MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON COMMERCE AND LABOR

Eighty-First Session
April 5, 2021

The Committee on Commerce and Labor was called to order by Chair Sandra Jauregui at 6:14 p.m. on Monday, April 5, 2021, Online. Copies of the minutes, including the Agenda (Exhibit A), the Attendance Roster (Exhibit B), and other substantive exhibits, are available and on file in the Research Library of the Legislative Counsel Bureau and on the Nevada Legislature's website at www.leg.state.nv.us/App/NELIS/REL/81st2021.

COMMITTEE MEMBERS PRESENT:

Assemblywoman Sandra Jauregui, Chair
Assemblywoman Maggie Carlton, Vice Chair
Assemblywoman Venicia Considine
Assemblywoman Jill Dickman
Assemblywoman Bea Duran
Assemblyman Edgar Flores
Assemblyman Jason Frierson
Assemblywoman Melissa Hardy
Assemblywoman Heidi Kasama
Assemblywoman Susie Martinez
Assemblywoman Elaine Marzola
Assemblyman P.K. O'Neill
Assemblywoman Jill Tolles

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblywoman Danielle Monroe-Moreno, Assembly District No. 1
Assemblywoman Sarah Peters, Assembly District No. 24

STAFF MEMBERS PRESENT:

Marjorie Paslov-Thomas, Committee Policy Analyst
Sam Quast, Committee Counsel
Terri McBride, Committee Manager
Julie Axelson, Committee Secretary
Cheryl Williams, Committee Assistant

OTHERS PRESENT:

Tiffany Hoffman, Private Citizen, Reno, Nevada
Sandra Koch, M.D., representing Nevada Section, American College of Obstetricians and Gynecologists
Amanda Macdonald, Private Citizen, Reno, Nevada
Danielle Yeager, Private Citizen, Las Vegas, Nevada
Erika Minaberry, Private Citizen, Reno, Nevada
Riley Sutton, Private Citizen, Reno, Nevada
Mary Gilbert, Private Citizen, Sparks, Nevada
Keith Brill, M.D., Private Citizen, Henderson, Nevada
Kathy Buchanan, Private Citizen, Sun Valley, Nevada
Zack Chatelle, Private Citizen, Reno, Nevada
Mandy Bengtson, Private Citizen, Reno, Nevada
Kendreia Dickens, M.D., Private Citizen, Las Vegas, Nevada
Staci McHale, M.D., Private Citizen, Las Vegas, Nevada
Alicia Sowers, Private Citizen, Pahrump, Nevada
Allyson Juneau-Butler, Co-Chair, Nevada Midwives Association
Justin Watkins, representing Nevada Justice Association
Marlene Lockard, representing Nevada Association of Professional Midwives
Danielle Gallant, Private Citizen, Henderson, Nevada
Elissa Wahl, Private Citizen, Las Vegas, Nevada
Jessica Lagor, Private Citizen, Las Vegas, Nevada
Colleen Ohlandt, Private Citizen, Las Vegas, Nevada
Jollina Simpson, Private Citizen, Las Vegas, Nevada
Rebecca Wells, Private Citizen, Las Vegas, Nevada
Janelle Johngrass, Private Citizen, Las Vegas, Nevada
Magdalena Alvarez, representing Nevada Friends of Midwives
Erin Lynch, Chief, Medical Programs Unit, Division of Health Care Financing and Policy, Department of Health and Human Services
Romina Paulucci, Private Citizen, Las Vegas, Nevada
Camila Santiago, Private Citizen, Las Vegas, Nevada
Corrine Flatt, Private Citizen, Las Vegas, Nevada

Chair Jauregui:
[Roll was called.] We have one bill on the agenda, and it is Assembly Bill 387. I will open the hearing on A.B. 387. I have Assemblywoman Monroe-Moreno here to present the bill.

Assembly Bill 387: Revises provisions relating to midwives. (BDR 54-225)

Assemblywoman Danielle Monroe-Moreno, Assembly District No. 1:
I am here to present Assembly Bill 387, which establishes the Board of Licensed Certified Professional Midwives. I am joined tonight by Tiffany Hoffman and Amanda Macdonald, both of whom are midwives here in Nevada. I am also joined by one of my cosponsors for

the legislation, Assemblywoman Peters and Dr. Sandra Koch, who is a respected Nevada obstetrician and gynecologist (OB/GYN).

I will open the presentation, and as you know we are at that time of session where we are multitasking, so I will be turning my presentation over to Assemblywoman Peters and then to Ms. Hoffman and Ms. Macdonald, who have a PowerPoint presentation. We will end with comments from Dr. Koch. When they are finished, hopefully I will be able to jump back in to go through the details of the bill and the amendment [Exhibit C], which is pretty lengthy, and I apologize for that. I will then answer any questions you might have.

Midwifery has been a practice in the United States for hundreds of years. Midwives provide care throughout the prenatal, delivery, and postnatal stages of childbearing to women who are healthy and experiencing a normal pregnancy. A midwife monitors the physical, psychological, and the social well-being of the birthing parent through the childbearing cycle. When needed, a midwife identifies and refers the few women who need the attention of an obstetrician.

Midwives who attend births at home and at birth centers have excellent outcomes and the cost is approximately one-third less than hospital deliveries. The latter accounts for approximately $110 billion a year in health care costs, which is just in the United States. The advantages of care by midwives include excellent outcomes at lower costs, healthier babies, and Medicaid savings. Each childbearing person on Medicaid who chooses an out-of-hospital birth with a midwife can help lower Medicaid costs, since Medicaid would otherwise pay for a hospital birth at a greater cost with a higher likelihood of the need for a cesarean section. According to an analysis by the Washington State Department of Health, its Medicaid program saved almost $500,000 in C-section reductions alone over a two-year budget cycle with licensed midwives attending just 2 percent of the births.

During the last legislative session, for those of you who were here, I brought before the body Assembly Bill 169 of the 80th Session, which created the Maternal Mortality Review Committee. I brought that bill because the United States has some of the highest numbers of child and maternal mortality. We are a developed nation; why do we have those numbers? Those numbers are births that are within hospitals. We were able to pass the Maternal Mortality Review Committee bill last session, and this session we are building upon that bill to have data collected for communities of color that were omitted in last session's bill.

I see A.B. 387 as another option for mamas to have healthy babies. The reason this is personal for me is that during my first session here, my firstborn was giving birth to her firstborn, and she decided to use a midwife. At the time, I thought she and her wife were absolutely crazy because I had all my children in the hospital. I was able to go to California to be with my daughter as she and her wife gave birth to their firstborn at home, in a pool. It was the most amazing, holistic experience I have ever experienced. I realized we need more options for mamas.

As we live through the COVID-19 pandemic in which moms could not go into hospitals, or birthing parents into hospitals with their partners, I truly realized we needed options. I was also getting calls from some of my constituents who had utilized midwives in our community. Some of them had some serious negative outcomes. They asked me, "Could you please provide a licensure for midwives?" While I agree with them that their negative outcomes were traumatic, I also understand that this has been a practice that has gone on for thousands of years. I did not want to negatively impact those who did not wish to have a license. That is the premise for A.B. 387.

Licensure is a key to providing safe care for Nevadans that is consistent with the scope of practice defined by the profession. It also makes midwifery more accessible and enables them to participate in an integrated system that includes opportunities for consultation, collaboration, referral, and multidisciplinary peer review. Currently, Nevada does not have a license for midwives. However, the state does permit midwives to deliver babies and provide care throughout the birthing cycle.

Ms. Hoffman and Ms. Macdonald have been working with me for over a year now to bring this bill to this legislative body. We have been involved with numerous stakeholder meetings up until Saturday night where we had almost a four-hour meeting, and we have been receiving amendments to this bill up until 2:30 p.m. today. We have done our due diligence. It is not a perfect bill, and I do not know if there ever is one, but we are trying to get to perfection. With that, I will turn the presentation over to Ms. Hoffman and Ms. Macdonald.

Chair Jauregui:
Ms. Hoffman and Ms. Macdonald, when you are ready, we will go to you. Then, we will go to Assemblywoman Peters.

Tiffany Hoffman, Private Citizen, Reno, Nevada:
I am here with my colleague, Amanda Macdonald. We are Certified Professional Midwives practicing in Reno, as well as licensed midwives in the state of California. We want to talk to you today about our interest in the licensure for certified professional midwives in the state of Nevada.

Nevada has a proud history of birth freedom, as well as a history of contentious relationships between home and hospital providers. This contentious history dates back to methods in which birth was moved from the home to a hospital setting, and the overmedicalization of birth in America.

Writing this bill has been a focused effort to reduce harm, honor traditions, increase accessibility, improve outcomes for all birthing people while working to build bridges, and close the divide between home and hospital providers. We have reviewed research and statements from major organizations invested in the safety of community birth. We have listened to consumers of all types of midwifery services, families who have experienced losses and bad outcomes, and every type of midwife. We have also listened to the Nevada Hospital Association, physicians, lobbyists, and legislators in creating this bill. Everyone

interested in this topic is extremely passionate, and there is little middle ground. Every attempt has been made to come to a center. The questions we asked in creating this bill over the last year were:

- How can we improve safety and satisfaction for consumers?
- How do we honor and respect the history of midwifery while advancing the profession?
- How do we protect choice for Nevada families?
- What is the bottom line to improve outcome according to available research?
- How can we best improve access to community birth for all Nevada families?
- How do we increase the number of underrepresented midwives to provide culturally and linguistically congruent care?
- How do we begin to bridge the divide between community and hospital providers?

We have a presentation [Exhibit D] to share. What is a Certified Professional Midwife (CPM)? A CPM is an autonomous primary perinatal care provider for pregnant women with healthy pregnancies. We are distinctly different from the profession of nursing or medicine. We provide comprehensive care prenatally, during labor and birth, and during the postpartum period. We also provide well-woman and well-person care in the perinatal care unit, including pap smears and sexually transmitted infection testing. We are experts in the wellness-centered model of care and the physiologic approach to pregnancy and birth. In our expertise in providing care in the home and freestanding birth centers, we are the only type of perinatal care provider required to have experience in the community birth setting for certification. Community birth is defined as a planned birth outside of a hospital setting in homes and in birthing centers [page 2].

One of the benefits of CPM care—because we are able to offer a truly personalized, one-on-one physiologic approach to perinatal care for healthy pregnancies—is that we see a significant reduction in intervention during labor and birth. For example, we see substantially lower rates of inductions and C-sections compared with the medical model of care. We pride ourselves on providing client-centered care and highly valued shared decision making. Certified Professional Midwives can also provide extensive postpartum support during the first six weeks after birth. Certified Professional Midwives can help provide access to care in rural areas and those areas experiencing a perinatal care shortage.

Community midwifery care has recently come into the spotlight during the pandemic as families have become concerned about acquiring COVID-19 in the hospital and having restrictions on the attendance of their friends, family, or doula during their hospital stay. Midwifery care and access to midwives in all settings were associated with significant increases in spontaneous vaginal births, successful vaginal births after a cesarean, breastfeeding at six months, and a significant reduction in C-section rates, preterm births, and low birth weight. We will speak further to this later in the presentation [page 3].

Benefits of CPM care in the state of Nevada also include Medicaid cost savings due to lower intervention rates and C-section rates. This map [page 4, Exhibit D] shows the current licensing trends in the United States with 36 states offering licensure to CPMs, and as you can see, Nevada stands alone in the West as the only unlicensed state. As we consider licensure, what has been shown to improve home birth outcomes? What we see is that it is collaboration, integration, and autonomous practice. The reason that U.S. home birth outcomes cannot be directly compared to the improved outcomes of home births in other countries is because of the lack of integration of CPMs into our medical system, a lack of collaboration between perinatal care providers, and the inability of CPMs to practice to their full scope. According to the "Mapping integration of midwives across the United States: Impact on access, equity, and outcomes" study, which was published in 2018, outcomes were best globally when midwives are regulated and practice to their full scope. This study convened a multidisciplinary task force with expertise in maternity services, research, public health, midwifery, obstetrics, epidemiology, consumer advocacy, and/or enrolled in midwifery legislation, regulation, and law. In 2014, *The Lancet* reported the national investment in midwives, and in their work, environment, education, regulation, and management is crucial to the achievement of national and international goals and targets in reproductive, maternal, newborn, and child health.

According to "Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care" published in *The Lancet*, on a global scale, maternal and perinatal outcomes are better in jurisdictions where midwives are regulated and have the legislative authority to practice to their full scope across birth settings, including collaboration with or referring with other health professionals.

We created some slides [pages 6 and 7]. These are Midwifery Integration scores. The Midwifery Integration Scoring System (MISS) was created by a multidisciplinary group of experts to determine whether integration of midwives into the health care system improved outcomes. A MISS score of 100 would indicate that a family in that state would have full access to high quality maternity care in all settings. Higher MISS scores were associated with significantly more access to midwives, significantly higher rates of physiologic birth outcomes, lower rates of obstetric interventions, and fewer adverse neonatal outcomes. Nevada's MISS score is 29, which ranks us thirty-fifth in the nation. The top three MISS scores are Washington at 61, New Mexico at 59, and Oregon at 58. These three top-scoring states have a common theme—integration and regulation. Certified Professional Midwives in all three of those states are reimbursed by Medicaid, and they can own and work in birth centers as well. Regulations have been identified by the International Confederation of Midwives (ICM) as one of the pillars of a stronger midwifery profession.

The second MISS slide [page 7] explains that MISS scores also correlated with density of midwives and access to care across birth settings. In the United States, about 10 percent of births are attended by midwives, and 50 percent to 75 percent of births are attended by midwives in other high-resource countries. On this slide we see that the states with higher MISS scores all have significantly higher rates of midwifery care than Nevada's mere 5 percent. All three were also higher than the national average. We see a significant increase

in spontaneous vaginal births, vaginal births after cesareans, and breastfeeding at birth and six months. You can also see a huge difference in C-section rates. Nationally, higher MISS scores are correlated with lower rates of premature birth, low birth weight, and neonatal mortality.

Further, there was a birth settings report by the National Academies of Sciences, Engineering, and Medicine, and they created an ad hoc committee of public health stakeholders in academia, health care provider organizations, women's health organizations, and third-party payers, and they sought to explore the differences across birth settings and outcomes in the United States. Why did they look at birth settings? They started this report because the U.S. has the highest mortality and morbidity rates among all high-resource countries, despite spending the most. Care that is evidence-based and linguistically and culturally appropriate and safe is not available to everyone. This is all despite the fact that the majority of U.S. pregnancies are low-risk. Additionally, Black birthing women and babies die at rates much higher than their white counterparts. They are two to six times more likely to die in childbirth depending on where in the country they are giving birth. Conclusions that the birth settings report came to is that the U.S. maternity care system underutilizes evidence-based beneficial care and overuses care that is not medically indicated. In other words, it is either too much too soon or too little too late. We are striving for the right amount of care at the right time. Interventions in care provided too much too soon and too little too late contribute to high levels of morbidity and mortality [page 8, Exhibit D].

To generally improve outcomes, what was advised is to provide respectful, high-quality care, provide true informed consent and informed refusal around decision making regarding risk in all maternity care settings, and integrated and collaborative care between all birth settings. Also advised was to increase access to affordable, safe, respectful, linguistically and culturally appropriate prenatal and mental health care that works to reduce disparities created by structural racism and the long-term effects. It ensures levels of payment for maternity and newborn care across birth settings and increased diversity, size, and distribution in the maternity and newborn care workforce. The suggestions for improved hospital births were developing midwifery-like units in the hospital settings, greater collaboration between maternity care providers, teaching and providing respectful care, true informed consent and refusal, and decreasing unnecessary intervention.

For the home and birth center setting, the items that were recommended to be improved were integrating home and birth centers into a regulated maternal and newborn care system, care and access to safe and timely transport, seamless transfer across settings, appropriate and ongoing client risk assessment and risk selection, and well-qualified maternity care providers with training to manage first-line complications. Also recommended was access to licensure at the state level, and mechanisms for attaining and maintaining accreditation for birth centers to improve access in quality of care, and the ability of all Certified Nurse-Midwives, Certified Midwives, and CPMs who meet ICM standards to practice to the full extent of their scope.

How does A.B. 387 help to improve the safety of community birth [page 9, Exhibit D]? The goal of A.B. 387 is to improve outcomes, provide accountability, and improve accessibility, all while providing CPMs the ability to practice autonomously to their full scope. Assembly Bill 387 would require a Midwifery Education Accreditation Council (MEAC)-accredited education after January 1, 2025, with the opportunity to apply for an extension to this date for rural students and students from groups with marginalized identities. These are defined as an identity that causes or has historically caused a person of such an identity to be disproportionately subjected to discrimination, harassment, or other negative treatment as a result of that identity. Assembly Bill 387 would require direct onsite supervision of students and midwife assistants by CPMs. In addition, A.B. 387 would require basic training requirements for midwifery assistants, and it would also require antibias and antiracism training for license renewal in statute.

Why promote MEAC-accredited education for CPMs [page 10? The U.S. Midwifery Education, Regulation, and Association (US MERA) is a coalition of representatives of various national midwifery associations, credentialing bodies, and education accreditation agencies. The U.S. Midwifery Education, Regulation, and Association includes the National Association of Certified Professional Midwives (NACPM); the Association of Certified Nurse-Midwives and their certifying agency, American Midwifery Certification Board; the National Association to Advance Black Birth; and the North American Registry of Midwives (NARM). The U.S. Midwifery Education, Regulation, and Association's vision was to come up with ways to help build an integrative health care system where everyone has access to midwives and midwifery care that improves health. One of the ways they recommended to work towards the goal was to encourage states presenting new licensure bills for CPMs to require MEAC-accredited education for midwives certifying after January 1, 2020. Of the last 12 jurisdictions to pass CPM licenses, 11 have included this US MERA language requiring an accredited education in their licensing bills. All of the other states currently working to pass licensure laws are including US MERA language as well.

What is a MEAC-accredited program and what are its benefits [page 11]? One route to become a CPM is a MEAC-accredited education; MEAC accredits stand-alone midwifery programs in institutes as well as college programs offering degrees in midwifery. The Midwifery Education Accreditation Council is approved to accredit midwifery programs by the U.S. Secretary of Education. The education requirements required by MEAC for CPMs meet ICM minimum educational standards without any additional continuing education units (CEUs). This route honors the legacy of learning through the centuries-old apprenticeship model, while adding a standardized evidence-based didactic component that will foster well-rounded community midwifery providers. This route requires the completion of a three-year accredited education program, as well as a minimum two-year apprenticeship with a NARM in-school approved preceptor. Candidates may then sit for their credentialing exam.

Midwifery Education Accreditation Council accreditation verifies that a program meets established standards of education. It provides an opportunity for inter- and intra-institutional cooperative learning and practices. This can be the basis for future

collaborative relationships with hospital-based providers. The Midwifery Education Accreditation Council promotes ongoing improvement of programs and creates a system of accountability for students, preceptors, and staff. It also helps guide financial support for midwifery education.

The NACPM, as well as six other organizations in US MERA, support MEAC-accredited education as a requirement for the newly licensing states. To be clear, A.B. 387 would only require MEAC-accredited education for newly credentialing CPMs. Current CPMs trained in the Portfolio Evaluation Process (PEP) would only need to complete the Midwifery Bridge Program previously mentioned by 2025.

The other way to become a CPM is through the PEP process [page 12, Exhibit D]. According to NARM, the PEP process originally began as a way for midwives with experience and skills to have their qualifications evaluated for credentialing. The PEP is an educational competency-based evaluation process with three different educational requirements before sitting for the credentialing exam. Part one is a list of general educational requirements, reading material, and resources provided to candidates to be studied. Part two is a minimum two-year apprenticeship with a NARM-approved preceptor. Part three is clinical skills verification, which requires two preceptors to sign off on skills competency. Then, PEP students are qualified to sit for the NARM exam for credentialing.

Some PEP-trained CPMs go on to complete a Midwifery Bridge Certificate [page 13]. The Midwifery Bridge Certificate was created to develop and fill a perceived gap between PEP education and minimum ICM competencies and emergency skills. The ICM supports the creation of international minimum educational standards for midwives. The Midwifery Bridge Certificate requires 15 CEUs in emergency skills, 15 CEUs in emergency newborn skills, and 20 CEUs designated as "other." This program must be completed within five years.

Why is accreditation and licensure good for the public [page 14]? How is it going to benefit Nevada families? We know that MEAC-accredited schools are meeting certain standards of criteria for the curriculum. We know that the full gamut of educational topics are being required in a student's didactic course. This is important for the health and safety of Nevada families. Whether certified or not, I think midwives can agree there is a difference between being able to pass a certification exam and truly understanding midwifery topics in the depth required for safe practice. The Midwifery Education Accreditation Council education helps to ensure topics are not being overlooked or skimmed over. There is accountability for the schools, accountability for preceptors, and accountability for the students. If the students are having an issue with the preceptor, they have a resource for help. If a preceptor has a concern about a student, they have resources to help. This promotes the integrity of skills development and appropriate and productive student/preceptor relationships and expectations. Thoroughly and properly trained new midwives help keep families choosing to birth at home or at birthing centers safely.

Accreditation can also save the state money because MEAC-accredited schools already have processes in place for monitoring and evaluating students' education so states can trust that the schools have provided appropriate education and training without needing to create their own state process to evaluate applicants before licensure. Licensure provides a way to hold midwives accountable if practicing outside of their scope or otherwise practicing unsafely. If there is a bad outcome, there are official processes and paths to possible recourse for both the family and the state, if warranted.

Assemblywoman Monroe-Moreno went over some of these same figures, so I will not spend a lot of time on this slide [page 15, Exhibit D]. What we know is that there is substantial cost savings to using CPMs for care. Nevada's cesarean rate is 34 percent, and our vaginal birth after cesarean rate is only 12 percent. The nationwide out-of-hospital-birth cesarean rate is 5 percent versus 26 percent for first-time cesareans in low-risk birthing people in the hospital setting.

Why is accreditation good for the midwifery profession [page 16]? Accreditation promotes standards of practice and advocates for rigorous preparation. As I previously noted, this is important for public health and safety. One of the big arguments against requiring MEAC-accredited education is that of access for students; MEAC education is often much more expensive than the PEP process route. However, an overlooked part of the discussion of student access is the availability of funding. Many MEAC-accredited schools have federal funding options via grants and loans available, just like a standard college program would. Mary Lawlor, the Executive Director of NACPM has been working to secure funding for midwifery education through the Midwives for Maximizing Optimal Maternity Services Act of 2019. That Act secures $35 million of funding through Title VII and Title VIII available for midwifery students in accredited programs, for expanding midwifery programs, and to help support more preceptors. There is $2.5 million designated specifically for underrepresented students in midwifery education to help support the development of a midwifery workforce that represents the racial and ethnic demographic of the childbearing population. The funding would be available starting in 2021 to 2025.

Another access concern is having to leave one's community to complete their education. There are several MEAC-accredited schools which would require only occasional travel to campus, and in some cases, none at all. Students can remain in their own communities 100 percent of the time, working with a local preceptor. If you are interested in a full list of MEAC-accredited schools along with tuition costs, physical attendance requirements, and availability to federal funding options, we have that available.

As for licensure, it fosters accountability. Peer review is typically required for license renewal. Midwives can hold each other accountable knowing what the standards of practice are supposed to be. This is where consistency in knowledge base and skills also comes into play. Through these peer reviews, midwives can help each other find potential deficits or oversights in their practices, and licensure would open up the opportunity for interdisciplinary peer reviews.

Licensure can help to facilitate recognition and broader acceptance of out-of-hospital midwifery by other health care providers. We cannot speak to southern Nevada's climate, but here in northern Nevada, we are often called "lay midwives," which is perceived by midwives with formal education as offensive. We see our clients being referred to as having no prenatal care if transfer to the hospital occurs during labor, even when the staff has been provided with a full chart complete with standard lab and ultrasound reports and complete prenatal labor records. Referrals to perinatologists are unavailable altogether in northern Nevada. For our clients with gestational diabetes, many dieticians will not accept our referrals, and many pelvic floor therapists cannot or will not accept our referrals. Families will receive safer and more comprehensive care if CPMs are recognized as legitimate, autonomous health care providers with more collaboration and integration available.

Studies show that interprofessional teamwork is essential to the provision of high-quality maternity care. When professionals collaborate on decision making, and when coordinated care is seamless, fewer interpartum, neonatal, and maternal deaths occurred during critical obstetric events.

Assembly Bill 387 would also specifically define supervision, and a licensed midwife must be physically present on the premises and able to intervene when a student midwife performs any clinical tasks at births, prenatals, or postpartum care visits. Assistance would also be subject to this rule. This is a matter of safety for families. It also provides protections for students and assistants and their preceptors and supervising midwives. The NACPM supports this stance on direct supervision. Some midwives in Idaho became concerned about this rule, which is included in several other states' licensure laws. They asked what would happen if a midwife needed to go to sleep, get food, or check on another client, and the NACPM's response was very simple. If a person is at a stage of labor where they require midwifery care, then that midwife must be in attendance. A student does not perform any clinical task such as a cervical exam, check vitals, listen to fetal heart tones, et cetera. They are only there to provide emotional support and physical comfort measures, basically acting as a birth doula, then they are not in violation of the NACPM essential documents. Any clinical assessment of a client without supervision is a violation of the NACPM essential documents.

Assembly Bill 387 would require midwife assistants to have a basic knowledge and training before attending births with their supervising midwife [page 17, Exhibit D]. Details have not been completed, but requirements would not be extensive or complicated. California currently requires their midwife assistants to have training if they are not a student at a MEAC-accredited school. I know there are concerns that this would limit access to assistants, and midwives may be more likely to attend births alone. Luckily, especially now during the COVID-19 pandemic, there are a variety of online assistant trainings. Supervising midwives could help their assistants learn the necessary hands-on skills before assistants begin attending births. The Midwifery Board would be able to allow those midwives to create a program for their own assistants [page 18].

We believe licensure and regulation is essential for meaningful integration and collaboration between CPMs and other health care professionals. This in turn has been shown to improve outcomes. We want to provide respectful and safe care to our Nevada families choosing community birth as autonomous providers practicing to our full scope. As the slide [page 19, Exhibit D] says, "Regulation is a mechanism by which the social contract between the midwifery profession and society is expressed. Society grants the midwifery profession authority and autonomy to regulate itself. In return, society expects the midwifery profession to act responsibly, ensure high standards of midwifery care and maintain the trust of the public."

Thank you so much for your time this evening. We know you are busy doing really important work, and we have a whole new appreciation for what it is that you do. If you have any questions, we are here to answer those.

Assemblywoman Sarah Peters, Assembly District No. 24:
I want to thank Assemblywoman Monroe-Moreno for bringing this bill, and I am honored to be a cosponsor and copresenter of A.B. 387. There has been a lot of misinformation circulating about the genesis of this bill. It is unfortunate that a community made up of a value system designed around support would attempt to demonize those who would seek to enhance access and financial coverage and security to a greater number of birthing people in our state. What I hope today's presentation does is set the record straight regarding the intent of this legislation and clear the names of those attempting to address these basic and simple issues.

I am a home-birth mother. I hired a midwife for all three of my births. I had insurance coverage during all three of my births. However, my desired service was not covered under two of those births because we have no regulatory certification for midwives in Nevada. The third one was not covered because of an insurance loophole. All in all, the cost of birthing my three babies at home was more than the out-of-pocket maximums, and my midwife had to set up a payment plan with me that was such a financial burden, I almost went back to the hospital model for fear of the inability to pay my other bills. I am going to check my privilege here because I was in a stable financial position where the burden was real but absorbed in our ability to "trim the fat" of our small family budget. I am also a white cisgendered woman, which makes it easier for me to find a job and obtain coverage for both insurance and physicians. I always had a backup plan. Additionally, my family is local and supportive. My mother used the same midwife who birthed my children when she birthed me. I knew that if I ever needed help, I had a safety net in my privilege.

Not every birthing person is so lucky. Around 60 percent of births in Nevada are had by people with Medicaid insurance. The Medicaid provider model requires providers to enroll with the state and provide credentialing. Although there are some exceptions, Medicaid, as a general rule, requires specific credentialing to provide reimbursement for services. To date, Nevada has no such recognized credentialing for midwifery or other support services. Only 40 percent are covered under single payer or company plans or are uncovered in some cases. That means, unless the birthing person can pay out of pocket for midwifery services,

60 percent of the birthing population does not have access to one of the safest ways to birth their baby. Actually, in Nevada, 25 percent of birthing people do not receive prenatal care at all in the first trimester; and 11 percent of children are born premature; and 9 percent are born low birth weight at delivery. It may or may not surprise you that these numbers are all worse than the national average.

The Department of Health and Human Services has been working to increase these outcomes, and in 2020 had a goal to improve prenatal service for Medicaid-covered pregnancies by 10 percent but fell short of this goal. In 2020, 34,985 births occurred in Nevada. Of those, 19,696 were covered under Medicaid. The cost to the state of only the newborn care with low birth weight babies, preterm babies, and babies needing continued services was $51,668,621. This was an increase of $16,323,953 over the year. We know this is not a money committee, but I think it is important to see the cost to the state when discussing an alternative proven birthing model access. A 2018 study concluded that midwifery care and low-risk pregnancies reduced preterm birth and labor interventions. The study also cited that women in midwifery care were less likely to be Black, have Medicaid insurance, or have a history of pregnancy complications or previous cesarean births. Additionally, women in midwifery care were less likely to end up having a preterm or cesarean birth. All of these outcomes reduced costs of care with cesareans being one of the highest-cost birthing scenarios available.

Birthing people go through a physically trying period. Conceiving, growing, and birthing a child takes an incredible amount of work. I sometimes joke that my son tried to kill me because while pregnant with him, I was so sick I do not remember a day during that pregnancy that I did not throw up. It can also be incredibly rewarding or incredibly traumatic. I got to witness a traumatic birth firsthand in college. At 20 years old, I got to hold the hand of a friend who was pregnant and covered under Medicaid. She obtained prenatal care from a physician who scheduled her birth. When I asked the mother about this, she did not know that she could have a choice to go into labor naturally. The doctor induced labor by giving her Pitocin. There was no reason for the woman to go into labor on this day besides that it was the birthing model of her care provider. I would be lying if I said I remembered everything that happened that day, but I do remember that Pitocin was given multiple times. By the time contractions started, the mother had been in the hospital for over 24 hours, all at a cost to the state. When she went into labor, her doctor gave her an epidural, which then made her so numb, we had to tell her to push based on the reading from the monitor and a screen. The doctor used every intervention I can imagine at a cost to the state, for what? There was no need for this level of intervention. The woman did not know she had choices in these areas.

One of the consistencies of this discussion, regardless of opposition or support, has been the idea of choice. Birthing people deserve choice in care and services obtained during pregnancy, birth, and beyond. The current single model of covered care does not work to allow for those choices to be made by all birthing people. One thing I think we can all understand is that the relationship between a person and their medical professional is sacred,

and that regulation in that area should be deeply assessed to ensure the rights of the patient are retained, while also supporting the highest possible standards of quality within the provider's field.

I believe in the purpose of this bill, albeit the initial language did not get us there. We know this is part of the process. We know working together makes for better legislation. I am grateful for the feedback and community interest in this legislation. I think we all want the same things—increased outcomes and increased choice.

Sandra Koch, M.D., representing Nevada Section, American College of Obstetricians and Gynecologists:
I am an obstetrician and gynecologist. I have been practicing in northern Nevada for over 30 years. I am here today to speak in support of A.B. 387. Although the American College of Obstetricians and Gynecologists believes that hospitals and birth centers are the safest settings for birth, we recognize that each woman has the right to make a medically informed decision about where they deliver and who their provider is. Assembly Bill 387 will allow licensure of qualified midwives in Nevada. Women who choose a licensed midwife to assist them in their birth will be assured that their midwife has met the requirements set forth in this bill and have agreed to practice in compliance with the restrictions listed. The bill will establish that when women do not meet the requirements for normal, low-risk delivery in pregnancies, they will be informed of the increased risk associated with their diagnosis and they will be referred for consultation, or an indicated transfer for a higher level of care. It will ensure that the standard of care, based on current science, is consistent for women regardless of their chosen place of birth or their chosen provider.

A working group that will form after the bill is signed into law will promote smooth transitions between levels of care. As Ms. Hoffman and Ms. Macdonald referred to earlier, this is a critical point of contention and a place where we can significantly improve outcomes for home birth and people who choose to deliver out of hospital.

In addition, A.B. 387 will require the collection of data for all planned out-of-hospital births by licensees. This will allow Nevada to evaluate the outcomes for women who do choose to deliver out of hospital. We, the Nevada State Medical Association and the Nevada Section of the American College of Obstetricians and Gynecologists believe that passing this bill will significantly improve the safety of out-of-hospital births in Nevada, and we strongly support passage.

Assemblywoman Monroe-Moreno:
Thank you to my copresenters and everyone's patience. We gave a long presentation, but it is a very important subject matter. As the bill came out, we went through it line by line and word by word, and there were some items in the bill that were not necessarily the intent of the bill. As I said in my introduction, we have diligently been working collectively with midwives across the state, the doctors, hospital associations, and other legislators who actually took the time to read the entire bill when it came out, and it is 136 pages. Because of that, we have presented to this Committee an amendment [Exhibit C] to make sure that the

legislative intent of this bill and the language actually matches. If you would like, I can go through the amendment, and the midwife and medical professionals who are on with me can answer any questions you might have of the changes.

In section 3 of the bill on page 4, line 8, the word that is being deleted is "birth assistant," and it is replaced with "Certified Professional Midwife birth assistant." In section 11, on page 5, line 6, "midwifery" is replaced with "Certified Professional Midwifery." In section 14, on page 5, line 18, "CPM student midwife" replaces "student midwife." Section 15 was completely deleted by the amendment. Section 16, subsection 2, paragraph (b), replaces language with "an APRN, CPM, or OB with experience working in the home setting."

There are also amendments made to section 16, subsection 2, paragraph (d). The next section is section 18, subsection 1, paragraph (a), which removes language and replaces it with "CPM." Section 19, subsection 1, replaces language with, "An applicant for a license as a midwife must submit to the Division an application in the form prescribed by the Division. The application must be accompanied by a fee in the amount prescribed by regulation of the State Board of Health . . . ." It goes on into the next page [page 3, Exhibit C].

Section 21, subsections 1, 2, and 3, added language which is the "CPM." Section 22, subsection 1, added "certified professional midwife." Section 22, subsection 1, paragraph (b), adds "certified professional" or "certified nurse-midwife." Section 22, subsection 3, adds "A certified professional midwife." Section 23 added conformed language, as did section 24. In section 25, on page 13 of the bill, line 24, there was language that was replaced. The language in red was what was stricken out, and the language in green was what was added. Section 26, on page 14, line 14, added "in the birthing center setting."

Section 31 removes language and adds the green language that you see on your amendment [page 5, Exhibit C]. At the bottom of that amendment page, section 69 of the bill, on page 54, line 22, "licensed certified professional midwifery" was the wording added. In section 75, subsection 2, the language "any other type of midwife" was removed. In section 77, "CPM" and "certified professional midwife" were added. The final two sections, sections 101 and 102, added language to the bill. If you have any questions as to why those changes were made, we are here to answer any of those questions.

Chair Jauregui:
Before we go to questions, I would like to hand it over to Assemblyman Frierson for a comment.

Assemblyman Frierson:
I wanted to take a minute to thank Assemblywoman Monroe-Moreno, Assemblywoman Peters, and Ms. Hoffman for what I believe is understated in how long this has been worked on. I think we have been receiving emails suggesting that this is a regional issue or there was some rush to some policy. I do not remember exactly when, but it was as recent as 2013 and possibly even 2011 when this first came up. I remember distinctly there being a concern about whether or not the community was ready. There was a period of time when the

midwifery community wanted to be allowed to do what they do, and over the years, there was a concern growing about mortality rates in childbirth and the impact it had on communities of color. I wanted to make sure that everyone knew this was something that has been contemplated over several years, literally eight to ten years of discussions about if and when this was the right time. I am glad to see us having this conversation and glad to see it be [audio was lost].

Chair Jauregui:
With that, are there any questions?

Assemblywoman Hardy:
Thank you for this presentation. I definitely learned a lot about something I knew very little. I am just trying to sort this out. From my understanding, there is MEAC education and PEP. A lot of midwives in our state have the PEP education, and this bill would require the MEAC education. Do I have that right? [One of the presenters said, Correct.] I was trying to write down the requirements quickly. It is a three-year program, they have apprenticeships, a clinical requirement, and they sit for credentialing. Why would we be doing away with the PEP education and just have the MEAC? Does Nevada currently have the MEAC education?

Amanda Macdonald, Private Citizen, Reno, Nevada:
We kind of talked a little bit about the US MERA task force that was put together. They came together and said, "How can we make a system where all of these midwives are a little better integrated and a little bit more understood about where they are coming from?" If these midwives had a really standardized education, people might feel a little better about integrating them into their system. I know when I speak with doctors, they are sometimes really nervous and have no idea what our level of education is because a lot of midwives go through that PEP process. That PEP process is really individualized. Yes, in going through PEP you learn the same set of skills, and you learn the same information that can get you to pass the exam, but making sure that everything is hit and all of those sections have been covered thoroughly is not there. You never really know exactly what is included in a PEP education because it is sort of like self-study. There is a lot of information out there. I know a lot of amazing PEP-trained midwives. The idea of the MEAC accreditation program is that it is standardized. There are no questions about who got what and when and how. It is, "MEAC does this. They have to be accredited. They have to meet these standards. This is the education they get. This is the process they go through. This is the paperwork they do." It is very standardized.

Tiffany Hoffman:
It has been presented as an important and nonnegotiable piece for collaboration and integration. As we see, that improves outcomes, and that is why it is important.

Assemblywoman Peters:
I wanted to add that this bill does not obligate every midwife to this education track. It is only for midwives who would obtain or choose to obtain that certification.

Assemblywoman Hardy:
What happens to the people who currently have the PEP education?

Amanda Macdonald:
For those midwives who already have their CPM through that PEP process, the requirements for licensure would be the Midwifery Bridge Certificate that we talked about with the extra 50 CEUs. They would have their CPM credentialing that happened through the North American Registry of Midwives (NARM) based on their PEP education, passing their exam, and getting through all the skills checks. They would then get that Midwifery Bridge Certificate they would be eligible to apply for licensure here in Nevada. I know a lot of the CPMs who are PEP-trained either have their Midwifery Bridge Certificate here already, or they are currently working on it. It is a matter of finishing that up. By the time they do, chances are that will be when we are starting to do all the paperwork and get things going. It would not mean that they have to go back to school and get a PEP education. They can use exactly what they have now up until that cutoff point, which is in 2025.

Tiffany Hoffman:
We put a piece in the bill that would allow individual extensions to that date for rural midwives and midwives who represent communities that have been historically marginalized. We want to make sure we create a more diverse midwifery workforce.

Assemblywoman Monroe-Moreno:
That additional time would be on a case-by-case basis. The Board of Licensed Certified Professional Midwives will be able to look at those on a case-by-case basis if they have to be extended. There was a lot of conversation from other midwives that there are not a large number of midwives from communities of color or in rural communities, and they were finding it difficult to get the training. That is why the extension was put in the amendment [Exhibit C] in order to give the Board that ability to do that on a case-by-case basis.

Assemblywoman Marzola:
How long does it take to get certified, and how much is it?

Amanda Macdonald:
It takes varying amounts of time. When it comes to a PEP education, typically those programs are considered three years for the didactic portion. They want a minimum of two years for the apprenticeship section of it, and those can happen concurrently. You can do your three years of didactic study more quickly than that if you can. Generally, the bare minimum is two years in this program. We often see CPMs taking much longer than that. It is really common because it depends on how many people are having babies out of the hospital in your community. What is your availability for preceptors? What does your family structure look like? Are you able to be a full-time student and attend five births a month, or can you only attend two births a month? It really depends on how long it takes you to get those clinical skills down and finish that didactic portion. If you are doing distance learning, and some of those MEAC programs involve distance learning, you can work around

your schedule a little differently than having to travel to school that is on a much more set schedule. There are many different factors in there.

I can speak for MEAC education, and some of those programs range anywhere from $9,000 to well up into the tens of thousands of dollars. It depends on the program. The PEP process is dependent on how you are going through things with your preceptors. Some preceptors charge a fee, and some do not. Some student midwives are paid by their preceptor for attending births, and some are not. There are scholarships available for MEAC programs and grants as well. There might be some scholarships out there for PEP programs as well, but usually they are going towards the MEAC schooling. It varies depending on your path and what you are doing.

Assemblywoman Dickman:
It seems like we are placing some burdens in training requirements on birth assistants. They only provide support during birthing, overseen by a qualified midwife. Should this pass the way it is, do you think that is going to place rural midwives at a severe disadvantage?

Tiffany Hoffman:
Honestly, the training for assistants is not extensive, and it is not burdensome. When we attend births in the home setting, attending alone is not generally the safest way to attend a birth if there is a complication that arises during that birth. That assistant is there as a clinical assistant. That person will have to be responsible for clinical tasks. Sometimes that includes the resuscitation of a newborn. It might be giving medications for a hemorrhage that is occurring. It might be cardiopulmonary resuscitation (CPR) to a mother or birthing person. That person has to be well-trained in some way, fashion, or form. Having someone who is untrained or just started attending births and has had zero training whatsoever, learning on the job in this case is probably not the best way. Yes, you will learn as you attend births, but you need to have some basic foundational level of education or training before you start attending births in that assistant role.

Assemblywoman Dickman:
What are some of the restrictions on someone who moves to Nevada, as far as experience?

Tiffany Hoffman:
I believe you are referring to the reciprocity agreement, and it is currently listed as five years. We are open to changing that if necessary. That was not a piece that we were strongly tied to. If that were something that seemed to be burdensome, we would be absolutely willing to change that.

Assemblywoman Dickman:
I think that would be good because the more we have available, the better it is.

Assemblywoman Monroe-Moreno:
In response to Assemblywoman Dickman's question, I appreciate your comments. However, the training a midwife would receive in another state then coming to our state, if that person wanted to be a midwife in the state and have a license, they would have to meet the standards of this state. If the licensure in another state was less than Nevada, they would have to meet the standards of Nevada. Does that make sense?

Assemblywoman Dickman:
I think that makes perfect sense. Could we speed it up if they do have the same requirements or qualifications?

Assemblywoman Monroe-Moreno:
I believe the bill does address that if they did have the same requirements or even if the standards were higher than those in Nevada, then they would be eligible to apply for licensure in our state.

Assemblyman O'Neill:
I need one question clarified, and that may require a follow-up. If a midwife currently has PEP training here in Nevada, to get that MEAC, they still have to show they have had someone monitoring them during five births. Is that correct, or did I misunderstand that?

Amanda Macdonald:
Are you asking about the amount of training you would need to become a midwife going through a MEAC-accredited school?

Assemblyman O'Neill:
I guess so, yes. I am looking at midwives in places such as Tonopah who have PEP training and have been active for seven years. To convert over, does she have to have you come monitor her or her five deliveries?

Amanda Macdonald:
If it is someone who has been practicing, and he or she is not a CPM now, he or she could continue to practice just like he or she is right now and opt not to get a license. He or she would continue what he or she is doing right now other than letting the client know, "I do not have a license in this state." If it is a student who is working towards the CPM and trying to become a CPM, he or she does need to be overseen by a preceptor who is a CPM. The number of births the student has to be overseen is up to 55. Many attend more than that because the certificate may take longer. It really depends on what route that person is going. If he or she is going to remain unlicensed, and that is the plan, there are no changes he or she has to do. He or she does not have to be supervised. If he or she is a student planning on getting the CPM, he or she will need to be supervised.

Tiffany Hoffman:
If this is a current CPM who would like to qualify for licensure in the state of Nevada and has gone through the PEP route, the only thing that would be required is the Bridge Certificate, which is that 50 CEUs that he or she has five years to complete. I think it is four years right now with what we have in our bill, and that would be available until 2025.

Assemblyman O'Neill:
I am still slightly confused. As Assemblywoman Hardy said, there is more information here than I ever thought I would know about midwives. I am still trying to digest it.

Chair Jauregui:
I do have a question for you, Assemblywoman Monroe-Moreno, or your copresenters. It is regarding the amendment [Exhibit C]. I notice that you are completely deleting section 15, and I want you to walk us through what the intent was behind that. I know section 15 was the section that gave people who did not want to get the licensure the authorization to provide a document saying he or she was not licensed. Also, it contained the requirement to keep records. It was also the section that had the exemption for other licenses and gratuitous care by friends or members of the family. Can you walk the Committee through what the intent was behind deleting section 15?

Assemblywoman Monroe-Moreno:
Having meetings with other midwives in our state, it was brought to our attention that having that section set them apart, and we had two classes of midwives. The midwives who were not licensed were the only ones being obligated to have this form and save it for five years. We thought it would be better to treat everyone as equals, so everyone would have the form, thereby letting their clients know what type of midwives there are available in the state and not setting anyone aside. It would be that all midwives have the form. It is an informed consent for their clients. That is why that section was taken out. It was to make this bill more equitable. We know not every midwife in the state wants to have a licensure. We did not want to impede upon that, but we want every birthing parent to know who they are hiring and what the scope of practice is of the person the birthing parent is hiring.

Chair Jauregui:
That leads me to my second question. If I read it correctly, this is completely optional. A certified midwife can choose to get the license or to not get the license.

Assemblywoman Monroe-Moreno:
Correct.

Assemblywoman Tolles:
I do appreciate you asking that question about section 15 because I was also wondering about that, which brings another question. What is the key difference of benefit for those who are licensed versus those who are not? I know this is kind of the crux of this bill. Is it Medicaid coverage? Can you just summarize the overall presentation to make it clearer in my head?

Assemblywoman Monroe-Moreno:
I am going to start, and then I am going to ask Ms. Hoffman and Ms. Macdonald to take over. As I said in my opening statements, there were constituents in my district and other districts who came to me who had negative outcomes with the midwives they hired thinking the state of Nevada had a licensure. When they found out there was not, they asked how we can set that licensure up. There have been some amazing outcomes with midwives. I say more than 90 percent of the births with midwives have wonderful outcomes. You will hear stories of negative outcomes from people who will be joining us in support and opposition to this bill. They asked me how can we provide that licensure? How can we establish regulations? You heard Assemblywoman Peters say that in utilizing her midwife, she was not able to use her insurance. Some people are and some are not. You also heard the Medicaid savings that would come with the licensure of the midwife. I will now turn it over to my copresenters.

Amanda Macdonald:
This is the big part of the conversation where people go back and forth asking why on earth you would want licensure if you are living and practicing in a state that does not require it. Why would you subject yourself to the state coming into your practice and telling you what to do? There are two sides to this. I will start from the unlicensed side. Midwives who choose not to be licensed do not have the state overseeing their rules. They have full autonomy with their client families to make those decisions that feel best for those families. That may not be the same as the boundaries the other midwives might feel comfortable with. They do not want to be restricted by the rules of licensure, so they will choose to remain unlicensed because they want that freedom and they value that freedom. It serves their communities best, and that is what they feel comfortable doing. Those are the midwives those families feel comfortable hiring.

On the licensure side, yes, there are restrictions that come with licensure. We know that to be the case. There are also a lot of positives, including accountability, which is huge. If a licensed midwife is practicing in a way that is negligent, unacceptable, or needs to be adjusted, there is a process for that. There is a way to work through those issues and get that sorted out; collaboration is a huge piece. We talked about the safety issues, and one of the ways of making out-of-hospital births safer is by collaboration and integration. We have medical professionals who are really nervous about collaborating with out-of-hospital midwives because we are not licensed. I hear it over and over again, "We do not know what kind of education you have. We do not know where your boundaries are. We do not know how you are practicing or what your charting looks like." When you have something with set standards, other professionals have an idea of, "Okay, this is what the norm is for this group of midwives. This is what we can expect."

Access is huge. We talked about the financial benefits and being able to accept insurance from clients more easily is helpful. I always get really excited when I find out that my families are able to fully utilize their health insurance benefits. I have pretty decent luck because I am licensed in the state of California, so that helps out a lot. In the state of California, I can accept Medi-Cal. I do not practice over there very often, so I have not gone

through the process. It would be expensive for me, and I do not have many Medi-Cal clients over on the California side. However, you cannot do that if you do not have a license, so that is access for families. You heard of the birth center bill [Assembly Bill 287]. If birth centers come about in this state, we will not be able to work in them unless we are licensed. That is an access issue for families. If there are birth centers that are run by CPMs who are licensed in this state, that is access for families. Some families do not want to have babies in their home, and they feel more comfortable in a birthing center setting. That is huge.

The piece about referrals goes back and forth. While this licensure would not require that any provider collaborate with us, and we cannot require that they do that, it might open the doors to bridging that gap between, "Okay, I will go ahead and see one of your clients. I have never done this before, and I am a little bit nervous about it because this is very different." Now that we have some sort of guidelines and some sort of regulations, this relationship might be easier on both sides. There are pluses to licensure, but there are also downsides to licensure. There may be some restrictions that people do not like to see, but those are things the Board would come up with. Being unlicensed is similar to what is happening right now. If someone is okay with the way his or her practice is going right now, and the families are happy with the care they are receiving, he or she can continue to go down that unlicensed path.

Assemblywoman Tolles:
That was helpful.

Chair Jauregui:
Are there any questions? [There were none.] I would like to give everyone listening the lay of the land of what testimony will look like. I will be taking 30 minutes of testimony in support, 30 minutes of testimony in opposition, and 30 minutes of testimony in neutral. I do have a couple of people who will be testifying on video, so we will start with them and move over to the telephone lines and then to the next part of the testimony. With that, we will move to testimony in support.

Danielle Yeager, Private Citizen, Las Vegas, Nevada:
I am a Nevada home-birth loss mom, and I hired a CPM. We did not know there was a difference between a midwife's education. There are a lot of different types of midwives. You think they are all the same, but they are not. We thought we hired a nurse-midwife, and as it turned out, we hired somebody who was actually criminally charged in California for practicing without a license where a baby almost died under her care. We did not know any of this until after our son died. She left California, which is a licensed state, and came to Nevada where we have no regulations, and she continued practicing.

We tried to file a complaint. We contacted as many different boards in the state to let them know what happened, but there was none who dealt with midwives. There is no oversight here, and there is nothing we can do. Since there was nothing to do, there was no way to hold her accountable and let anyone know what she had done. We could not make anyone aware.

We need to have some type of oversight, some type of board, or some type of regulation to keep them ethical and on par with what we have. This is care, and they need to be professional, ethical, and responsible for the families in our communities.

I support this much-needed and long-time-coming bill to give education to midwives, to hold them accountable, and to make sure student midwives are giving the proper care. You do not want them alone on the job, just like you would not want somebody alone on the job who is learning and has no idea what is going on when this has to do with birth. We just do not know. They could misdiagnose, and there could be a lot of things that could go wrong. It is very important for midwives to have the proper training, so they know what they are doing.

I do agree with the copresenters that the midwives working with the hospitals and the medical staff is very important for making assessments, risking people out, and making transfer safer and easier. Boy, do I wish I would have had that because my life would be completely different if we had the proper assessments by a doctor and a transfer plan that was actually put in motion.

No one ever expects something to go wrong, but having the proper care with the teams ready and available and working together makes all the difference between life and death. Choice means safety by getting better and improving care. Without the accountability, updating education, and bridge between out-of-hospital and hospital care, our state is lacking safety, care, and informed consent, which means there are no real choices for women and their families. This does not mean we are taking away rights or choices for birth options. It is making those choices better and safer for everyone who is choosing those different types of out-of-hospital options.

Our state has seen hard times with the COVID-19 pandemic. Many families are looking to other birth options to keep their family safe from the virus. Creating regulations while building a more open relationship between out-of-hospital and hospital care, especially during this time and for the upcoming future, is how we keep families safe. It is our right as Nevada citizens to be given better and safer choices. That means bumping up our out-of-hospital providers with the necessary regulations and to give the proper level of care for everyone.

I cannot stress this enough because I obviously did not know about all this. I just want everyone to know that regulation is so important in updating their care. The education may seem like it is a little bit here and there, and it might seem like a lot, but that education does matter to the families. It truly matters because if they do not have the proper education, they miss red flags where they could send someone to the hospital and save the child or the birthing person. That is all I have to say. [Written testimony, Exhibit E, and an article, Exhibit F, were submitted.]

Erika Minaberry, Private Citizen, Reno, Nevada:
I am testifying in support of A.B. 387. In 2013, I had a home birth that ended in a hospital transfer where I had to have a C-section. My midwife took incredible care of me and

exercised the utmost in safety, including my mental health. I had a beautiful, healing birth despite the C-section because of this. If my midwife had put their own biases and agenda before the safety of my baby and myself, I would not have had the same outcome. You are about to hear a bunch of testimonies in opposition to this bill. [Unintelligible] birth workers who do just that, put their own self-interest before the safety of a client in the name of maintaining freedom. Outside the fact that this bill does not impact the freedom of anyone, I do wonder if these opposers consider the freedom of the Black parents and babies who are dying at six times the rate of their white counterparts. One has to ask what type of practitioner opposes things like antiracism and antibias training for those marginalized communities. What type of practitioner is against informed consent? It is not just insulting that these conspiracy theorists nay say government regulation to this governmental body, but the falsities of their claims are dangerous to the Nevadans who are the most vulnerable. For these reasons, I ask the Committee to please vote yes on A.B. 387.

Riley Sutton, Private Citizen, Reno, Nevada:
I am speaking in support of A.B. 387. I want to tell you a quick story about why I support this bill. I called 9-1-1 on February 17 just after 3 a.m. because my third child had been born at home, and he was born virtually lifeless. After a minute or two of CPR and oxygen, which felt like an eternity, the baby was so unresponsive, the midwives instructed me to call an ambulance. This was a very different birth than the births of my two other children. Our first son was born in the hospital. The birth was fine, but afterwards with the constant check-ins, monitoring, trash collection, and the general public at the hospital, we found it impossible to rest. We had a home birth with our second child, and that home birth went just fine. Afterwards, it was lovely to be home in our own bed, eating our own food, and with our family around. It was just great.

Our third baby, not to bury this too far down, he is now happy and healthy, and he is just an impossibly naughty and willful one-year-old. The issues he faced at birth were a total statistical aberration and had nothing to do with our midwives. We feel that home birth families in the future should know that. Or, on the flip side, they should note there was an issue that was the fault or the negligence of the midwives. With commonsense regulations and reporting, standards of education, and certification, more families in the future can feel comfortable to have the kind of home birthing experience we had, at least with our second child. Licensure and mechanisms for correcting issues or revoking a license are much needed to ensure safety and transparency.

Our midwives, Ms. Hoffman and Ms. Macdonald, who you have been hearing from kept Aaron alive. They were professional, they were quick, and they were 100 percent on top of it. Yet, when the first responders arrived, they did not take Ms. Hoffman and Ms. Macdonald seriously. A minute wasted felt like hours in redoing vitals and other checks. This is not at all a knock on first responders. I want to be very clear about that, but they just did not know what the level of training and expertise of the midwives was. They did not know what they were walking into. This is the other main reason I support this bill. With the provisions to

recognize this as a profession and create a system to make sure first responders know they are dealing with trained professionals, they will be able to administer life-saving care much more quickly. Again, I urge your support for A.B. 387.

Mary Gilbert, Private Citizen, Sparks, Nevada:
I am a midwifery student in Reno, Nevada. I know you may hear a lot of folks who are opposed to this bill, and they are typically much louder than those in support. I would like to acknowledge that many of the people who are in support of this bill may not be here because, like myself, they are tirelessly working to serve their cities, so I will speak on behalf of myself and them.

I have been attending births since 2008, and when I first began my journey into midwifery, I was much like these folks who are opposed to this bill. I believed that to put regulations on midwifery was almost sacrilegious. I believed this work to be beautiful, wonderful, safe, and full of magic. I still believe this work is magical, do not get me wrong. Now that I have done this work for over a decade, I realize how important this bill is.

As a midwifery student in my first year of attending births as an apprentice, I went to a birth where the primary midwife was not there when I showed up. In fact, she was over an hour away, and the client was pushing. I caught the baby by myself, and when the mother hemorrhaged, the midwife instructed me to inject Pitocin in a manner that has not been practiced since the 1970s. I needed my primary midwife there; the client needed the primary midwife there. The client deserved better. A licensed midwife should be at all appointments, labors, and births. A student should never have to experience this alone until they are ready and properly educated. This outdated advice the midwife gave me should have been brought to the attention of the peer review so others could educate her on new evidence-based practice.

As a midwifery student, I have also witnessed the disconnect between midwives and hospital staff. I cannot express how important it is for me to have the opportunity to create and cultivate relationships with doctors, specialists, and hospitals to help keep birthing people and babies safe. On the topic of keeping birthing people and babies safe, as a student, I also want to be able to have access to lifesaving medications and other equipment at a birth that I attend. These lifesaving medications helped me during the birth of my children while I was hemorrhaging. My first child was born in a hospital.

Chair Jauregui:
We still have people who need to get through their testimony. If you could send the rest of your testimony into our committee manager, she will make sure to include it in the record. [Written testimony was submitted, Exhibit G.]

Keith Brill, M.D., Private Citizen, Henderson, Nevada:
I am the president of the Nevada State Medical Association and past chair of the Nevada section of the American College of Obstetricians and Gynecologists (ACOG). I began practicing in Nevada in 1999 on the labor ward at Nellis Air Force Base. Our four OB/GYNs

worked collaboratively with two certified nurse-midwives and truly enjoyed our working relationship sharing low-risk and high-risk patients at a safe and effective environment. I learned a great deal from these midwives.

When I entered private practice in Las Vegas in 2003, I immediately began seeing how midwife delivery patients transferred to hospitals typically with complications from childbirth that had already occurred. Through my national involvement with ACOG, I watched other states research the need for proper education and licensure of home midwives. The professional degree of CPM became a standard term in the midwife field. There ought to be a way for apprenticeship training and direct-entry midwives who did not go through a master's or a nursing master's degree training to continue to practice as midwives. This was thoroughly reviewed in the CPM PowerPoint presentation [Exhibit D] we just heard. We have always known that midwives [unintelligible] home births. The standards endorsed for licensure allow these midwives to meet the international standards we heard described through the International Confederation of Midwives and MEAC [unintelligible] your questions during the question session.

It is time for Nevada to uphold the standards of midwifery care expected of those in other nations around the world. You will hear opposing views that giving birth is a natural physiological process that has been attended to for centuries by midwives. I agree that birth is a natural physiological process, but do you know what else is? I will start with this one: digestion. I know I am hungry right now, and I am sure many of you are skipping meals tonight. When our natural physiological processes go wrong or cause disease, our public relies on training and licensed gastroenterology specialists to care for them. Another example is the beating of our hearts and the circulatory system. Yet, when one of the leading causes of death in America—cardiovascular disease and strokes—occur, we rely on licensed cardiology and emergency specialists. I can go on and on. If you break a bone or your child breaks a bone, I think you want a licensed orthopedic surgeon taking care of your child. I use these examples to give some perspective and to remind the Committee members that all births are not the same, and even low-risk out-of-hospital births can quickly become high-risk or develop complications that require immediate attention.

I am fully aware of the current home birth climate in our state. I am also aware of the pitfalls of the current system of what can and has gone wrong. [Written testimony was submitted, Exhibit H.]

Chair Jauregui:
Dr. Brill, thank you so much for your testimony, and we appreciate you sending in your written remarks.

Kathy Buchanan, Private Citizen, Sun Valley, Nevada:
I will try to do this as fast as possible. I am a veteran of the United States Army, First Captain, Brigade Level Combined Arms. One of my roles was actually auditing software at the National Aeronautics and Space Administration at their Alabama location. I am a former unit clerk for the intensive care nursery, and I have an associate's degree in science for health

care management. I am a former medical biller and coder. I have three biological children. The first one was born with Van der Woude syndrome. My attending OB/GYN stated nothing was wrong. I did not know she had Van der Woude syndrome and had been born without a soft palate until she was three months old, and I was administering CPR in my living room. My second was a very traumatic C-section, and he was born six weeks premature. Following that, I joined the United States Army and got a healthy dose of post-traumatic stress disorder due to a military sexual trauma.

I met Tiffany Hoffman when I was pregnant with my third child at the age of 36. That was the first time I breastfed, and the first time I was with a midwife. I know why they say time with a patient builds a different level of relationship and allows you to practice skills.

I want to call your attention to the American Society for the Positive Care of Children that says the highest rate of child abuse under federal guidelines under the age of one is 25.7 percent, and an annual estimate of 1,840 children die from abuse and neglect, and that was as of 2019. Then I will draw your attention to childwelfare.gov, and their public health approach. A number of experts have championed a public health approach to addressing child maltreatment fatalities, which focuses on improving health and well-being of individuals in communities before child maltreatment happens. A public health approach involves defining the problem and identifying the risks and protective factors, understanding consequences, and developing prevention strategies. Additionally, a public health approach engages the entire community in preventing child maltreatment and ensuring that parents have the support and services they need before abuse or neglect could occur.

In addition to those statements, I would like to say that during the national pandemic, the availability of care [allotted time was exceeded].

Chair Jauregui:
We appreciate your calling in today.

Zack Chatelle, Private Citizen, Reno, Nevada:
I will try to be brief. I am a working firefighter/paramedic in the Washoe County community. My wife and I had our first child three months ago, and with the overall COVID-19 environment, we wanted to do a home birth with a midwife. We had two certified midwives, one being the main, and our experience was amazing. It did not go as planned, and we ended up having to go to the hospital later in the pushing phase of labor, which was the call of our midwives and was greatly appreciated. Because of the work that our midwife had done in building a network and relationship with the hospitals, she was able to advocate for us before we ever got there. All our information and needs were there. They knew we were going for a natural-style birth, so that was kept in mind. Overall, we had a great experience.

As a paramedic, accreditation to me means continuity of care for our patients, and that should be the goal of every clinician at any level. We want the best outcome for our patients, and we all have a uniform standard of care. We can all rely on each other. One of the other testifiers said we can assume our job and take action sooner, and we do not have to wait for all of the steps that have already been taken.

Hospitals, for everything else, are used to emergent situations, and labor is not an emergent situation in and of itself, but it can become one. Because of that accreditation, it should allow, or will allow, midwives to have access to medications such as TXA [tranexamic acid] for postpartum hemorrhage and magnesium sulfate for eclamptic seizures, which are widely accepted in my field already, both out of hospital and in hospital, as life-saving and good medications and good practice. I think everything about this bill is a good thing and should be a yes for everyone hearing it tonight.

Mandy Bengtson, Private Citizen, Reno, Nevada:
I am a former patient of Tiffany Hoffman and Amanda Macdonald. I am really grateful for the level of care Ms. Macdonald and Ms. Hoffman provided when my daughter was born in June 2020. My daughter was in a position during labor that required the help of a vacuum assist. Because of their excellent medical training and experience, they strongly encouraged me to transfer to the hospital when I did. That timely transfer allowed me to successfully deliver a healthy baby girl vaginally without medication or other complications. While it was not the birth I had planned, I felt incredibly empowered by my birth experience because of their care, and the support of my partner, my doula, and the exceptional hospital staff who accepted me at the hospital.

Even though I did not deliver at home, I would absolutely still try for a home birth. There are several reasons. First, I was able to work through the toughest parts of my labor at home where I felt most comfortable. The hospital staff has strong relationships with my midwives and were kind and encouraging to me upon arrival. I received amazing prenatal care with each of my prenatal visits with Ms. Hoffman being 50 minutes long, and she ensured I was as healthy and supported as possible. After my daughter was born, Ms. Hoffman made one-hour postpartum visits in our home within the first six weeks to ensure my daughter and I were healthy and adjusting to our new family life. This is not the standard of care birthing people receive, but it should be available to anyone regardless of a person's financial resources. I strongly support A.B. 387 because it would greatly expand availability of safe out-of-hospital births in our state, and it would ensure the safety of birthing people and their babies.

Kendreia Dickens, M.D., Private Citizen, Las Vegas, Nevada:
I am a board-certified OB/GYN in Las Vegas. I have been practicing in Nevada since 2004. I started out originally in a rural city north of Mesquite, Nevada. I practice currently as an obstetric laborist, which is a physician, an OB/GYN who is board-certified and practices solely in the hospital. We provide care for emergencies in patients who may or may not have a physician who is taking care of them. My team of laborists and I have been directly affected by unregulated practice of some midwives in the state of Nevada. I want to go on

the record to say there are lots of great midwives. I train with midwives, and there are midwives who have a level of care and know when it is time to refer. Unfortunately, there is a large degree of outliers out there. We have taken care of many women who have conditions and risk factors which would not at all be ideal for home births. This would include women attempting breech deliveries at home, [unintelligible] after cesarean sections coming in with ruptured uteruses, and home deliveries of women with complex medical conditions. In the last month, my team has witnessed two babies that have died as a result of attempted home births with conditions that were really high-risk.

For the record, I am truly an advocate for women and believe women have the right to choose their birth experience. I do believe they also need to be very aware of the education, training, experience, and any past disciplinary action taken against any provider. Unfortunately, in our state, midwifery has not been regulated much in that same way and has not been held to the same types of standards and accountability. For this reason, I am in full support of A.B. 387. I believe it will outline common moderate and high-risk obstetric situations in which patients should be counseled better that they may not be great candidates for home delivery. I think it will also develop a professional board for midwives to develop standardized criteria for education, outline a path to licensure, and provide oversight and disciplinary action when needed. I think it will require some full disclosure to make the public clear on the differences between the different midwives. I also think this will help bridge the gap between OB/GYNs and midwives. I do not think there is one that is better than the other necessarily. I think it is a matter of selection by the patient, but I think that is where we are falling short in the regulation. I think it is very important that we are collaborative because in times of need, we are definitely aware [allotted time was exceeded]. [Written testimony was submitted, Exhibit I.]

Chair Jauregui:
Thank you for your testimony.

Staci McHale, M.D., Private Citizen, Las Vegas, Nevada:
I am the current president-elect of the Clark County Medical Society. I am a Nevada-licensed and board-certified OB/GYN physician in Clark County, and I have lived in Las Vegas for 13 years. I have actively provided obstetric care to women in Nevada for those 13 years.

Prior to moving to Nevada, I had the opportunity to learn from many different birth providers. In Pennsylvania, during my residency training, I was taught primarily by obstetric physicians, but I was also fortunate to have been taught by certified nurse-midwives who delivered both in a licensed free-standing birth center as well as in our hospital. I am a better obstetrician because of the lessons I learned from these amazing women. I learned the importance of provider education and collaboration and allowing for safe birth experiences. The Pennsylvania community had direct-entry and certified professional midwives as well. These birth providers all had physicians they could consult with and refer patients to if needed. I learned that the best birth providers were not those who were cavalier and could "handle everything" but instead those who recognized their limitations and were willing to

ask for collaboration and assistance when it was warranted. These amazing midwives, as well as all the OB/GYN physicians who nurtured and taught me during my four years in Pennsylvania, made me the obstetrician I am today.

When I moved to Nevada, I learned quickly that this was not the case, and there was a division between the midwifery community and the community of OB/GYNs. This is something I believe needs to be repaired. I support safe birth options for women in Nevada. I am in support of licensure and educational requirements for all providers of birth in Nevada, including physicians, certified nurse-midwives, certified professional midwives, and direct-entry midwives. The safety of mothers and babies in Nevada is of the utmost importance, and I support legislation that allows birth to be a safer experience. It is my hope that passage of A.B. 387, along with prior past legislation that allows for the development of the maternal mortality review committee, will continue to improve the safety of women who give birth in Nevada and continue to improve the quality of health care in our state. [Written testimony was submitted, Exhibit J.]

Chair Jauregui:
We have time for one more caller in support, and then we will move to opposition. If you have been waiting on the line, thank you so much for your patience and for calling in to provide your testimony. Unfortunately, we will not be able to hear everyone's testimony who is on the line. I encourage you to please have your remarks emailed to the committee manager.

Alicia Sowers, Private Citizen, Pahrump, Nevada:
I am a home-birth loss mom. I delivered twins [unintelligible] at home on May 7, 2020, when we lost our firstborn son, Sullivan. Many of the aspects of this bill would have made a difference in our situation. Requiring more training, having an organized body for oversight, recording the actions of midwives, and not allowing student midwives to conduct care unsupervised are all pieces that will make safer changes for Nevada families. A researchable record of our midwife's past would have been something that would have been hugely useful to us and would have perhaps saved our son's life. These standards and requirements for care would have changed our lives. It would not have allowed student midwives to care on their own unsupervised. We were left for several hours while I was in labor with just the student midwife before our midwife came to attend. During that time, the student midwife told us that just recently, at that point, she had gone to another birth she attended where the midwife did not show up, and the student midwife did the entire birth on her own. I support this legislation, and I urge you to pass it. [Written testimony was submitted, Exhibit K.]

[Exhibit L, Exhibit M, and Exhibit N are letters of support that were submitted but not discussed and will become part of the record.]

Chair Jauregui:
At this time, we are going to move on to testimony in opposition. Before we go to those on the telephone line, we are going to take one of the testifiers on video.

Allyson Juneau-Butler, Co-Chair, Nevada Midwives Association:
I am a Nevada-based CPM and a licensed midwife, licensed in Arizona. We are in opposition to A.B. 387 as it was posted to the Nevada Electronic Legislative Information System (NELIS). The Nevada Midwives Association (NMA) consists of around 40 midwives across the state, including CPMs, traditional midwives, and community midwives who are deeply committed to providing the highest-quality midwifery services. As a small business owner, I have served families in the Las Vegas and Henderson area, and also from Tonopah to Kingman, Arizona, and Pahrump to Moapa with evidence-based reproductive health care services.

Of approximately 30 midwives serving in southern Nevada, I am the only CPM who has graduated from a MEAC-approved program, and thus, I am the only midwife who currently meets all of the requirements that A.B. 387 wants to put in place for the future since this bill eliminates the primary way CPMs have received their education and board certification in Nevada. This represents a huge access and equity issue for Nevada's midwives who have overwhelmingly accessed workforce training, apprenticeship, and PEP pathways to becoming midwives. Assembly Bill 387 does not negate or alleviate even one of these steep barriers for Nevada midwives since there are no MEAC-accredited midwifery schools in Nevada. Not all individuals are able to afford MEAC tuition or access federal student aid funding; only 5 of the 11 MEAC schools accept federal student funding. Students may not be able to relocate out of state to attend the eight MEAC schools that only provide in-person education; and not everyone is able to access online education due to rural Internet issues or because of lack of good fit to online learning models, as we have seen throughout the COVID-19 pandemic.

Despite my passion for the MEAC pathway to midwifery education, I recognize that these challenges may be even greater barriers for already underrepresented individuals in midwifery in higher education, including Black, Indigenous, and other people of color.

Speaking personally, while I am broadly in support of a pathway to licensure in Nevada for CPMs, and I am extremely proud of my MEAC education, I stand in opposition to A.B. 387 in solidarity with my Nevada Midwives Association colleagues who are experienced traditional midwives and CPMs who went through the NARM PEP process to become national board-certified midwives.

I am someone who significantly values the wonderful relationships that I have with physicians, nurses, hospitals, and other allied health professionals in southern Nevada. I can also speak for my personal experience as an Arizona-licensed midwife that despite regulation, licensure, and parameters meant to enhance midwifery integration into the Arizona health care system, that licensure has not in any way integrated midwives with physicians, hospitals, and allied health professionals who refuse to collaborate with licensed midwives such as myself, despite standardized licensing requirements.

Shifting to the statements from the Nevada Midwives Association, we oppose A.B. 387 as it was posted on NELIS. While NMA has a variety of concerns about A.B. 387, as it relates to

commerce and labor, NMA is primarily concerned that A.B. 387 would cause the elimination of an established workforce through the restraint of trade. Additionally, we are also concerned with the bill's disregard for acceptability in equity in the pathway to licensure and training, along with A.B. 387 requirements that extend outside of licensed CPMs to other direct-entry midwives to meet requirements that they and their clients are not in support of. Restraint of trade is the action that interferes with free competition in the market. Assembly Bill 387 restricts the trade of long-established small businesses operating in the state of Nevada, which includes historically women-owned businesses.

We cannot ignore that historically and currently, midwifery licensure regulation that has made becoming a midwife extremely difficult or prohibited has been a tool of oppression, control, racism, and marginalization. It has been used to disenfranchise already historically marginalized communities from receiving culturally competent and representative midwifery care by and from the midwives of these communities. Our national and state maternal, parental, and newborn mortality and morbidity numbers show the outcomes of this approach. My midwifery colleagues and over 1,100 families they serve have voiced, via NELIS, that this bill will only repeat what has happened in other states historically, which is to increase health care inequities in a variety of sections of the bill and decrease access to midwifery education, especially for midwives who are historically marginalized and underrepresented in health professions, including but not limited to women, Black, Indigenous, other people of color, immigrants, LGBTQIA+ folks, single parents, low-income individuals, rural residents, and others.

To close, we cannot support a bill that will decrease the midwifery labor workforce in Nevada, negatively impact future workforce development, detract from Nevada's historical support of apprenticeship trades, negatively impact primarily women-owned businesses, have negative financial impacts on the economy, and cause the domino effect of restricting the choices of women and birthing people in Nevada. Midwives make a difference in Nevada's parents, babies, and families, and communities are counting on their current and future midwives. We need more midwives, not fewer. [Written testimony was submitted, Exhibit O.]

Chair Jauregui:
I want to see if any members have questions for you. Are there any questions for Ms. Juneau-Butler?

Assemblywoman Dickman:
If licensing and registration are optional, how would this be a conflict for you and to the current system?

Allyson Juneau-Butler:
Currently, we have the majority, except for three midwives in this state, who have become CPMs by going through the PEP process. That represents a historical and current access issue for MEAC education. While there is a pathway or bridge to be licensed for those who have previously done PEP education, what that tells us is that this bill is doing nothing to

close the barriers that prevented those individuals who are going through the MEAC education pathway in the future. This means that our workforce is not going to continue to be replenished. We need more midwives and not fewer. If the vast majority, or over 90 percent, of midwives could become a CPM through the PEP process, then that tells us that there are issues that are way broader than A.B. 387 allows to address. We cannot ignore the future impacts through this bill.

Chair Jauregui:
Are there any other questions? [There were none.]

Justin Watkins, representing Nevada Justice Association:
I would like to start off by commending the bill sponsor and presenters today. I thought it was a very organized and well put together presentation. It was one of the best I have ever seen. I want to support the bill, but it falls short in one major component, and that is the stated goal of accountability. I have had the unfortunate circumstances of representing clients who have had babies die as a result of midwife negligence. The accountability that would be created under this bill currently would result in licensure being revoked or some sort of administrative effort, but that does not fully make good on accountability. There is a second prong, which is to ensure that the person who has been harmed is made whole.

Here, the bill would provide for protection by the medical malpractice economic damages cap, which means if a baby was killed or a mother was harmed as a result of negligence of a licensed midwife, the maximum compensation that anybody could ever receive, other than medical staff, is $350,000.

On the flip side, there is no requirement for any licensure bond or insurance limits. While we do not have anything in statute that requires that of doctors who practice in hospitals, the hospitals themselves are going to require that of any doctor who has administration in the hospital, so insurance coverage is not a problem. In the cases that I have represented my clients, none of the midwives has had any insurance coverage. Therefore, there is limited, if any, ability to make my clients whole financially or otherwise. For those reasons, we oppose this bill.

Marlene Lockard, representing Nevada Association of Professional Midwives:
I am in opposition to this measure reluctantly because the Nevada Association of Professional Midwives has a bill in the Senate, Senate Bill 271, which we feel more comprehensively addresses the goal of licensure of CPMs and accomplishes that without undue burden to some of our most vulnerable rural and minority midwives who would like a path to licensure.

We have offered an amendment to A.B. 387. The last I checked, it was not posted online yet. However, our amendment allows for more educational pathways, which opens the opportunity for licensure among minorities and those from rural Nevada. Applicants must have successful completion of an educational program or pathway accredited by MEAC,

which you have heard a lot about tonight, or successful completion of the Midwifery Bridge Certificate. The NARM has recommended that the PEP process continue to be accepted. We feel that A.B. 387 would prevent current PEP students from getting licensure and prevent those working on the Midwifery Bridge Certificate from obtaining licensure because of the limited time allotment. This requirement is more restrictive and disproportionately prevents those from rural Nevada and minorities from being able to obtain licensure. We are still hopeful.

Chair Jauregui:
We do have to take other callers in opposition, and we are on a time limit. I do have a question for you though. Did you work with the bill sponsor throughout the process, and did the bill sponsor address any concerns through her amendment [Exhibit C]?

Marlene Lockard:
Yes, we have been holding stakeholder meetings all summer long and last fall. Assemblywoman Monroe-Moreno participated in a number of those stakeholder meetings. We have sent our amendment to Assemblywoman Monroe-Moreno, and we had a discussion as late as today about the amendment. We continue to be hopeful that on the narrow issues that I think remain to be resolved that they can be resolved.

Chair Jauregui:
We urge you to continue working with the sponsor. I would like to remind everyone that we have strict Committee rules that require all amendments and exhibits to be in by 12 p.m. the day before the Committee meeting. If you do not make that timeline, your material has the possibility of not making it onto NELIS in time.

Danielle Gallant, Private Citizen, Henderson, Nevada:
I have had two home births: one in California and one in Las Vegas. The California birth was overseen by a MEAC midwife, and the Las Vegas home birth was overseen by a PEP midwife. When my husband and I decided to have a home birth in California, it was partly because as self-employed persons, we could not afford a hospital birth, and living in the San Francisco Bay Area was beyond expensive. We made a decision based on economics. I handled labor better than most, and it was a good experience. We wanted to have the same experience in Nevada with our second child. Both births were amazing, but I will say that my Las Vegas birth was emotionally a more positive and more welcoming experience. My midwife, Sherry Hopkins, doula, husband, and our oldest son welcomed our little one into the world. I cannot explain in tangible terms, but I can tell you that it just felt better.

I am all for licensing for midwifery in the state of Nevada, but this bill only allows one type of education from one organization: MEAC. That is like only allowing certified public accountants, doctors, or attorneys from Harvard. That does not open up options for women but rather drastically limits it. The Midwifery Education Accreditation Council is not available in Nevada and is expensive. It would make midwifery in Nevada only for the elite.

I am interested in a thoughtful inclusive bill to provide licensing that will give Nevadans a safe home birth but also options and accessibility for women who want home births or cannot afford a hospital birth. Allowing other education outside of MEAC will allow for more qualified midwives in Nevada and allow women to have that same experience that I have been lucky to have.

Elissa Wahl, Private Citizen, Las Vegas, Nevada:
I am just a freedom-loving mom with a lot of friends who are midwives and was interested in a home birth myself. The way I see it, you are dealing with philosophical differences. People who see birth have it either medical or natural. You can legislate birth to be more and more medical, but then what happens to the parents who do not hold that same philosophy, parents who see birth as more natural? Fear and anger that you may have seen in emails or heard in testimony is really about the lack of clarity in the intent that there will soon be non-CPM midwives, and not just unlicensed midwives, but non-CPM midwives. Without acknowledging this, there is a very real possibility that the new regulatory board could make regulations, which is their job, about other types of midwives. This will drive midwives, other types of midwives, underground. That community feel that the authors wanted would not happen. There will be more unassisted births and more division. Please be careful not to legislate out a legal option, or to allow this new regulatory board to legislate out legal options.

Jessica Lagor, Private Citizen, Las Vegas, Nevada:
I am a midwife and home birthing mother in Las Vegas. This bill removes my choice of birth attendants because all of my four previous perfectly normal births would be considered illegal under this bill. Ironically, I am currently over 43 weeks pregnant, which makes me taboo to attend under this bill, but I still believe in autonomy. Obstetricians and gynecologists who are responsible for fetal demise continue practicing despite their licensure requirements.

As it stands, Nevada is one of the very few states left with complete freedom of birth choices and parental rights in childbirth. Women and their families travel from surrounding states to have their babies with Nevada midwives, including CPMs, because we are free to support them in their completely autonomous choices. Currently, personal responsibility is still a thing in Nevada, but if you allow this bill to pass, we will not be able to say that anymore. Additionally, the families that I serve do not want to sign informed consent or refusal forms because their choices do not come with fine print.

Assembly Bill 387 makes Nevada no better than the other surrounding tyrannical states which would force these families into choices that are not theirs. They have mentioned that it is still an option to hire an unlicensed midwife. However, there are not many of us who do not desire licensure, and we cannot absorb the volume of women who will not qualify for a birth with the licensed CPMs. The women will choose to have their babies completely alone in order to avoid unnecessary interventions or arbitrary rules they do not agree with, and that is their right.

This bill was written by two midwives. However, the Nevada Midwives Association has tracked down over 40 midwives who are opposed to this bill. As an industry, we do not approve of two people making decisions that affect everybody. There are many reasons for that, which you will find in your email boxes, so please read those. You will also notice that there are over 1,100 votes in opposition to this bill in the poll on NELIS because the families do not consent to this bill.

Assembly Bill 387 removes many currently valid and perfectly acceptable paths to midwifery, including placing restrictions on the time-honored art of apprenticeship. The bill writers and bill sponsors have consistently been closed to communication; they have been stubborn about their wording with quite a few amendments offered; and they are nonresponsive to requests for meetings, including one of the three members of the National Association of Certified Professional Midwives Nevada chapter who was denied access to stakeholder meetings when this bill was being written. [Written testimony was submitted, Exhibit P.]

Chair Jauregui:
We have to move on to the next caller, thank you.

Colleen Ohlandt, Private Citizen, Las Vegas, Nevada:
I am a mother of four children, and all were born in the state of Nevada. I have had two doctor-directed hospital births and two midwife-assisted home births. I am strongly against A.B. 387. This proposed act of establishing a board of licensed CPMs, and included exceptions, provisions, and requirements is burdensome, overreaching, and unnecessary. I believe it will be just the beginning of marginalizing, and one day outlawing, my current freedom to home birth with an unlicensed midwife here in Nevada.

I know that all guarantees, accountability, or better outcomes are only provisions to compensate financially when something goes wrong or breaks. Therefore, I have never held the belief that doctor-directed births are safer or even that a midwife-assisted birth was less harmful. In each choice in birthing options, I made the best informed decision I could for my family, my babies, and myself; fully understanding the best outcomes are not always achieved despite licensure, accredited doctors, or word of mouth unlicensed midwives.

How much financially was it for my family for my midwife-assisted birth? It was less than $5,000 combined, while the burdens placed on my family to have two doctor assisted-births was upwards of $25,000, and these were healthy births. With the regulated license-ensured, doctor-directed births, less time was given to care, and it cost more money and more physical harm done to my body due to protocols required and directed by my doctors. My parenthood began at the age of 34 and ended just shy of my forty-first birthday, thus designating each pregnancy as an at-risk pregnancy.

Finally, my fourth home birth could not have happened in the manner it did in a hospital due to the restrictive protocols. My last child was a child with Down syndrome. I was told by the perinatal expert that my daughter would not live long within my womb, and he was

wrong. She lived until just before a scheduled C-section with that same doctor. Yet, with the help of my midwife, Palm Mortuary, the coroner's office, and other doctors, I was able to have an amazing healthy, an emotionally healthy home birth that deeply elevated our families mourning of our child. I enjoyed the freedom to choose the best option for my family.

Chair Jauregui:
We have to move on to the next caller, thank you.

Jollina Simpson, Private Citizen, Las Vegas, Nevada:
I am also in opposition to A.B. 387. I find that A.B. 387 would cause the elimination of an established workforce through the restraint of trade. This bill may have a disproportionately negative financial impact on rural and BIPOC [Black, Indigenous, and People of Color] midwives, their students, and their communities.

Additionally, I am also concerned about the bill's utter disregard for accessibility and equity in the pathway to licensure and training. Assembly Bill 387 restricts trade of long-established small businesses operating in the state of Nevada, which includes historically women-owned businesses that serve rural and marginalized communities. It would also restrict, and, in some cases eliminate, the midwifery workforce by leaving only one pathway to licensure and eliminating the ability for CPM students to find preceptors in their own communities. This would cause students to incur deep financial losses in pursuit of training.

The lack of diversity, accessibility, and equity in midwifery education has long been documented. This bill perpetuates historical biases and disenfranchisement. Historically, underrepresented and marginalized midwives in states with this particular type of legislation are demonized and pushed out of the marketplace. Assembly Bill 387 would create an environment that eliminates the primary educational pathway of future licensed midwife students who would choose the apprenticeship model to CPM certification.

Over 1,100 Nevada residents have responded to this poll on NELIS in opposition to this bill, and I am unified with them in opposition to A.B. 387 because it does not represent us, and it is not acceptable and equitable.

It is also important to know that I am a midwife of color who has extreme barriers. Those who say it is not a financial barrier, you can get a scholarship, et cetera, have obviously never tried to get into a midwifery school or any school. It is a greater burden for us to try to extend our training and get what we need in a historically marginalizing and racist education system. To say that there are no barriers, or the barriers are minimal, means they have not walked a day in my skin. They have not stepped through the hoops I have had to step through to get the training I needed to get. [Written testimony was submitted, Exhibit Q.]

Chair Jauregui:
Ms. Simpson, we appreciate you calling in and sharing with us. We do need to move on to the next caller.

Rebecca Wells, Private Citizen, Las Vegas, Nevada:
I am a Nevada midwife, and I oppose A.B. 387. I am honored to be given the opportunity to learn the trade of midwifery by the age-old tradition of apprenticeship with two of Nevada's most experienced midwives. They began helping women deliver their babies outside of the medical model and in their own homes in the late 1970s and early 1980s. Between the two of them, they represent approximately 5,000 deliveries over more than four decades. One of them is still helping women have their babies and also opposes this bill. During my apprenticeship, they conscientiously passed their knowledge and experience on to me as we attended births together over the course of approximately three years.

Assembly Bill 387 seeks to eliminate this pathway to midwifery and instead replace it with only one exclusive path. There is only one organization in which to obtain a CPM certificate and requiring one in Nevada to practice midwifery will severely limit those who can assist other women in out-of-hospital deliveries.

There will always be women who wish to deliver their babies outside of the medical model. If the number of midwives is limited, then those women are left with limited choices. Most, if not all of them, will still deliver their babies in their home, but they will do so without any type of trained attendant. We know this because we have been watching the results in other states who license one type of midwife while criminalizing other midwives. If those women have the ability to travel to Nevada for their births, they often do. If they do not, they will go it alone.

If this bill passes as written, it will severely limit trade in Nevada. Please know that this bill was written and supported by only two of Nevada's midwives. The remainder, approximately 40, are opposed to this bill, but many of them are in favor of S.B. 271, which is another bill for licensing midwives. Proponents of this bill claim it will only affect those CPMs who wish to be licensed, but that is patently false. They have written into A.B. 387 the requirement that midwives who wish to remain without a license must have their clients sign a form provided by their board stating that they are unlicensed. Our clients already know this. This is what they are choosing. We do not wish to be governed by their licensure bill, but rather to be left alone to continue doing what women have been doing for each other since the beginning of time. [Written testimony, Exhibit R, and a copy of an email, Exhibit S, were submitted.]

Janelle Johngrass, Private Citizen, Las Vegas, Nevada:
I have four children who were all born in Nevada and all were home births. I never intended to be a home birthing mother. With my first birth, I was going to have a water birth at Summerlin Hospital with Dr. Steven Harter. The day I was in labor, upon arriving at the hospital I was informed that Dr. Harter was not on staff, and the doctor on staff was not comfortable with a water birth, so that would no longer be a delivery option for me. I was then put into a bed. I went from being home where I was able to move my body freely to being stuck in a bed. The fetal monitor kept slipping down my stomach causing the baby's heartrate to go missing, which caused my anxiety to spike. When the doctor came in, they told me they needed to do an ultrasound and see the baby's positioning upon which we

discovered he was breech and said I needed to have an emergency C-section. I asked the doctor to give me a moment so I could process and talk it out. She said, "What is there even to think about? If you do not have a C-section, you will kill your baby." I researched first, and I knew that I had some options to try to get the baby to move. I could walk around or do sitting baby techniques, but they told me no, and I had to stay in a bed.

When my doula arrived, I asked if she knew any other options as I desperately wanted to have a natural birth. I knew that having a C-section would be difficult to heal from, and I wanted to prevent myself from having one. I also knew women who had delivered breech babies naturally. She told me my only option was to hire a midwife. She quickly made phone calls and found one.

I did have the natural birth I wanted, but I just had to do it at home, and I did not kill my baby. The doctor was wrong. My home birth changed my life and empowered me as a woman, mother, and a person. I urge you to vote against this bill. My birth experience would not have happened with a regulated midwife. Assembly Bill 387 would take the choice away from mothers to birth on their terms with whom they choose.

Chair Jauregui:
We will take one more in opposition, and then we will transition over to testimony in neutral. Those who are in opposition and were not able to testify, please send in your written remarks to our committee manager, and she will include them in the record.

Magdalena Alvarez, representing Nevada Friends of Midwives:
Since 2002, Nevada Friends of Midwives has worked to protect parental rights as they pertain to childbirth. We have hundreds of members, and we are strongly opposed to A.B. 387.

I would like to share my personal story. When I was pregnant with my third baby, I lived in Arizona. I had done a lot of research, and I knew what I wanted for my birth. I was under the care of a licensed certified nurse-midwife and using Medicaid. Imagine my disgust and anger when I learned the state board prohibited her from attending me at a birthing center simply because I had a previous C-section. I looked for other options, but home birth midwives in Arizona are also not allowed to do vaginal birth after cesareans. This prohibition was not based on evidence, and I knew it. My choices were to give birth in a hospital or give birth at home alone. Both were out of the question for me, so I moved back to Nevada to give birth. Yes, that is correct, I moved from another state to have the birth I wanted. I gave up my Medicaid coverage despite being an extremely poor person, and I hired an unlicensed midwife after very carefully informing myself in regard to her experience and training.

In weekly support groups, we have heard hundreds of stories similar to mine. The bill author states that parents will still be able to hire whomever they like, but A.B. 387 is missing important intention language. If the intent is to license CPMs, then all other midwives must be completely exempt. They are not carrying drugs, they are not practicing medicine, and

they do not use Medicaid. They do not belong in this bill. Section 15, subsection 2, requires nonlicensed midwives provide a so called "informed consent" form. This requirement implies incorrectly that non-licensed midwives need permission from the state to practice.

Please know that all midwives in Nevada have always been legal and attempts to place them under a board have been rejected again and again. Notably, in 1982, the Attorney General refused to place midwives under the State Board of Health stating that it would restrict trade and be paramount to a licensure scheme. This language is denigrating and marginalizing. It is meant to manipulate public opinion against some midwives. Some of these midwives have been practicing since the 1980s and have delivered thousands of babies. It also implies that the parent is culpable in some way, and they have to answer to someone for their decisions. The agreements that parents and midwives make are intensely personal and private, and such a form is an invasion of privacy.

The parents of Nevada have spoken loud and clear on your opinion poll. They are saying, "My body, my birth, my choice." Nevada Friends of Midwives hope to see this bill dropped completely. [Three documents were submitted, Exhibit T, Exhibit U, and Exhibit V.]

[Exhibit W, Exhibit X, Exhibit Y, Exhibit Z, Exhibit AA, and Exhibit BB, are letters in opposition that were submitted but not discussed and will become part of the record.]

Chair Jauregui:
At this time, we are going to move to testimony in the neutral position. I would like to note for those wishing to testify in the neutral position that testifying in the neutral position means you do not take a position on the bill. You are not in support of it or in opposition of it. You are in a neutral position, meaning you do not have a position on it. If your testimony is indicative of leaning in support or opposition, I will ask you to redirect your comments or terminate them and move on to the next caller. With that, is there anyone wishing to testify in the neutral position?

Erin Lynch, Chief, Medical Programs Unit, Division of Health Care Financing and Policy, Department of Health and Human Services:
I am presenting in neutral on A.B. 387. The Division of Health Care Financing and Policy within the Department of Health and Human Services analyzed the cost of adding CPMs as a covered service by reviewing several studies and the savings to Medicaid programs. Our analysis views the cost-saving methodology in these studies and determined there would be a cost savings. Overall, I am pleased to say that our analysis resulted in a cost savings of about $409,000. The medical savings on that was approximately $461,830, and there are some system costs involved at about $52,000. Overall, we have a cost savings of over $409,000. When you look at the fiscal note for the Division of Health Care Financing and Policy, you will see negative fiscal numbers there, which means it is a cost savings.

Chair Jauregui:
Ms. Lynch, you are testifying on behalf of the Division of Health Care Financing and Policy with the Department of Health and Human Services?

Erin Lynch:
Yes, correct.

Chair Jauregui:
If you would, I would like to check with the Committee members to see if there are any questions for you. Are there any questions for Ms. Lynch? [There were none.] We will move on to the next person in neutral.

Romina Paulucci, Private Citizen, Las Vegas, Nevada:
I am a partera midwife in Las Vegas. I apprenticed here under non-CPMs, one of whom was MEAC-certified. For lifestyle and philosophical reasons, I did not sit for an exam to be judged by other CPMs. I am so thankful I did not because what I feared then is here now: restricting a woman's choice over their own bodies and families. [Written testimony was submitted, Exhibit CC.]

Chair Jauregui:
We are in the neutral category, so we are not taking more testimony for people who are in opposition of the bill at this time. You can email your remarks. Is there anyone else wishing to testify in neutral? [There was no one.] At this time, I would like to call Assemblywoman Monroe-Moreno back to give any closing remarks.

Assemblywoman Monroe-Moreno:
Thank you to those who testified on this piece of legislation. What we heard were a lot of passionate comments. In response to the opposition, a number of the comments were made about the bill as it was introduced. As I said in our opening statement, we, too, were in opposition to some of the items in the bill as introduced. Therefore, those items were discussed and addressed in the amendment [Exhibit C]. As I said in my opening comments, I started having meetings on this bill back in April 2020. [Audio was lost] a number of people who commented in opposition, which are included in the amendment [Exhibit C].

There was also reference to S.B. 271. That is a bill that is being carried by Senator Hammond in the Senate. We, as a group of supporters of A.B. 387, had numerous meetings with the stakeholders of that bill. However, I did go out of my way earlier today and had communications with Senator Hammond about his bill and wondering where it was at in the Senate. I am not in that body, so I am not sure how things are progressing through their house. His comment was that his bill has a number of problems and, therefore, he does not know if he will be able to fix it in time for this legislative session. I do not know where that bill is going.

I would like to thank an organization named Make it Work. It is an organization that works with women's health care issues, especially in our communities of color, which you heard about a number of times from some of the opposition. Make it Work offered to hold community stakeholder meetings to get information for me that I was not able get because we are in a legislative session, and my schedule is a little tight. With those meetings, it opened the conversation to people we had not had conversations with leading into this

legislative session, but also continuing the conversations we have had with a number of midwives to address some of the issues. The last meeting was actually Saturday afternoon and was almost four hours. Ms. Jollina Simpson, who testified in opposition, gave a number of suggestions that are included in the amendment [Exhibit C].

I admit that I did not have a conversation with everyone who was in opposition—some of the people were very threatening in some of their emails and Facebook posts. I felt it was not in the best interest of my time or in the best interest of the state to have a conversation that was not going to be fruitful to come and a mutual conclusion.

There was a lot of information that was shared today. You probably know more about midwives than you ever thought you would want to know. As a mother and a grandmother, my daughter had options. I want moms and families in the state of Nevada to have options. Yes, women have the last voice over what happens to their bodies. No one else can say what happens to a woman's body other than that woman. This bill does not take that option away at all. The only thing it does is give another option for families and mothers. It also gives the state an opportunity to have midwives who choose to become licensed an opportunity to save money on the state side. It in no way interferes with a woman's choice, and the licensure is optional. For Mr. Watkins who called in, those were very good points that we had not thought of, and I would love to talk to you as we continue the conversation to get this bill where it needs to be so we can have a work session on it. I hope to have your support for A.B. 387.

[Exhibit DD was submitted but not discussed and will become part of the record.]

Chair Jauregui:
With that, I will close the hearing on A.B. 387. Our last agenda item for this evening is public comment. Is there anyone wishing to give public comment?

Romina Paulucci, Private Citizen, Las Vegas, Nevada:
I ask everyone here today that they remember a time in their lineage before obstetric care colonized and erased old world tradition. What we were speaking on today does not only affect people who still do not remember or still have not yet returned to more of their traditional, cultural, and natural roots due to deterioration and previous colonization. I think all of us here have had some sort of erasure because we do not recall birth before 200 years ago when doctors and effective care came into being. The women that I serve choose to see me instead of someone else because I speak their language. I also hold birth to be a sacred, rightful ancestral passage, and most likely their obstetrician will not. She may choose to continue to be supported by someone who aligns with her cultural and familial traditions. For this reason, I ask again that you recall your previous lineage before obstetric care. I ask that you remember and speak with your families and see what came before. I also urge you to look to Senate Bill 271, which is a bill whose authors have given time to hear and appropriately rework sections of the bill in response to midwives who align with this kind of birth, women's choice, and familial, traditional, and cultural birth.

Janelle Johngrass, Private Citizen, Las Vegas, Nevada:
I heard a lot of comments tonight about why midwives need to be regulated to protect the women giving birth in the family. I want to say, as a woman who has empowered herself and educated herself on birth, it is not the government's job to do my due diligence on being educated and empowered on birth practices and who is attending me at my birthing. Again, I urge you to vote against this bill.

Chair Jauregui:
Your earlier remarks completely fell within the purview of this Committee, so I allowed them to go on, but if you are speaking to the bill now, I have to stop you because we have closed testimony on the bill.

Camila Santiago, Private Citizen, Las Vegas, Nevada:
I am originally from Brazil, but I am currently a United States citizen and Nevada [unintelligible] since I arrived in 2007. Both of my children were born here and at home with the assistance of a certified professional midwife (CPM). If you do not know, Brazil is known as the country of C-sections. I was only able to achieve that home birth because I was here, and I would benefit from the freedoms that this state has to offer for home birth mothers as well as providers. I have always had a passion for midwifery, and I chose to advance my midwifery study while I was also becoming a mother.

If it was not for the Portfolio Evaluation Process, and the local Nevada preceptors, I would not have the financial means and time to become a CPM when I chose to become one. Because I was an immigrant, my college units were not valid here. [Unintelligible] it would particularly require prerequisites such as English as a second language, English 101, Math 101, plus the midwifery prerequisites in making this process more expensive, more time consuming, and more inaccessible compared to someone who was born here and attended high school and college in the United States. [Unintelligible] training, and the North American Registry of Midwives already requires that type of training for phase one of the PEP process. The Bridge Certificate requires 50 continuing education units from accredited sources such as the Midwifery Education and Accreditation Council, American College of Obstetricians and Gynecologists, American College of Nurse-Midwives, [unintelligible], and the National Perinatal Association.

Chair Jauregui:
Thank you for calling for public comment, but we do have to move on.

Corrine Flatt, Private Citizen, Las Vegas, Nevada:
I was not fast enough to get into a different queue, but I would like to encourage the members of this Committee to please look at the opinion poll that is on the Nevada Electronic Legislative Information System regarding Assembly Bill 387. The parents of Nevada have spoken.

Mary Gilbert, Private Citizen, Sparks, Nevada:
I want to say that Medicaid being able to cover midwives would make a radical difference in our communities. As the director of a nonprofit in Reno, I work with marginalized communities and unsheltered neighbors. Many people currently do not have access to midwifery care because it is not covered under Medicaid. I think that is really important to note. When I gave birth to my son 12 years ago, I paid $15,000 out of pocket because I was not insured. When I paid for my midwife, it cost less than $5,000. There is a radical difference in how much money can be saved with midwifery care.

Kathy Buchanan, Private Citizen, Sun Valley, Nevada:
I am a former medical biller and coder. I believe the Affordable Care Act includes all races and individuals and was taken in great consideration for numerous amounts of dollars to be spent [unintelligible] to be formatted. Licensed midwives would adhere to the scorecard given to other providers by the state of Nevada. I would like your board of Nevadans to decide on Nevada's policies which are in line with Nevada Medicaid, and that is providing more coverage and accountability to a certain set of standards. I thank you for all your time and consideration.

Chair Jauregui:
Is there anyone else wishing to give public comment? [There was no one.] We will see you on Wednesday. Please be on the lookout for the time on the agenda as we will be starting earlier than our normal scheduled start time at 1 p.m.

We are adjourned [at 9:02 p.m.].

RESPECTFULLY SUBMITTED:

_____
Julie Axelson
Committee Secretary

APPROVED BY:

_____
Assemblywoman Sandra Jauregui, Chair

DATE: _____

EXHIBITS

Exhibit A is the Agenda.

Exhibit B is the Attendance Roster.

Exhibit C is a proposed amendment to Assembly Bill 387, submitted and presented by Assemblywoman Danielle Monroe-Moreno, Assembly District No. 1.

Exhibit D is a copy of a PowerPoint presentation titled "Licensure for Certified Professional Midwives," submitted by Tiffany Hoffman, Private Citizen, Reno, Nevada, regarding Assembly Bill 387.

Exhibit E is written testimony submitted and presented by Danielle Yeager, Private Citizen, Las Vegas, Nevada, in support of Assembly Bill 387.

Exhibit F is a copyrighted article published by GateHouse Media titled "The Midwife: She broke the law and kept practicing; then a baby died," dated November 25, 2018, presented by Danielle Yeager, Private Citizen, Las Vegas, Nevada.

Exhibit G is written testimony dated April 5, 2021, submitted and presented by Mary Gilbert, Private Citizen, Sparks, Nevada, in support of Assembly Bill 387.

Exhibit H is written testimony dated April 4, 2021, submitted and presented by Keith Brill, M.D., Private Citizen, Henderson, Nevada, in support of Assembly Bill 387.

Exhibit I is written testimony dated April 5, 2021, submitted and presented by Kendreia Dickens, M.D., Private Citizen, Las Vegas, Nevada, in support of Assembly Bill 387.

Exhibit J is written testimony dated April 4, 2021, submitted and presented by Staci McHale, M.D., Private Citizen, Las Vegas, Nevada, in support of Assembly Bill 387.

Exhibit K is written testimony submitted and presented by Alicia Sowers, Private Citizen, Pahrump, Nevada, in support of Assembly Bill 387.

Exhibit L is a letter submitted by Kelly Aguilera, Private Citizen, Reno, Nevada, in support of Assembly Bill 387.

Exhibit M is a letter dated April 5, 2021, submitted by Emily Campbell, Private Citizen, Reno, Nevada, in support of Assembly Bill 387.

Exhibit N is a letter dated April 6, 2021, submitted by Shawna Kneesel, M.D., Private Citizen, Las Vegas, Nevada, in support of Assembly Bill 387.

Exhibit O is a letter dated April 5, 2021, submitted and presented by Allyson Juneau-Butler, Co-Chair, Nevada Midwives Association, in opposition to Assembly Bill 387.

Exhibit P is written testimony submitted and presented by Jessica Lagor, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 387.

Exhibit Q is written testimony submitted and presented by Jollina Simpson, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 387.

Exhibit R is written testimony submitted and presented by Rebecca Wells, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 387.

Exhibit S is a copy of an email dated April 5, 2021, submitted and presented by Rebecca Wells, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 387.

Exhibit T is a letter submitted by Magdalena Alvarez, representing Nevada Friends of Midwives, in opposition to Assembly Bill 387.

Exhibit U is a document titled, "Explanation of Data from 2020 Nevada Home Birth Poll," submitted by Magdalena Alvarez, representing Nevada Friends of Midwives, regarding Assembly Bill 387.

Exhibit V is a copy of an email dated March 27, 2021, submitted by Magdalena Alvarez, representing Nevada Friends of Midwives, in opposition to Assembly Bill 387.

Exhibit W is a copy of an email dated April 5, 2021, submitted by Jessi Bridges, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 387.

Exhibit X is written testimony submitted by Karen Fullam, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 387.

Exhibit Y is a letter dated April 2, 2021, submitted by Marcie Webb, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 387.

Exhibit Z is a letter submitted by Rachael Skanes Reed, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 387.

Exhibit AA is a copy of an email dated April 5, 2021, submitted by Shannon Anderson, Private Citizen, Nevada, in opposition to Assembly Bill 387.

Exhibit BB is a copy of an email dated April 5, 2021, submitted by Suzan Reed, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 387.

Exhibit CC is written testimony dated April 5, 2021, submitted and presented by Romina sPaulucci, Private Citizen, Las Vegas, Nevada, in opposition to Assembly Bill 387.

Exhibit DD is a document titled, "Planned Home Birth," submitted by Jaron Hildebrand, Executive Director, Nevada State Medical Association, regarding Assembly Bill 387.