000.24-- $13,024 before insurance. If you have a hard time finding the fees for Nebraska, it's because you can't have a midwife attend your birth in Nebraska. My own home births averaged about $4,000 apiece. This cost included a birth kit, the prenatal care for my entire pregnancy, infant assessments at delivery and postpartum, and any postnatal visits that they deemed necessary. According to Healthnews, home birth has risen 56% across the nation between 200-- 2016 and 2022. Midwives are in high demand and Nebraskans need to be allowed to have the freedom to choose their healthcare providers. My husband and I chose to have a midwife-attended home birth because I wanted someone who could help us if the birth did not happen without complications. My birth story will illustrate a few complications, being overdue, breech, and dystocia. My fourth baby was overdue by 2 weeks and presenting breech. That's where her feet are down. Right. Not the way you want to have a baby. She had been flipping back and forth for a month. We'd been monitoring and checking and measuring. I

had no other abnormal symptoms, and my baby's heartbeat was strong. By the time I went into labor in the evening, the baby had turned and was headed out. Her labor was difficult. I rested on my side until it became time to push. As she was being born, she got her shoulder caught.

HARDIN: You're in the red, but I cheated you out of the first 30 seconds, so keep going.

SALLY HUFSTADER: OK. So her shoulder got caught. This is called shoulder dystocia. My midwife was quick to respond, and she knew just what to do. Her clever hands brought out my daughter and then stimulated her to breathe. She responded and recovered quickly and has no problems. She was 10 pounds, 1 ounce. I'm going to stand up. I'm 5 foot 2. I had a 10 pound, 1 ounce baby, right, with her shoulder stuck, and she came out-- in under 2 minutes, she had me turned and that shoulder wiggled out and the baby was healthy. Resus-- like, all she had to do was rub her chest and she started breathing, or she was ready to resuscitate that baby. My nephew was born in a similar situation. OK. Can I go ahead?

HARDIN: We encourage you to wrap up very soon, would be good.

SALLY HUFSTADER: This is by contrast. OK. He was born in a hospital. He was born closer to his due date. She was-- he was 7 pounds at the time he was born, and my sister-in-law is larger than I am by 4 inches. His head had been pulled on by the nursing and obstetrics team, and then his shoulder got stuck and they broke his collarbone on the way out. He was a fussy baby. They didn't realize his shoulder that had been broken until 2 weeks later. My experience with homebirth has been fantastic. I have a very well-educated midwife who sees what's going on. I was, I was educated. If you have a breach, baby, this is what we will do. If you hemorrhage, this is what we will do. If this, then this. Right. I didn't go into this uneducated and ill-informed. I had somebody hired that I knew was well trained and had lots of experience. She gave me references, just like you would find a good mechanic or a great plumber. Yes. We need to have access to experienced, capable midwives and help us giving birth because these people should not fear criminal prosecution for doing this work in our state, which obviously they are doing. OK. Question?

HARDIN: Is your, is your oldest a gymnast?

SALLY HUFSTADER: My oldest is not a gymnast.

HARDIN: OK. I just wondered, because they figure that out, that, that flipping around.

SALLY HUFSTADER: Yeah. Well, this is my fourth that was flipping around.

HARDIN: Your fourth was the gymnast.

SALLY HUFSTADER: Yeah.

HARDIN: OK.

SALLY HUFSTADER: Yeah.

HARDIN: I appreciate you being here. Questions? Any questions, Merv? It's you and me.

RIEPE: No, no, no. No.

HARDIN: OK.

RIEPE: No, I have--

HARDIN: Thanks for sharing.

SALLY HUFSTADER: Yeah.

HARDIN: Time's up.

SALLY HUFSTADER: Thank you.

HARDIN: Yes. Appreciate it very much.

SALLY HUFSTADER: All right.

HARDIN: Proponents, LB374. Proponents, LB374. Welcome.

DAVID NELSEN: Thank you. Thank you, Senator Hardin, Senator Riepe, for still being here. I wrote something out here. I'm going to summarize rather than just read it. My wife might not be happy with that, but I'm going to do that. You've heard from many women. You've heard from a few fathers. You've heard from many medical--

HARDIN: Can you state, can you state and spell your name for me, please?

DAVID NELSEN: Went off script. So David Nelsen, D-a-v-i-d N-e-l-s-e-n. So I was raised right here in Lincoln, Nebraska, just a few blocks away from here. I experienced home birth, unplanned, at a young age with my mother, who might be in the other room watching. Oh, she's back there. And then from that, because it was a very fast labor, she went down the path of having a midwife at home so she could immediately lay down and labor would not progress very fast. Had 2 great, fantastic births, including 1 full breech birth that the midwife took care excellently. And I observed that at a young age. Then, because of what we heard earlier in testimony, some of the-- I guess, clamped down in the early '90s that midwives stopped practicing and went to-- my-- what-- my mother went to hospital care and had 2 very good births, but much higher stress situation. Fast forward several years later. I was living in California with my wife. We were able to get excellent care with CPMs and CNMs in a independent birthing center. It's outside of a hospital. After 3 amazing, unique births in this birth center in California, we decided to pursue, pursue home birth with a certified professional midwife that would travel to us because we now live much further away, more than an hour away from where we wanted to give birth. During that pregnancy, we actually transferred care because a high-risk situation came up, transferred to the hospital at about 35 weeks. They identified the risk. The risk was taken care of and we transferred care back to our home, ended up having a highly successful home birth, at full term. When we moved back to Nebraska here about 10 years ago, we very quickly found that the home births, the CPMs, and even the CNMs were under much more scrutiny. And essentially, they're functioning underground. So we had to make a decision if we wanted to have unassisted home birth or an assisted home birth. For a while, I was considering doing unassisted home birth. I changed my mind. Thank God, I changed my mind. We had an assisted home birth and had a certified professional midwife there, had a few more births after that. And all those turned out great. Then, because of some changes, a few years ago, my most recent child was actually going to be born in hospital. But because we live over an hour away, one of those deserts, as they're being called, we hopped in the van in the middle of the night. And the baby was early, 35 weeks, and my son delivered the baby as we were racing down the road, trying to get to the hospital. It's probably the most executive decision I've ever had to make, with my wife screaming at me to pull over right now. But I decided we were close enough that she could deliver the baby and we would get to the hospital because it was a near-term birth. So we've had quite the different birth stories out there. So I see my red lights going off.

HARDIN: Yes. If, if you can help us out, that would be great.

DAVID NELSEN: Yep. Yep. The Licensed Midwives Practice Act, I believe, will provide the avenue for many more midwive-- midwives to practice in the state of Nebraska and it would create more opportunities for high-quality, quality midwifery care for people like me and my family who live far from a population center and who have desired to have a low-stress delivery, when applicable, for both the mother and the baby. So I encourage you to support LB374 and I'll gladly take any questions, as I've witnessed many of the scenarios that the midwives were explaining happened, from a father's perspective.

HARDIN: Where, where do you live?

DAVID NELSEN: Red Cloud, Nebraska.

HARDIN: OK.

DAVID NELSEN: South of Red Cloud.

HARDIN: Gotcha. OK. Questions?

RIEPE: Thanks for coming.

DAVID NELSEN: Little worried about the icy roads out there, but you tell me the highways are. OK, so.

HARDIN: Be safe. Thank you. Appreciate it. Proponents, LB374. Any more proponents? Do we-- we, we, we, we found one? OK.

DANIEL LANCASTER: I can't believe they're aren't more in here.

HARDIN: Don't be shy. You're welcome.

DANIEL LANCASTER: Thank you. Good evening to the committee, the Health and Human Services Committee. My name is Daniel Lancaster, D-a-n-i-e-l L-a-n-c-a-s-t-e-r, just like the county we're located in, no relation. I'm the father of 4 children, the first 3 of which were born in a hospital environment, the fourth of which was born in a home birth, planned here in Nebraska. I'm here to testify in support of this bill for that reason. Now, you've already heard some spectacular testimony from a variety of people this evening, fathers like myself, mothers, midwives, telling you all the good reasons to support this. But I'm going to give you something a little bit different than what you've already heard, at least in this hearing. Unfortunately, I have to use

the naughty term brain drain. We hear about this over and over again in all of these hearings, and I watch a lot of them so I know you guys have heard it. There are people that say if you implement too much conservative legislation in this state, they're going to take their college degrees and leave town. I'm here to tell you that that's a 2-way street. I have 2 bachelor's degrees, a graduate certificate, and a master's. I moved into this state because it's conservative. This legislation right here is part of the reason why. When you give people the right tools to raise a family, they are going to come here. And they're not just going to come here with their college degrees. They're going to come here with their family. If you want more people in this state, bills like this are a way to do it. If you want to listen to doctors who say that home birth is bad and evil and scary, we already know there is 38 other states out there that disagree. I've got Google Maps and I know where to rent a U-Haul. For that reason, I'm encouraging you all to pass this legislation. I will happily accept any questions.

HARDIN: Thank you. Questions? It's a fresh perspective. I appreciate you listening. Don't think we have any more questions for you. Thank you, Mr. Lancaster.

DANIEL LANCASTER: Thank you for your time.

HARDIN: Other proponents for LB374. Welcome.

LAUREN HUSTON: Hi, my name is Lauren Huston, L-a-u-r-e-n H-u-s-t-on. Thank you for having me and for listening. I'm here in support of LB374. I grew up in Nebraska. I moved to Washington State, and then I recently joyfully moved my family back to Nebraska. I've been fortunate enough to have had a home birth legally assisted by a CPM midwife in Washington state in 2020, and then again, 1 month ago, a midwife-assisted home birth here in Nebraska. When I moved back to Nebraska in between the births of my 2 children, I was floored by the lack of accessible and safe care for birthing women in my home state. It was incredibly challenging to find the care that I deserved and wanted for our home, home birth. Most women I know give birth-- giving birth in Washington have midwife assisted home births. It's just the cultural norm out there, and I have yet to hear of any adverse outcomes for moms or babies from those women in Washington. And I know many women who choose to give birth here in Nebraska, too-- to give birth at home, regardless of our state's laws. But few have access to integrated care. I want to stress that our midwife-assisted home births in both states were peaceful and above all, safe. It's

important to note, as many have said, that Washington is one of the easiest and safest states in which to give birth at home, as midwif-- midwifery care is integrated so seamlessly into the medical system. Licensure makes it easy for families to check their midwife's credentials and qualifications, and for midwives to connect with other providers and institutions for issues that are out of their scope of practice. There have been many studies done on the safety of midwife, midwife assisted home births, and the consensus is that the outcomes for mother and baby are by and large the same as low-risk births that occur in hospitals and birth centers, and often involve far fewer interventions. I have, on the back of my written testimony, included many studies that will verify this information and support these statements. Thank you so very much for your time, and I encourage you to support LB374.

HARDIN: Thank you. Questions? Senator Riepe.

RIEPE: Thank you, Chairman. Were most of your friends that did home birth in Washington young cohorts like yourself, not at the 40-45 year age group?

LAUREN HUSTON: I did know actually quite a few moms who are in their 40s who are giving birth at home.

RIEPE: Oh really? OK. Thank you.

LAUREN HUSTON: Yeah.

RIEPE: Thank you, Chairman.

HARDIN: Other questions? Seeing none, thank you.

LAUREN HUSTON: Thank you.

HARDIN: Proponents, LB374. Any more proponents? Just so you know, we're going to-- I'm probably going to squeeze all of the proponents out now, so we're not going to do another revolution, if you will. So we're going to go from this back to opponents, if there are any. and give one more opportunity for the neutral. Then we'll be done. So make sure that if you're a proponent that you step forward in this grouping, if you wouldn't mind. And so with that, welcome.

JONATHAN GOODDING: Thank you. My name is Jonathan Goodding. It's J-o-n-a-t-h-a-n G-o-o-d-d-i-n-g. My wife and I are lifelong Nebraskans. We have 8 children, many of whom are sitting back there,

all of whom were born under the care of midwives in both hospital and birth center settings. We have not had a home birth. As you may be aware, the Lincoln Birth Center just closed while we were pregnant with our eighth baby, and it was a time of extreme uncertainty and discouragement in my family. Over the years, as we've gained more experience with birth and know the type of care that we need and what type of environment is best for our family, for my wife, for the births, which she's obviously very skilled at giving birth, we've become increasingly frustrated and disheartened by the state of birthing freedom, and I do mean freedom, in Nebraska. We have a lack of freedom that other places in the United States have. When it comes to home birth, Nebraska law is restrictive and oppressive. Apparently, the state thinks it knows better than mothers when it comes to birthing their own children. This issue, more than any other, makes us wish we lived in a different state. Technically, I know homebirth is legal in Nebraska, but having a trained professional assisting a birthing mother at home is prohibited and prosecuted. In my estimation, that's bad law. Why does the state presume to think that it has more wisdom than the billions of women who have birthed their babies at home under the care of midwives for thousands of years? As citizens of the state, we should be free to make our own decisions about when to seek medical care. Having a baby is among the most natural processes in existence. The state should not dictate whether we have to go to a hospital. The state should not prohibit us from hiring a trained professional in our own home to assist us in giving birth and advise us where it's best to seek further medical care. While I do understand that the state has a responsibility to protect their citizens from those who claim to provide, claim to provide medical care but have no training or experience, certified professional midwives are neither untrained nor lacking in experience. They should be licensed in our state, as they are in many others, so that they can provide much needed maternal care without the fear of prosecution. Senators, I implore you, give certif-- give certified professional midwives the right to practice in our state and begin to restore birth freedom to the families who are your citizens. Thank you.

HARDIN: Thank you. Questions? Seeing none, thank you. Proponents, LB374. Welcome.

JAAKAN NELSEN: Hello. Hello. My family and I-- well, my name is Jaakan Nelsen, first.

HARDIN: Can you spell your name for us?

JAAKAN NELSEN: Yes. J-a-a-k-a-n N-e-l-s-e-n. My family and I live down on the Nebraska/Kansas state line on a farmstead. And I wanted to tell you a little bit about my experiences with home birth and midwives, even though I have yet to have a birth. Out of my 8 siblings, I remember 5 of their births. In all of these, my mother's and baby siblings' health were immeasurably blessed and immeasurably impacted by the midwives who aided us with their skills. When we moved back to Nebraska from California, my parents could not find any midwife options in the area, so they realized they needed to plan for an unassisted home birth, but God graciously provided a midwife, however, so an unassisted home birth became unnecessary. The midwife at that birth ended up saving my mom's life. Because of her extensive experience, our midwife was able to stop the unexpectedly severe bleeding when my mom hemorrhaged. She was able to stop that with the knowledge she had accrued, even without the ability to carry Pitocin or other basic lifesaving equipment. Our first Nebraska birth could have easily been an utter tragedy, but it wasn't because of our knowledgeable midwife, and for that I am very grateful. The midwives we've been blessed with in Nebraska have been perfect for our family. They've been flexible to our scheduling needs, to our large size, and to our rural location. They have been kind, very calm and gracious when working through many health issues, they've been incredibly professional with giving us information on the options and with keeping detailed records for other midwives or other medical professionals to look back on. Our-- in fact, our family's experience with them has been so good that I cannot imagine not having access to them for my own future births. A side note about maternity care deserts. My youngest sister was born in a 15-passenger van because there was no maternity care near enough and accessible enough when we needed help with that. But the main thing I wanted to communicate is that we care. And by we, I don't just mean midwives, I don't just mean mothers and fathers, I mean the future generation, the coming generation of which I'm a part. What's more, access to midwifery-- midwives have been essential to our past and will be integral in the health and wellbeing of future births for, for myself and others in this state. I care about my and my children's future, about my freedom to have a natural, normal birth aided by skilled local midwives. That's why I'm asking you to support LB374. Thank you for your time.

HARDIN: May I ask what year in school are you?

JAAKAN NELSEN: I'm technically, I could-- because I'm home schooled.

HARDIN: Yeah.

JAAKAN NELSEN: I could be graduated. However, I have not graduated yet because I-- there are more things I want to pursue.

HARDIN: I see. OK. So you-- you're younger than 35 is what you're saying?

JAAKAN NELSEN: Yes.

HARDIN: You're my hero. You've done an amazing job here today. Thank you. Questions? Senator Riepe.

RIEPE: I guess I would ask the question, are you the oldest of all the children?

JAAKAN NELSEN: Yes, I am the oldest of 9.

RIEPE: So you're the junior mom?

JAAKAN NELSEN: Kind of.

RIEPE: Kind of?

JAAKAN NELSEN: Yeah.

RIEPE: Wow. God bless you, and thank you, and you did a very nice job. I wanted to echo what the chairman was-- said you did a nice job.

JAAKAN NELSEN: Thank you.

HARDIN: Other questions? Thanks for being here.

JAAKAN NELSEN: You're welcome. I'm here because I actually care about this. And it-- a side note. It will influence-- it will dramatically influence where I decide to live my life, what freedoms I have in the various states. And home birth is a big aspect of that for me.

HARDIN: All right. Thank you.

JAAKAN NELSEN: Thank you.

HARDIN: Proponents, LB374. Welcome.

RYAN BOURLIER: Good to see you again. My name is Ryan Bourlier, R-y-a-n B-o-u-r-l-i-e-r. I'm going to cut this in half in the interest of time. I have an MBA from the University of Nebraska-Lincoln. I have my own CPA practice in my hometown of Kimball, Nebraska. We're located

in Senator Hardin's district, about 20 miles from both the Colorado and Wyoming lines. My wife was trained as a doula and has attended around 40 births in a variety of settings. We now have 5 children, ages 2 to 7, and are expecting our sixth child later this summer. Over the past 8 years, we have received services from nearly every type of maternity, maternity care service provider, including doulas, childbirth educators, labor and delivery nurses, lay midwives, certified nurse midwives, certified professional midwives, and also an OB-GYN physician. We have received these services in every type of setting: home, birth center, and hospital. Our primary maternity care provider for each birth was a midwife. I'm grateful that our experiences with each type of provider has been positive. Each has an important place in the maternity care ecosystem. Our first 2 children were born at a hospital here in Lincoln, and our next 3 were successful planned home births. However, due to the lack of home birth midwives in our area, we chose to travel out-of-state to birth at a friend's homes across the border. None of our planned births-- home, home births required any hospital-based interventions. And currently, we're using a midwife who is licensed and practicing in another state. And I'll stop there. Thank you for-- thank you for your time and thanks for supporting LB374.

HARDIN: Thank you. Questions? Yes, Senator Riepe.

RIEPE: I want to say thank you for traveling, and I know you've been here for some other hearings. We appreciate it.

RYAN BOURLIER: Thank you.

RIEPE: Thank you, Chairman.

HARDIN: That's what I was going to say. Thank you for making the 740-mile round trip.

RYAN BOURLIER: It just turns a 5-9 day into a 9-- in-- a 9-5 day into a 5-9 day.

HARDIN: OK. Thank you.

RYAN BOURLIER: Thank you.

HARDIN: Any other proponents, LB374?

ERIK BAUER: In the interest of time, I will also be very brief and--

HARDIN: Well, thank you.

ERIK BAUER: --won't even give a ratio. My first name is Erik, E-r-i-k, last name is Bauer, B-a-u-e-r. Thank you, gentlemen. I know it's late and you've been extremely patient, so I really appreciate that. I wanted to bring something just very brief and very unique to what's been said today. In our situation, my wife had 3 C-sections. We were born and raised here before moving out of state. But those 3 C-sections were here in, in Lincoln, actually. They were performed by a doctor, an OB-G, who was-- graduated first in his class. In each one of these instances, the diagnosis was failure to progress, which, looking back now, in all honesty and not to be snarky, was failure to not really utilize the services of a midwife, a licensed midwife. And when we moved out of state, my, my wife was able to find and leverage the services of an incredibly talented midwife, And the 2 subsequent in-home births were unbelievable. The thing that I just wanted to point out was I know there's a lot of talk about physicians and, and facilities and, and capabilities to respond, but the one thing that I don't think has been emphasized has been that there's a categorical distinction between a midwife and a physician, and even a nurse. The midwife is skilled in the art and the science of childbirth. And that relationship formed with the mother and the engagement of that has-- is such a powerful and a beautiful thing that I've witnessed, versus the experience in the fully operative and capable hospital setting. It's just entirely different. And I'm really grateful that I have-- we were in a state that did support that, and it's been very difficult, as many have said here, that Nebraska is not one of the 38. And hopefully, the 39th, if the legislation did pass. Thank you for listening. Appreciate your guys' patience and, and reflecting on this. Any questions?

HARDIN: Thank you for a fresh perspective on that today. Senator Riepe.

RIEPE: Thank you, Chairman.

ERIK BAUER: Yes.

RIEPE: this is a little imposing, but was your wife able to get an epidural through the midwife? I don't know whether they have that.

ERIK BAUER: No. In fact, my wife's desire--

RIEPE: It's more of a natural birth?

ERIK BAUER: Correct. She didn't, she didn't want the epidural, and the midwife was able to guide her through that, even with back labor, which is, as you know, very, very challenging. So.

RIEPE: Do you know if midwives are able to do epidurals?

ERIK BAUER: I do not. We didn't have to go to down there.

RIEPE: No. I see. No. OK. OK. Just Curious George here. Thank you.

ERIK BAUER: Appreciate the question.

HARDIN: More questions?

ERIK BAUER: OK.

HARDIN: Seeing none, thank you.

ERIK BAUER: Thank you.

HARDIN: Proponents, LB374. Welcome.

NICOLETTE BAUER: Thank you. I am Nicolette Bauer, N-i-c-o-l-e-t-t-e B-a-u-e-r. Today, I would be so grateful to briefly share about my experience of witnessing my 2 brothers home births, which had midwifery assistance, and to ask you to support LB374, as this bill enables midwives to play an active role in the delivery of babies in Nebraska. My mother gave birth to my 2 sisters and I by C-section, all of which were not medically necessary, before undergoing heart and lung recoveries from those surgeries. A few years later, she became pregnant again, and after much research and consulting of doctors and midwives, planned to have a natural homebirth with midwife assistance. She did. I was blessed to be there at my mom's first home birth. It was the most amazing experience ever. It was successful. It was safe. It was assisted and guided by an exceptional, caring, skilled midwife. A few years later, my mom became pregnant again, and I witnessed her second successful home birth, which was, again, aided by incredible professional midwifery care. When I have kids someday, this kind of experience is what I want more than any other in the world. When our, when our family moved here to Nebraska, we learned that midwives are not permitted to assist in home births here in this state, which meant my mom, as well as my sisters and I and any other woman, could not have a home birth with, with midwifery care. This included my aunt who is pregnant, living way out in the country. Recently, my pregnant aunt went into labor and my uncle raced her to the hospital. They barely

made it, and she gave birth in less than 5 minutes. If midwifery care were available, she and many other moms could have home births with excellent, experienced, skillful assistants, without the risk and drama my aunt faced. Having access to midwives who provide skillful care right up to the moment of birth is crucial for health and safety of babies and moms in Nebraska not only today, but also for the coming generation. For my and my future children's safety and well-being and for every mom and baby who needs access to skillful and experienced midwifery care, I ask that you support LB374. Grateful for your time. Thank you.

HARDIN: Thank you. Have you done this kind of thing before?

NICOLETTE BAUER: Only in a mock trial.

HARDIN: Only mock trial. Which was harder? Because you made this look easy.

NICOLETTE BAUER: I appreciate--

HARDIN: You're making the rest of us nervous.

NICOLETTE BAUER: This is an opportunity that I appreciate, just to, to be able to speak to what I believe are some of the most important things in life.

HARDIN: Thank you. Senator Riepe.

RIEPE: Well, with your extensive medical background now, would you consider going to medical school?

NICOLETTE BAUER: I'm not sure, but I am open to doing and making the best use of my time for the sake of those things that matter most.

RIEPE: Good. Thank you for coming. Thank you, Chairman.

HARDIN: Any other questions? Thanks for being here.

NICOLETTE BAUER: Thank you.

HARDIN: Proponents, LB374. This could be your last opportunity. Don't be shy. Welcome.

ZIARA YORK: Hi. Thank you. My name is Ziara York, Z-i-a-r-a Y-o-r-k. I am a certified holistic doula of nearly 5 years in practice. I am a traditional community health worker. Many people in my community will

call me and look up to me as a medicine woman, not a doctor. And I am a student midwife, as well, on the direct entry midwifery pathway. In my communities, I am well-known as an advocate for women and for their boy-- for their birth choice options, including the choice to birth at home. I have worked tirelessly to ensure that the women I serve have the best possible birth outcomes, regardless of their socioeconomic status and education levels. Unfortunately, though, as was mentioned by some previous testifiers, black women and indigenous women are anywhere from 2-5 times more likely to die during childbirth than white women in this country. This disparity goes beyond socioeconomic status. We have research that shows us that women who are-- you know, have the same medical history, the same income, the same education level, but have different colors of skin will unfortunately have different outcomes. And so this is an issue of medical racism. It's an issue of women not being listened to, which unfortunately, we have heard in some of our testimonies today. And these disparities between white women and black and indigenous women have been shown to practically disappear when women birth in out-of-hospital settings and have access to continuous, personalized, culturally competent care. So, this is a need of the community. This is a need of my communities that I come from. I've had a lot of women reaching out to me, asking who they can turn to for home births and not being able to find anybody who has credentials to be able to attend their births. So it's really unfortunate that, for me, as a student midwife, I have had to travel and I've had to go out of state and leave my community behind, rather than continuing to do the work that I've been doing in order to gain my clinical experience and doing the apprenticeships that I have done thus far. I've been blessed to be able to find women in other states who have been willing to take me on as a student, knowing that I may not be there to serve their communities. But it's really a shame and unfortunate that, you know, after all the work that I will have done at the end of my student midwife career, I will not be able to come here and service my community. So, yeah. I would ask that you free the people of our pain and suffering in this way, and give us an option. Because right now, women are left with nothing. And unfortunately, folks like myself who want to be able to provide access to care and to be able to share the knowledge that we've gained, we're not able to.

HARDIN: If I can encourage you to wrap up your final thoughts, that would be great.

ZIARA YORK: Sure. Sure. So, yeah. I would urge you to consider supporting LB374, and-- yeah. I will take any questions.

HARDIN: Thank you, Ms. York. Questions? Seeing none, thank you.

ZIARA YORK: All right.

HARDIN: Proponents, LB374. Any more in support? If you're not proponents, are you in support? How about that?

_____: Can I just ask a question to the floor?

HARDIN: Actually, no, because we have to do what is called transcription. And so, it has-- it all has to be through the microphone. Any other proponents for LB374? We are moving on to opponents, LB374. Anyone else in opposition? Anyone else in the neutral for LB374? Congratulations, Senator Hansen. You have broken the records again. So proponents online, 341, opponents, 122, and 6 in the neutral. So.

HANSEN: Yeah, I think last we checked, we had 370 actually--

HARDIN: Wow. OK.

HANSEN: --supportive and positive online comments.

HARDIN: Well, then dang it. We just didn't keep up with--

HANSEN: That was from this morn-- that was from this morning.

HARDIN: --the, the, the, the ticker tape that just kept going. So thank you.

HANSEN: Yep. And one of the things I kind of noticed and thank you for allowing me to come up here and provide a rebuttal to some of the opposition and retort a little bit here. But if you notice, a lot of the people in opposition came-- almost-- I think-- I believe all of them represented some organization or affiliation with, with some lobbying firm. Then you look at the people who came in support-- the one in opposition, notice how we didn't see any mothers that came and testified in opposition? All the people who came and testified in support were mothers, RNs, pediatricians, EMTs, American College of Nurse Midwives, ACLU, Women's Fund of Greater Omaha, APRNs, American Association of Birth Centers, LPNs, CPMs, people with biomedical science degrees, social workers, teachers, doulas, engineers, firefighters, Ph.D., school administrators, service members, licensed mental health counselors, former labor and delivery nurses, and professors. Those are all the online comments as well. And the two

notable ones, which you two pointed out was, I apologize, I get the names wrong. Jake and Nicolette, the two young ladies here. And you rightly pointed out how-- what intelligent responses they had, how they explained their support in a meaningful way. These are the type of people that we need to trust to make decisions about their healthcare when it comes to delivering their baby at home. These are the ones I think about, and they're-- I am not going to speculate how old they are, but imagine them as mothers and they're older. They know what they're doing. Our job is to make sure we can put some kind of guardrails of life in a certain place to allow them to do that. Senator Quick had a couple questions about how many people typically attend like, a, a home birth. And I, I got some feedback. And on average, it's at least two or more skilled individuals, along with the midwife that typically attend these births. One, the, the CPM will mainly look after the child, then they also have somebody looking after the mother. So I know you had a question about that, and so that's what I got in response, anyway. You also had a, a response, I think, about making sure-- and I think some of the opposition did, too, is that the mother had proper informed consent. Right. Here's the risks. Here's the training that's involved. Here's what can happen. And in the bill, we have that specifically about informed consent, that the CPM has to provide that before entering into a contractual obligation with the, with the mother. And one of the things I can-- and I think Senator Quick also brought this up as maybe a concern, which makes sense, that they don't have the same training as like, an OB-GYN. They don't have the same training because the responsibility and scopes of practices are much different. That's typically why. So they're not going to have the same-- they're not going to go to med school for 8 years. Right. Their responsibility is to recognize when they need to send somebody who's been in medical school for eight years. And according to the data and the research, they do in other states. I was hoping some of the opposition would be here to, to hear me at least kind of explain some of my disagreements with what they said. Dr. Maggie Kuhlmann, one of the first ones up here, she talked about preventable harm and CE hours, which is a good question, actually. That's one thing I didn't really know for sure. And again, the response I got is they need CE hours every 3 years, just like all other licensed healthcare workers. And all of her concerns-- and this is, again, a common theme among the opposition, all of the concerns they had are what they are trained for. I was a little discouraged for the disrespect from the second testifier, Dr. Johnson, with NMA and NMP, about the training of certified professional midwives and basically who they are. She said they just have a high school diploma

and observed a few things and now they're allowed to deliver a baby, like they just stayed at a Holiday Inn and now they can deliver babies. I thought that was a little disrespectful. They are trained. They are reliable. And she gave, I think-- and I couldn't tell from some of the other opposition-- they gave statistics about how safe home birth is compared to being born in a hospital. And I think from what Dr. Johnson said-- and I appreciate her actually giving this-- from the Journal of Obstetrics and Gynecology. According to that, there are twice as many deaths from home births as opposed to hospital births. I haven't seen that study. I'm assuming that's what some of the other testifiers in opposition were referring to. I didn't see any-- citing other studies in their, in their testimony, so I'm assuming that's kind of where some of that came from. So being from the Journal of Obstetrics and Gynecology, could be a little skewed, could not be. But one of the things they also mentioned was the American College of Gynecologists and Obstetricians. Let me make sure I got that right here. I had that right in front of me. I better be careful, Ellie is going to yell at me for not getting this right. I just want to make sure I say this right. I think the information they were giving was outdated. Because according to the most recent American College of Obstetrics and Gynecology, they respect-- and this is from their position statement, do they support homebirth or CPMs? Yes. ACOG respects a pregnant person's right to make a medically informed decision about their birth attendant and place of delivery. They later go on, mentioning CPMs specifically, birthing persons in every state should be guaranteed care that meets important minimum standards. And then lastly, AcCOG supports national uniformity in midwifery licensure and scope of practice laws across all states. So they were talking about the American College of Gynecol-- Obstet-- Obstetrics and Gynecologists like they didn't support it, but according to the most recent position statement, they do. So I don't know for sure what they were referring to in that one. And actually, the most recent one from the National Library of Medicine, planned home births in the United States have outcomes comparable to planned birth center births for low-risk birthing individuals. So they gave a lot of other statistics about how unsafe it is, but-- and that was from the National Library of Medicine from November of 2024. They're saying home births are the same as hospitals, according to their, to their data. And also, the gold standard, according to science when it comes to healthcare in particular, is the British Medical Journal. They actually said-- they actually did a, a large cohort study about those-- to evaluate the safety of home births in North America. Their conclusion: Planned home births for low-risk women in North America

using certified professional midwives was associated with lower rates of medical intervention, but similar intrapartum and neonatal mortality of that of low-risk hospital birth in the United States. The same thing the Library-- National Library of Medicine just said, the same thing that ACOG just said. It's the same. They're finding the same results. And then, according to our Nebraska statistics, the statistics-- Nebraska Vitality statistics, mortality rate in Nebraska for home births. 6.9, home-- those in the hospital, 6.2, so very, very comparable. So when they come here saying the world is going to end because we're allowing trained, competent midwives to deliver in a home is not true. And Dr. Johnson also mentioned, she's-- from what she hears, there's a lack of cooperation in other states from CPMs and hospitals. But what we heard today from CPMs in other states saying they cooperate great with hospitals and medical doctors from where they're at. Dr. Townley also came up here and talked about-- again, all the cases he gave were not CPMs that he's talked about. I think he gave two cases about where there was harm from a home birth. And I believe I'm familiar those two cases. Neither one of those midwives would have classified as CPMs, according to this bill. The statistics he mentioned were not cited in his testimony. And I don't blame him for like, his concern because he does see the worst cases. Dr, Townley sees the worst cases. And so I think from his lens, I could see where he has concern, maybe, about delivering at home without the supervision of a hospital. And I think, Senator Quick, you asked about training and forceps with him, too. There-- nurse midwives-- or CPMs cannot use forceps. I think that was when [INAUDIBLE] answered, Dr. Pinkall, I think, the next one, just wanted to reiterate that no bill, no matter what we passed in the state of Nebraska provides 100% assurance that the person delivering or caring for the child afterwards is adequately trained. I don't care how much training you had, how much we put in the bill, that's not going to 100% guarantee that that training is going to have no fault whatsoever. I appreciate Senator Riepe, Riepe for bringing up some of the rural problems in Nebraska. I think that's a valid concern. The lack of healthy and safe, reliable birthing options, especially in rural Nebraska, is a problem and a growing concern and one we've heard in HHS many times, not just with home births, but with all kinds of-- dentistry, all kinds of stuff. And I think this is one of the-- this bill can help alleviate that. The one fellow from the Board of Medicine, I didn't get his name, but he brought up a good point and something I actually completely agree with him. One of the most important aspects of healthy deliveries is being a part of a team. That's what this bill is trying to do, make them officially a part of the team. Right now, they

kind of are. They're just not licensed. Let's put some guardrails in place. And some information I got from some of the other-- just in, in closing here, CPMs do not administer IV meds, with the only exception being IV antibiotics if needed if this bill passes. So they do not do IV medications, from what was sent to me. Right now, without licensure, if-- a good analogy is almost kind of like mothers, they're going to deliver at home anyway if they really want to. So it's kind of like they're swimming alone. This bill gives them a lifeguard. They're still swimming, we're just putting a lifeguard there now. As much as I don't like government telling people what to do, it's sometimes is our responsibility to make sure that things are somewhat done in a safe manner, but without burdening the liberties of others. And I know the opposition did bring up certain cases that have happened in Nebraska, and I'm not going to go through because I had some very profound cases that have happened in hospitals, just as bad and if not more. But I'm not going to bring those up because I don't want to, I don't want to make that seem like what this is about. So, gentlemen, it's time to provide this option for many mothers and fathers in Nebraska. Let's advance this bill through the committee and get it on the floor for a good debate. Thank you, Mr. Chair.

HARDIN: Questions? Not an exact number by any means, but can you theorize for us how much underground is going on in Nebraska, given the fact that we have the conditions we do? I hear chuckles from the crowd.

HANSEN: OK. I, I can't specifically say. All I know is I've been in practice for 17 years as a chiropractor, and I have many mothers who've delivered at home over the years, many. Hundreds, probably. I can't think of maybe one instance where they had to refer that child to the hospital afterwards-- or during-- excuse me-- during the delivery. And I think that was a stalled pregnancy or maybe some hemorrhaging, and everything still worked out just fine.

HARDIN: Additional opportunities for questions? Seeing none--

HANSEN: Thank you for staying late. I appreciate it.

HARDIN: Thank you.

HANSEN: Thank you.

HARDIN: And thank all of you. Please drive safely home. We appreciate you being here. This concludes LB374 and our hearings for today.