My name is Jenda Stauffer, J-E-N-D-A S-T-A-U-F-F-E-R. I am a Certified Nurse Midwife (CNM). I am a past President of the Nebraska State Affiliate of the American College of Nurse-Midwives (ACNM), I am also serving as the CNM member of the Advanced Practice Registered Nurse (APRN) Board. My purpose in speaking to you is to explain the barriers that are imposed on CNM practice by the mandatory practice agreement requirement. It is also my intent to describe how the care of my patients is impacted when circumstances beyond my control may result in the loss of a practice agreement.

Bottom line--it is difficult for a CNM to secure a practice agreement with a physician. A written practice agreement declares that the physician is responsible for the practice of the CNM. When I have approached physicians about a practice agreement they often want to make sure that their attorney reviews the paper work first. I have direct relationships with physicians I can call for a consult or if necessary, they will accept a referral when a patient requires physician care, but they are hesitant to sign a contractual agreement.

It is no surprise that the formal practice agreement requirement thereby limits the number of nurse-
midwives in our state. Midwives must be employed by physicians, clinics or hospitals in order to practice. Few nurses in our state pursue a midwifery career because they see the barriers ahead of them. They see offices with established midwifery practices and little chance for employment and career opportunities. In rural Nebraska communities where there are progressively fewer OB/GYN physicians available, the opportunity for a practice agreement is slim to none.

At the last meeting of the applicant group with the Technical Review Committee, I heard commentary regarding concerns for public safety if CNMs were allowed prescriptive authority without the oversight of a supervising physician. I can tell you that in my 21 years of practice as a CNM, that prescribing practices are not supervised. Every prescription I write is for a medication that I am very familiar with based on my education and certification. These are medications used for the health maintenance of healthy women or treatment of common female problems. I do not manage anti-hypertensive medication, cardiac or diabetes medications. I rarely prescribe even a short course of narcotics. If a APRN-CNM were prescribing outside their scope of practice they would find themselves in front of the
APRN Board and would be accountable for their actions.

CNMs are members of a health care team in all practice settings and work with nurses and physicians, not only for the safety of mothers and babies, but also for the highest degree of satisfaction. CNMs are the experts in normal physiologic birth. We take care of healthy low-risk pregnancies. These are women who infrequently need induction of labor or other labor interventions such as epidurals, which often result in a cascade of other interventions that ultimately does not improve outcomes and can even worsen them. As midwives, we are at the bedside caring for a woman in labor, vigilant in identifying the abnormal and intervening before a crisis. There are sometimes babies that will not come out and a non-urgent cesarean delivery is required. I do not need a written practice agreement to consult with a physician for a cesarean. I can also testify that obstetric emergencies do happen, and an entire OB team is always on the ready to respond, and the team would never consider waiting for my supervising physician to drive across town in that circumstance. We need trusting relationships and good inter-professional communication to provide
seamless transition into the care of a OB/GYN physician should that ever be necessary.

The physician who currently holds my collaborative agreement recently went through an employment transition and I was suddenly confronted with the potential risk of losing this. I would have been unable to practice in the state of NE. CNMs do more than manage labor and birth. I provide healthcare for most of my patients in an office location for contraceptive management, annual wellness exams, and management of common gynecological complaints. I am also a International Board Certified Lactation Consultant (IBCLC), I couldn’t even practice as a IBCLC independently if I lost a practice agreement.

In summary, the requirement of a practice agreement threatens the stability of my practice and the health of hundreds of women I care for. A written practice agreement should not be a requirement for licensure. It is interprofessional collaboration that improves quality of care, increases access to care and reduces costs of care, not formal practice agreements.