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Report of Recommendations and Findings

By the Certified Nurse Midwives Technical Review Committee

To the Nebraska State Board of Health, the Director of the Division of Public Health, Department of Health and Human Services, and the Members of the Health and Human Services Committee of the Legislature

November 13, 2026

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Part One: Preliminary Information

The Credentialing Review Program is a review process advisory to the Legislature designed to assess the need for state regulation of health professionals. The credentialing review statute requires review bodies to assess the need for credentialing proposals by examining whether such proposals are in the public interest.

The law directs those health occupations and professions seeking credentialing or a change in scope of practice to submit an application for review to the Department of Health and Human Services, Division of Public Health. The Director of this Division will then appoint an appropriate technical review committee to review the application and make recommendations regarding whether the application in question should be approved. These recommendations are made in accordance with statutory criteria contained in Section 71-6221 of the Nebraska Revised Statutes. These criteria focus the attention of committee members on public health, safety, and welfare.

The recommendations of technical review committees take the form of written reports that are submitted to the State Board of Health and the Director of the Division, along with any other materials requested by these review bodies. These two review bodies formulate their own independent reports on credentialing proposals. All reports that are generated by the program are submitted to the Legislature to assist state senators in their review of proposed legislation pertinent to the credentialing of health care professions.

List of members of the Nurse Practitioners Technical Review Committee:

- Jacob Sikes (Chair)
- Mark Malesker, PharmD, FCCP, FCCM, FASHP, BCPS
- Tami Dolphens, PA-C
- Kevin Low, DDS
- Judy Neville, CPhT, CSPT
- Brandon Holt, BSRT [R] (CT) (ARRT)
- Stacy Waldron, PhD

Part Two: Summary of Committee Recommendations

The committee members recommended approval of the applicant's proposal by a vote of five in favor with one abstention and one vote against.

Part Three: Summary of the Applicant's Proposal

The applicant's proposal would, if approved, amend Neb. Rev. Stat. §§ 38-604, 38-606, 38-611 and repeal Neb. Rev. Stat. §§ 38-607, 38-609, 38-610, 38-613 in order to grant certified nurse-midwives full practice authority, without a supervisory agreement with a physician, and to allow certified nurse-midwives to attend home births for certain women with low-risk pregnancies. Their proposed legislative changes read as such:

> The proposed legislative changes were developed in collaboration with the Nebraska Medical Association in the 2025-26 legislative session and have been vetted and supported by a coalition of urban and rural healthcare stakeholders. This is the same language as was proposed in AM914 to LB676 in 2025-2026 which was largely supported by senators. This language is based on North Carolina's statute which took effect in 2024. Deleted text is shown with strikethrough; added text is shown with underline. Additional conforming changes to sections that reference these provisions will be required in final legislation.
>
> **Relevant repeals:** 38-607, 38-609, 38-610, 38-613
>
> **Section 38-604 (amended)**
> Approved certified nurse midwifery education program means a certified nurse midwifery education program approved by the board. The board may require such program to be accredited by the ~~American College of Nurse-Midwives~~ Accreditation Commission for Midwifery Education.
>
> **Section 38-606 (amended)**
> Certified nurse midwife means a person certified by a board-approved certifying body and licensed under the Advanced Practice Registered Nurse Practice Act to practice certified nurse midwifery in the State of Nebraska. Nothing in the Certified Nurse Midwifery Practice Act is intended to restrict the practice of physicians, physician assistants, nurse practitioners, or registered nurses in accordance with the Uniform Credentialing Act.
>
> **New Section: Gynecologic and episodic care, defined.**
> Gynecologic and episodic care includes, but is not limited to:
> (1) Routine gynecologic care, family planning, perimenopause care, and postmenopause care;
> (2) Screening for cancer of the breast and reproductive tract;
> (3) Screening for and management of minor infections of the reproductive organs;
> (4) Assessment and treatment of minor, self-limiting conditions, such as urinary tract infections, mild upper respiratory infections, and simple skin infections;
> (5) Provision of pharmacologic treatment in accordance with established clinical guidelines; and
> (6) Screening, counseling, and referral for conditions that require ongoing primary or specialty care.
>
> **New Section: Immediate newborn care, defined.**
> Immediate newborn care means care that focuses on the newborn up to and including seven days after birth, including but not limited to:
> (1) Routine assistance to the newborn to establish respiration and maintain thermal stability;
> (2) Routine physical assessment including Apgar scoring;
> (3) Vitamin K administration;
> (4) Eye prophylaxis for ophthalmia neonatorum;
> (5) Methods to facilitate newborn adaptation to extrauterine life, including stabilization, resuscitation, and emergency management as indicated; and

(6) Collecting and submitting blood specimens in accordance with section 71-519.

New Section: Intrapartum care, defined.
Intrapartum care means care that focuses on the facilitation of the physiologic birth process, including but not limited to:
(1) Confirmation and assessment of labor and its progress;
(2) Identification of normal and deviations from normal and appropriate interventions, including management of complications, abnormal intrapartum events, and emergencies;
(3) Management of spontaneous vaginal birth and appropriate third-stage management, including the use of uterotonics;
(4) Performing amniotomy;
(5) Administering local anesthesia;
(6) Performing episiotomy and repair; and
(7) Repairing lacerations associated with childbirth.

New Section: Low-risk pregnancy, defined.
Low-risk pregnancy means a pregnancy in which all of the following conditions are met:
(1) There is a single fetus;
(2) There is a cephalic presentation at onset of labor;
(3) The gestational age is ≥ 37 weeks and 0 days and ≤ 42 weeks and 0 days at the time of delivery;
(4) The patient has no preexisting disease or condition that adversely affects the pregnancy and that the certified nurse midwife is not qualified to independently address; and
(5) The patient has not previously had a cesarean delivery.

New Section: Postpartum care, defined.
Postpartum care means care that focuses on management strategies and therapeutics to facilitate a healthy puerperium, including but not limited to: (1) management of the normal third stage of labor; (2) administration of uterotonics after delivery of the infant when indicated; and (3) postpartum evaluation examination and initiation of family planning.

New Section: Prenatal care, defined.
Prenatal care means care that focuses on promotion of a healthy pregnancy using management strategies and therapeutics as indicated, including but not limited to:
(1) Obtaining history with ongoing physical assessment of mother and fetus;
(2) Obtaining and assessing the results of routine laboratory tests;
(3) Confirmation and dating of pregnancy; and
(4) Supervising the use of prescription and nonprescription medications, such as prenatal vitamins, folic acid, and iron.

Section 38-611 (amended)
A certified nurse midwife may~~, under the provisions of a practice agreement, (1) attend cases of normal childbirth, (2)~~ provide prenatal care, intrapartum care, ~~and~~ postpartum care, immediate newborn care, and gynecologic and episodic care consistent with the Core Competencies for Basic Midwifery Practice adopted by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board. ~~(3) provide normal obstetrical and gynecological services for women, and (4) provide care for the newborn immediately following birth. The conditions under which a certified nurse midwife is required to refer cases to a collaborating licensed practitioner shall be specified in the practice agreement.~~

New Section: Transition to Practice Authority.
(1)(a) A certified nurse midwife who has completed fewer than two thousand hours of active clinical practice shall enter into a transition-to-practice agreement with a qualified supervising provider. A transition-to-practice agreement shall provide for the delivery of health care through a collaborative practice and shall meet the requirements of this section.
(b) After completing two thousand hours under a transition-to-practice agreement, a certified nurse midwife may apply to the board for authorization to practice independently. Upon authorization, the certified nurse midwife shall be granted full independent practice authority and shall no longer be required to participate in a transition-to-practice agreement.
(2) Upon entering or terminating a transition-to-practice agreement, a certified nurse midwife shall report such information to the department on a form prescribed by the department.
(3) To be eligible to enter into a transition-to-practice agreement as a qualified supervising provider, a person shall be:
(a) A physician licensed in Nebraska with at least four years and eight thousand hours of obstetric or midwifery-related clinical experience; or
(b) A certified nurse midwife who has completed at least six years and twelve thousand hours of clinical practice.
(4) If a transition-to-practice agreement is terminated, the certified nurse midwife shall have ninety days to establish a new agreement and may continue practicing during such ninety-day period.

New Section: Prescribing Authority.
A certified nurse midwife may prescribe therapeutic measures and medications relating to health conditions within the scope of practice for which the certified nurse midwife is credentialed. A certified nurse midwife who is participating in a transition-to-practice agreement may only order or furnish controlled substances included in Schedules II through V of section 28-405 in accordance with policies and protocols established by the qualified supervising provider. Upon being granted full independent practice authority, a certified nurse midwife may independently prescribe controlled substances included in Schedules II through V of section 28-405 within the scope of practice for which the certified nurse midwife is credentialed and consistent with state and federal regulations.

New Section: Planned Out-of-Hospital Birth.
(1) The board shall adopt rules and regulations pursuant to section 38-126 to provide for a certified nurse midwife to attend a planned out-of-hospital birth.
(2) A certified nurse midwife who attends a planned out-of-hospital birth shall discuss with the patient the associated risks and obtain a signed informed consent agreement. The department, with the recommendation of the board, shall develop the contents of the informed consent agreement. The informed consent agreement shall include:
(a) Information about the risks associated with a planned out-of-hospital birth;
(b) A clear assumption of those risks by the patient;
(c) If the out-of-hospital birth services are not covered under a policy of liability insurance, a clear disclosure to that effect; and
(d) An agreement by the patient to consent to transfer to a health care facility when and if deemed necessary by the certified nurse midwife.
(3) A certified nurse midwife who attends a planned out-of-hospital birth shall provide the patient with a detailed, written plan for emergent and nonemergent transfer, including: (a) the name of and distance to the nearest hospital with at least one operating room; (b) the procedures for transfer; and (c) an

affirmation that the relevant health care facility and emergency medical service have been notified of the transfer plan.
(4) A certified nurse midwife shall only attend a planned out-of-hospital birth if the patient is determined to be experiencing a low-risk pregnancy.

New Section: Transfer Liability Protection.
A health care provider or health care facility that accepts a transfer of a client or patient from an out-of-hospital birth shall not be liable for an outcome arising from an action or inaction of the out-of-hospital birth attendant.

The full text of the applicant's proposal can be found under the Nurse Practitioners tab of the Credentialing Review program link at: https://dhhs.ne.gov/licensure/Pages/Credentialing-Review.aspx.

Part Four: Discussion on issues by the Committee Members

Applicant Comments

The applicant group designated Elizabeth Mollard, PhD, CNM, WHNP, IBCLC as the representative responsible for presenting information to and answering questions for the TRC. The applicant group is seeking full practice authority for certified nurse-midwives and permission for nurse-midwives to attend planned, low-risk home births. She presented the following background information regarding the nurse midwife profession.

Certified Nurse Midwives (CNMs):

- Are advanced practice registered nurses (APRNs),
- Complete graduate-level midwifery education,
- Have been a licensed profession in Nebraska since 1984,
- Are nationally certified through AMCB,
- Provide prenatal, birth, postpartum, newborn, gynecologic, and primary care, and
- Already practice in hospitals, clinics, rural communities, and health systems. (Additionally, CNMs can work in birth centers, but Nebraska no longer has any.)

CNM-led care improves the following maternal health outcomes. It results in:

- Fewer cesarean births,
- Fewer instrumental births,
- More spontaneous vaginal births,
- Better prenatal care engagement,
- Fewer preterm births,
- Lower rates of low birth weight,
- Higher breastfeeding rates, and
- Better reported experience of care.

CNMs have extensive experience and education. Every CNM has:

- Completed a bachelor's degree,
- Passed a national licensure examination,
- Practiced as a registered nurse (RN),
- Earned a graduate degree, and
- Passed another national certification examination.

Mollard also presented the following information about maternity care access in Nebraska. She explained that Nebraska has a maternity care access problem and licenses a workforce it is not using. She stated that 54.8% of Nebraska's counties are maternity care deserts. The state ranks 40th for preterm birth rate of 52 states and territories. The maternal death rate is 25.1 maternal deaths per 100,000 births compared to 18.6 nationally. And the state ranks 51st of 51 for midwifery integration. Mollard told the TRC that Nebraska has CNMs that the state is not using because of the regulatory scheme currently in place. Six in ten CNMs are not attending births in the state. Mollard stated this is in part because of inability to find a supervising agreement with a physician.

Mollard explained more about the physician practice agreement currently required for CNMs. She said that the actual document is not doing what it was intended. The average distance between doctors and midwives involved in these agreements is 279 miles, meaning that these physicians are not actually physically close enough to assist with emergency C-sections. Many of these agreements are actually purchased from doctors. This is in part because the strict language of these agreements ties the doctor's license to the CNM's in terms

of liability, meaning that often collaborating physicians don't want to sign them even if they have a good working relationship with a CNM. Additionally, Nebraska is the only state besides Georgia where CNMs are statutorily required to have these agreements. In 36 states and DC, CNMs have full practice authority.

Mollard then explained that there are different types of APRNs that have the same educational standard but are regulated unequally. Some have full practice authority, and some don't. The four types of APRNs are:

- Certified Nurse Practitioners (CNPs),
- Certified Registered Nurse Anesthetists (CRNAs),
- Certified Nurse Midwives (CNMs), and
- Clinical Nurse Specialists (CNSs).

In Nebraska, CRNAs received full practice authority in 2002 and CNPs received full practice authority in 2015. CNMs are still required to have a physician agreement.

Mollard stated that in addition to being a national outlier with regard to requiring CNMs to have a physician supervising agreement, Nebraska is a national outlier in that it is the only state that prohibits CNMs from attending home births. The applicant group is seeking the removal of this prohibition because it does not prevent birth from taking place at home, it simply prevents CNMs from attending.

Mollard presented both of the applicant group's requests compared to the six criteria the TRC is required to vote according to.

Mollard's evaluation of the full practice authority component:

Mollard first explained that according to the proposal, practice authority would be granted after 2,000 transition hours of practice, that the proposed legislation lists the explicit authority of CNMs, and that evidence suggests better safety and outcomes with full practice and authority for CNMs as well as increased access and workforce. Mollard explained how nurse-midwives would still collaborate with physicians under the new proposal. They would consult physicians, co-manage patients with elevated risk, and refer and transfer patients to physicians when appropriate. She explained that in certain situations, the physician supervision agreement can actually prevent collaboration, limiting CNMs' ability to consult several other health professionals

The six components:

- Present scope inadequately addresses public health, safety, or welfare: Supervision ties practice authority to physician availability, not competence.
- The change would benefit public health, safety, or welfare: Increased practice authority creates better outcomes and increases rural access.
- No significant new danger is created: There are no new tasks, patient populations, or settings and no states that have made this change have reversed it.
- Current education and training adequately prepare practitioners: All functions are already taught to CNMs in their current education and training.
- Post-professional programs and competence assessments are available: CNMs are certified and the transition to practice pathway is modeled on an existing structure.
- Adequate measures exist to assess competence and act on it: Licensure, renewal, complaint investigation, discipline, mandatory reporting, hospital credentialing, and NPDB reporting. None would be removed by dissolution of supervising agreement.

Mollard's evaluation of the home birth component of the proposal against the six criteria:

She first explained that home birth is a very uncommon practice, that Nebraska is the only state that makes it a felony for a CNM to attend a home birth, and that no comparable country has banned home birth. She clarified that the applicant group is not making a claim that a home birth with a CNM attending is perfectly safe. It is considered reasonably safe for certain pregnancies.

In Nebraska, home births are not illegal. CNMs are prohibited from attending. Physicians are not prohibited, but most would decline to do so. The prohibition of CNM-attended home birth in Nebraska has not prevented it from occurring. 721 intentional home births were recorded in the 10 years that the prohibition has been in place. This number is possibly underreported because people do try to hide their home births. Mollard stated that the prohibition has only prevented protections for women giving birth at home, not prevented the practice.

For low-risk pregnancies, home birth outcomes are good. There are consistently fewer interventions for mothers and absolute mortality is low. The CNM would have all the materials necessary, including medical equipment and medications, and would have a registered nurse with them. Mollard explained that the people currently attending home births do not have these things with them, are not health care providers, and do not have the proper training.

Certain things can increase the risk of home birth: multiples (twins or triplets), breech at term, preterm birth, and prior cesarean. In the applicant group's proposal, women with these types of pregnancies are not permitted to give birth with a nurse-midwife at home.

The six criteria:

- Present scope inadequately addresses public health, safety, or welfare: The prohibition does not prevent home birth, it prevents the most qualified attendant from being present.
- The change would benefit public health, safety, or welfare: It replaces an unregulated environment with a structured one with eligibility requirements, informed consent, and provider standards. A CNM can also follow a mother into the hospital since they also practice there.
- No significant new danger is created: The change would reduce risk by allowing qualified individuals to attend home births whereas now only unqualified individuals can.
- Current education and training adequately prepare practitioners: Out-of-hospital competencies are core in CNM education.
- Post-professional programs and competence assessments are available: the same infrastructure as the previous component, plus emergency skills maintenance and site-specific readiness requirements
- Adequate measures exist to assess competence and act on it: Board disciplinary authority is not limited by practice setting. The proposed risk stratification, documentation, and reporting requirements give the Board a richer basis for monitoring.

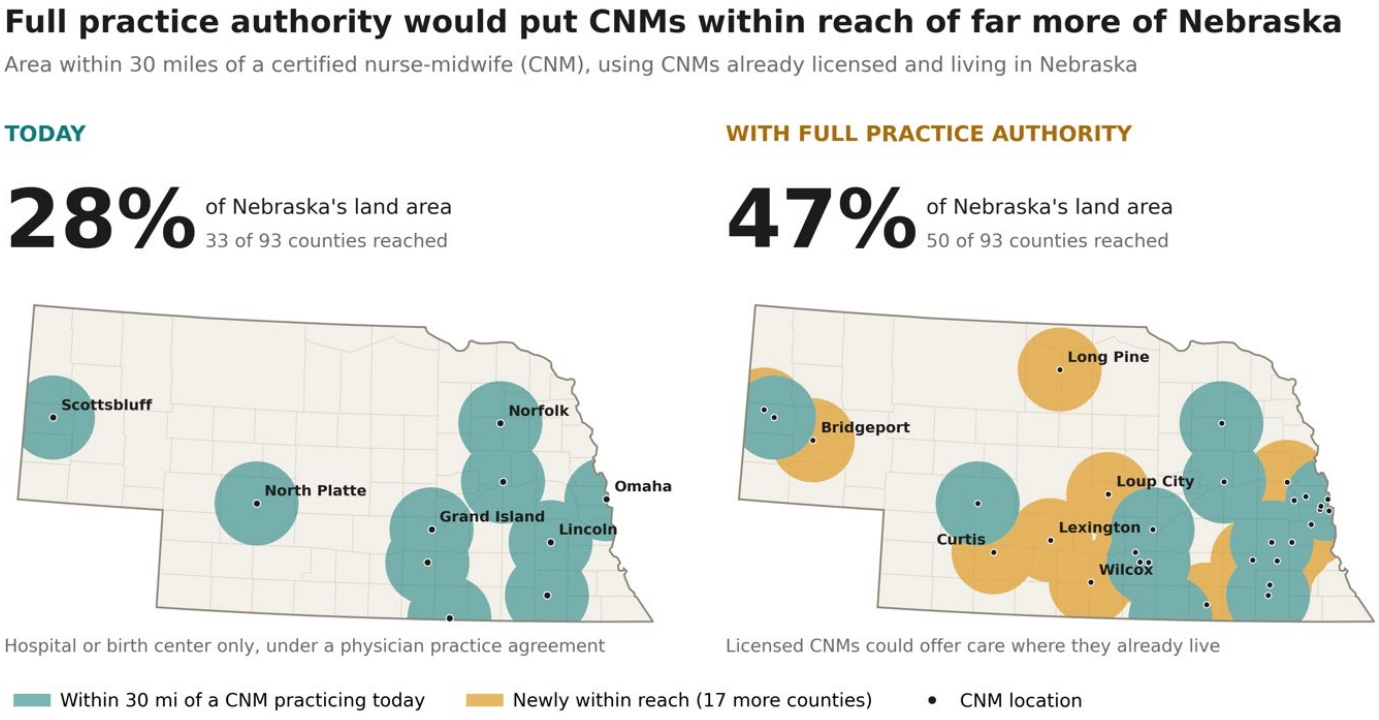
Mollard concluded her presentation as such:

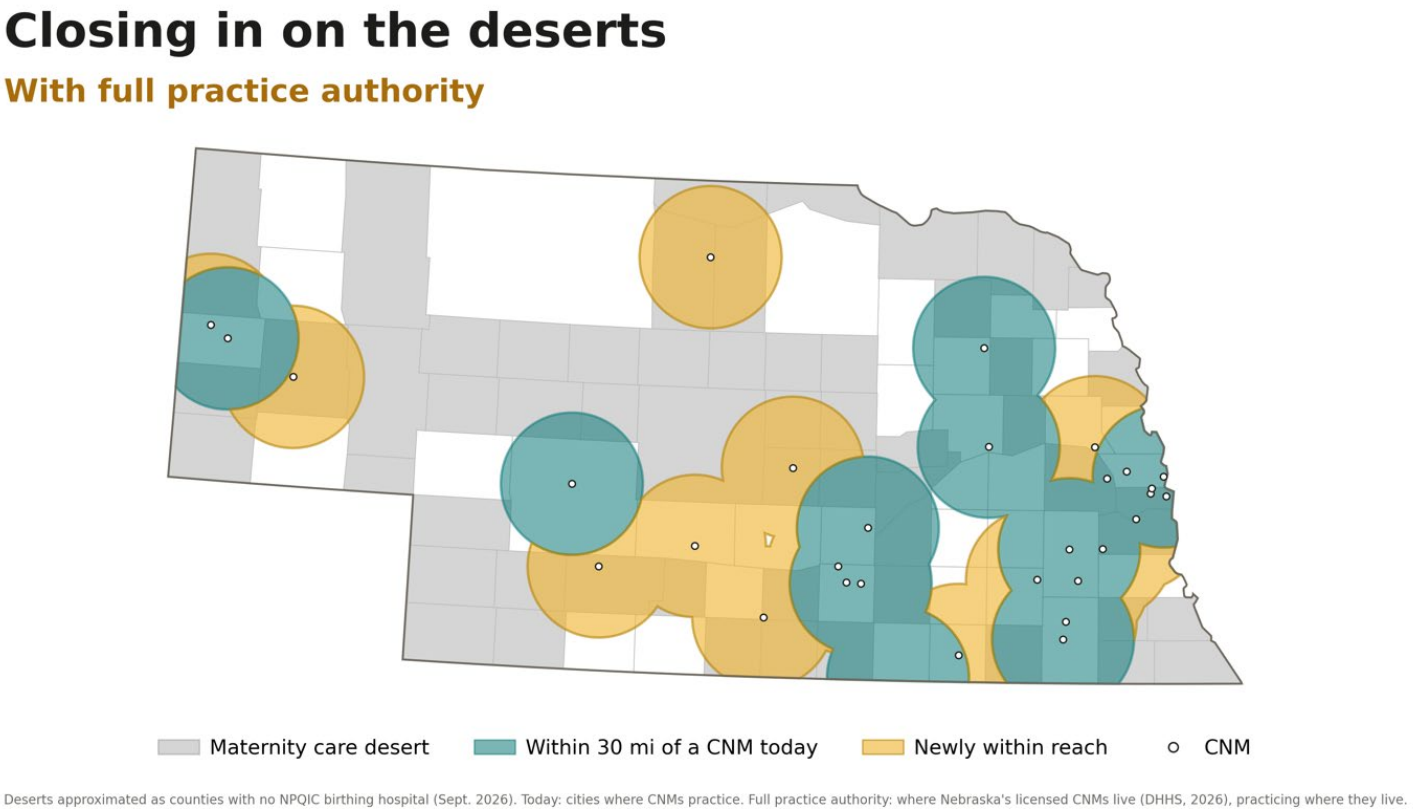
- Nebraska needs more access to educated and qualified maternity clinicians.
- CNMs are educated, nationally certified, licensed, and accountable clinicians.
- Where midwives lead care, outcomes are good.
- The applicant group wishes to align Nebraska's laws on homebirth with the rest of the country and world.
- The applicant group asks the TRC to recommend the proposal.

This application has the written support of 25 different healthcare organizations and providers, including the Nebraska Medical Association.

Questions for the Applicant Group from the Committee

The TRC asked the applicant group to provide maternity care desert data overlaid with data showing the locations of midwives in the state. Mollard presented a map that showed where nurse-midwives live in relation to maternal care deserts. CNMs are largely concentrated in metro areas, but there are also many in rural areas. Currently, CNMs provide care to about 28% of Nebraska's land area. With full practice authority, CNMs could reach up to 47% of Nebraska's land area. These maps are provided below:





The TRC asked what a CNM would be expected to do if they were caring for someone delivering at home in a rural location, far from healthcare resources, that needed to be transferred due to complications in delivery. Mollard answered that just because something becomes legal, that doesn't mean it is a good idea to do it necessarily. She explained that during home delivery, there will always need to be a transfer plan. Extended plans for neonatal stabilization during transfer are not unheard of.

The TRC asked who would determine if a pregnancy was low risk with regard to the proposed home birth provisions. Mollard answered that CNMs would be able to make that determination. She stated that all medical professionals need to follow the standard of care, which typically includes an early trimester ultrasound, another ultrasound at 20-something weeks, monitoring blood pressure and labs, etc. Those tests would be used to determine candidacy for home birth and candidacy could be revoked at any time during the pregnancy if complications developed.

The TRC asked if the applicant group was forced to choose either full practice authority or the removal of the home birth prohibition, which one they would choose. Mollard stated that CNMs strongly desire full practice authority because they want equality with other APRNs. Since their education is the same, it does not make sense that two groups of APRNs have full practice authority and one group does not. She also noted that the one group that doesn't have full practice authority happens to be largely comprised of women and taking care of all female patients. She stated that CNMs want to be able to care for patients, open businesses, and increase access to maternal healthcare. Not as many nurse midwives are interested in doing home births, but there's nowhere else in the entire world that limits its citizens in the same way. If the applicant group had to choose only one, they would like full practice authority. But the consumers that desire home births are very

vocal about it. Currently, Nebraska has an environment where those women are being exploited. She stated that pushing this underground, when we know it's a practice that's continuing to happen, is not being protective of consumers.

The TRC asked why the applicant group foresees an increase in working CNMs as a result of the proposed legislation. Mollard explained that collaborative practice agreements can be incredibly expensive and so can prohibit people from practicing. Some of these agreements can cost up to $1000 per month. Additionally, UNMC may like to start a nurse midwifery program in the future, but not until this change has taken place.

The TRC asked if any CNMs might be opposed to the removal of the collaborative practice agreement because they prefer to be overseen by a physician. Mollard answered that there is not a single one in the state, and she does know every single one. Without the agreements, CNMs will still collaborate with physicians. The agreements are not about facilitating collaboration, they are about supervision.

The TRC brought up Mollard's mention of an RN being present for a midwife-attended home birth in order to administer medications. They asked if an attendant is always present when a CNM attends a home birth. Mollard answered yes, because there are two patients present even before the second one is born. Ideally, a CNM would actually have two other people present. Mollard noted this doesn't really need to be written into law but should probably be part of regulation.

The TRC asked what a CNM would bring to a home birth. Mollard provided a sample checklist, which is available on the Credentialing Review program link at: https://dhhs.ne.gov/licensure/Pages/Credentialing-Review.aspx. She explained that to perform a home birth, midwives bring many different supplies including, but not limited to, medications and IV fluids to stop heavy bleeding after birth, oxygen, masks, resuscitation equipment, advanced life support equipment, IV antibiotics for GBS, mediations for emergencies, routine vitamin K, antibiotic eye ointment, Hepatitis B vaccine, sterile supplies and numbing medicine for laceration repairs, and a transfer plan including hospital and EMS contacts, records, and a handoff form ready before labor. She also explained that people who seem like they need more than standard care are not candidates for home birth.

The TRC asked what demographics of people CNMs typically serve. According to the CDC, CNMs attend more Medicaid births, but otherwise CNMs serve populations at similar rates to non-CNM birthing service providers. CNMs are currently serving a smaller percentage of the rural/non-metro population, but Mollard stated that this is largely due to the restrictions on where nurse-midwives are allowed to practice.

The TRC asked about the overlap of APRN-CNMs and APRN-NPs. Mollard presented a statistic that 19.7% of CNMs in Nebraska are also licensed nurse practitioners. The same clinician can practice independently as an NP, but not as a nurse-midwife.

The TRC asked Mollard what other types of protections she or the applicant group might want to see written into rules and regulations for women having planned births at home. Mollard responded that there are

stipulations in the proposed law regarding which pregnancies can be considered for home birth (ex. no preeclampsia, the baby must be head down, no multiples, no pre-term births). She said that the proposal also requires a transfer plan as well as other safety measures. The proposal also allows rules and regulations to be written in addition to the text of the proposed law. She said that because there are no regulated and licensed providers for home births in Nebraska, there's currently a black market. This will bring homebirth into a regulatory framework and allow the public safe options. She said all these regulations are written to ensure the standard of care.

The TRC asked why the applicant group has written more statutory language than is technically, minimally necessary to achieve their two goals. Mollard explained that the proposal is very in-depth because it was written by collaborating with other healthcare groups who asked for a specific scope of practice to be written into law, because by national standards, this is a restrictive proposal, and because the wider healthcare community also asked for a regulatory framework for births outside the hospital.

The TRC asked what percentage of CNMs are currently practicing in Nebraska. Mollard responded that the last she checked, 117 were licensed, 87 were practicing in the state, and about 47 to 50 of those practicing were providing birth care.

The TRC asked for more detailed information on CNM education. Mollard provided a handout that details this information, which is available on the Credentialing Review program link at: https://dhhs.ne.gov/licensure/Pages/Credentialing-Review.aspx.

Comments from Other Interested Parties
The applicant group had multiple letters of support.

At the public hearing there were eight proponents.

At the public hearing there were no opponents.

At the public hearing there were no neutral testifiers.

The letters of support and transcripts of the eight proponents' testimonies can be found on the Credentialing Review program link at: https://dhhs.ne.gov/licensure/Pages/Credentialing-Review.aspx.

During the September meeting, Amy Reynoldson, executive vice president of the Nebraska Medical Association provided some clarification to the TRC regarding the license CNMs have. She also stated that it had been an honor to work with Mollard, the certified nurse midwives, and the nursing association over the last two years.

She then spoke about Nebraska's problem of unregulated, unlicensed, lay midwives attempting to deliver babies at home with no plan, no consent, no arrangements with EMS, no arrangements with hospitals. She stated that NMA's physician members would like to communicate that a planned pregnancy at home that goes wrong and is taken into a hospital with no birthing capabilities is a nightmare. And that is happening in the

state. She noted there had been another death about ten days prior. There were multiple deaths in the state in the past year.

Reynoldson noted that it is her understanding that 721 home births is a very underreported statistic for the state of Nebraska. There are a lot of home births not being reported and it is an incredibly dangerous practice. She told the TRC that the state needs to regulate home birthing and that we need the absolute safest individuals with the most knowledge working with mothers giving birth at home. Reynoldson then noted that NMA's members have strong concerns about home delivery and had conversations very openly with Mollard and the certified nurse midwives. However, since home birth is going to happen, NMA would rather have an experienced, knowledgeable individual planning the birth, working with EMS, working with hospitals to reduce the burden and ultimately reduce costs on the healthcare system.

Reynoldson stated that she wanted to make certain that folks understand that certified nurse midwives are very important, critical members of the healthcare team. They've been a part of the healthcare team for decades and have been treating patients. NMA supports this application, both seeking independent practice and home birthing. NMA does not believe it is going to be a large percentage of nurse midwives doing home births, specifically because of the medical liability risks associated with it. There are only a couple medical liability insurers that will cover home birth, and neither are credentialed in the state of Nebraska to write insurance for those that want to do home delivery. So, work will have to be done to allow insurance in the state.

During the October meeting, Amy Reynoldson, executive vice president of the Nebraska Medical Association revisited a TRC member's earlier question regarding the applicant group's proposed changes to statute.

The TRC member had asked Mollard if the final statute changes only struck the location prohibition and the requirement for a physician's agreement, and did not add the applicant group's proposed language, how the trajectory of the 407 would change and would all of her goals to maintain patient safety be accomplished. Mollard had responded that all of the additions describe good clinical practice and that these additions don't technically need to be in statute, but their addition does not cause harm, it rather provides a basis for protecting the public if there ever arises a need. Mollard further stated that putting good clinical practice into statute will help maintain safety for the public in the future; it would be good for the people of Nebraska, but also good for the nurse-midwife profession as well.

Reynoldson stated that the NMA is in agreement with Mollard's comments and would likely change their position, and no longer support the application, if the applicant group only recommended the removals of statutory language without the proposed additions. She noted how much thought and deliberation was put into drafting the statutory language to set certified nurse-midwives up for success. She said that the NMA feels the application brought forth does an excellent job of both setting nurse-midwives up for success and protecting patients from potential harm.

Reynoldson also made a comment about the extensive training CNMs go through. She wanted the TRC to understand that people that practice in health systems have a credentialing body that gives them privileges. Those privileges come by way of those credentialing bodies ensuring that the standard of care is safe, appropriate, and followed. Education and licensing are a huge piece of that. She said that many experts have weighed in and agreed that the proposal would not impede the credentialing of CNMs. They have looked for, and not found, any new barriers to credentialing that would come from the new language proposed to be added to statute. Mollard added that the applicant group has been in collaboration with these other health organizations and wishes to maintain those relationships long after statutory changes have passed in order to provide patients with the best quality of care possible.

Reynoldson also said that the statutory language had been worked on for about 15 months to reach its current state. She mentioned the different types of providers that were consulted and their qualifications. She said the proposed language reflects nurse-midwives' true current practice authority in their current role. Logistically, on paper, things would change, but from a practical standpoint, the patients won't see a difference at all. The only difference will be the home birth piece. She stated that the NMA strongly feels the proposal belongs as a whole package.

Additional Information

The applicant group worked with several other healthcare organizations to develop their proposal. They had 25 supporters of their proposed statutory language on record.

The following organizations wrote 2025 coalition letters and letters of support in 2026:

- Nebraska Certified Nurse-Midwives
- Nebraska Medical Association
- Nebraska Nurses Association
- Nebraska Nurse Practitioners
- Nebraska Association of Nurse Anesthetists
- Nebraska Medicine

The following organizations and people wrote 2025 coalition letters only:

- Nebraska Academy of Family Physicians
- Nebraska Chapter, American Academy of Pediatrics
- Nebraska Academy of PAs
- Boys Town National Research Hospital
- Bryan Health
- Community Hospital, McCook
- Jennie M. Melham Memorial Medical Center, Broken Bow
- Nebraska Methodist Health System
- Brady Beecham, MD, CMO, Gothenburg Health
- Mark Davis, MD, CMO, Faith Regional Health Services

The following organizations wrote letters of support in 2026 only:

- Nebraska Section, American College of Obstetricians and Gynecologists
- American College of Nurse-Midwives
- Nebraska AWHONN
- CHI Health
- Nebraska Board of Nursing
- Nebraska Hospital Association
- NNA Clinical Nurse Specialists
- Nebraska Perinatal Quality Improvement Collaborative
- UNMC College of Nursing

All sources used to create Part Four of this report can be found on the Credentialing Review program link at: https://dhhs.ne.gov/licensure/Pages/Credentialing-Review.aspx.

Part Five: Formulation of Recommendations on the Applicant's Proposal

Committee action on the Six Statutory Criteria as they pertain to this proposal.

Criterion one: The health, safety, and welfare of the public are inadequately addressed by the present scope of practice or limitations on the scope of practice.

Mr. Sikes moved that the committee find this criterion met.

Discussion on Criterion #1:

There was no discussion on criterion #1.

Jacob Sikes (Chair)	ABSTAINED
Mark Malesker, PharmD, FCCP, FCCM, FASHP, BCPS	YES
Tami Dolphens, PA-C	YES
Kevin Low, DDS	YES
Judy Neville, CPhT, CSPT	YES
Brandon Holt, BSRT [R] (CT) (ARRT)	YES
Stacy Waldron, PhD voted	YES

Criterion two: Enactment of the proposed change in scope of practice would benefit the health, safety, or welfare of the public.

Mr. Sikes moved that the committee find this criterion met.

Discussion on Criterion #2:

There was no discussion on criterion #2.

Jacob Sikes (Chair)	ABSTAINED
Mark Malesker, PharmD, FCCP, FCCM, FASHP, BCPS	YES
Tami Dolphens, PA-C	YES
Kevin Low, DDS	YES
Judy Neville, CPhT, CSPT	YES
Brandon Holt, BSRT [R] (CT) (ARRT)	YES
Stacy Waldron, PhD voted	YES

Criterion three: The proposed change in scope of practice does not create a significant new danger to the health, safety, or welfare of the public.

Mr. Sikes moved that the committee find that this criterion met.

Discussion on Criterion #3:

There was no discussion on criterion #3.

Jacob Sikes (Chair)	ABSTAINED
Mark Malesker, PharmD, FCCP, FCCM, FASHP, BCPS	YES
Tami Dolphens, PA-C	YES
Kevin Low, DDS	YES
Judy Neville, CPhT, CSPT	YES
Brandon Holt, BSRT [R] (CT) (ARRT)	YES
Stacy Waldron, PhD voted	YES

Criterion four: The current education and training for the health profession adequately prepares practitioners to perform the new skill or service.

Mr. Sikes moved that the committee find this criterion met.

Discussion on Criterion #4:

There was no discussion on criterion #4.

Jacob Sikes (Chair)	ABSTAINED
Mark Malesker, PharmD, FCCP, FCCM, FASHP, BCPS	YES
Tami Dolphens, PA-C	YES
Kevin Low, DDS	YES
Judy Neville, CPhT, CSPT	YES
Brandon Holt, BSRT [R] (CT) (ARRT)	YES
Stacy Waldron, PhD voted	YES

Criterion five: There are appropriate post-professional programs and competence assessment measures available to assure that the practitioner is competent to perform the new skill or service in a safe manner.

Mr. Sikes moved that the committee find this criterion met.

Discussion on Criterion #5:

There was no discussion on criterion #5.

Jacob Sikes (Chair)	ABSTAINED
Mark Malesker, PharmD, FCCP, FCCM, FASHP, BCPS	YES
Tami Dolphens, PA-C	NO
Kevin Low, DDS	YES
Judy Neville, CPhT, CSPT	YES
Brandon Holt, BSRT [R] (CT) (ARRT)	YES
Stacy Waldron, PhD voted	YES

Criterion six: There are adequate measures to assess whether practitioners are competently performing the new skill or service and to take appropriate action if they are not performing competently.

Mr. Sikes moved that the committee find this criterion is met.

Discussion on Criterion #6:

There was no discussion on criterion #6.

Jacob Sikes (Chair)	ABSTAINED
Mark Malesker, PharmD, FCCP, FCCM, FASHP, BCPS	YES
Tami Dolphens, PA-C	NO
Kevin Low, DDS	YES
Judy Neville, CPhT, CSPT	YES
Brandon Holt, BSRT [R] (CT) (ARRT)	YES
Stacy Waldron, PhD voted	YES

Action taken on the proposal as a whole.

Mr. Sikes moved that this Technical Review Committee support the proposal.

Discussion on proposal as a whole:

The TRC was asked to consider adding language to this report detailing Dolphens' suggestions for changes to applicant group's proposed statutory language. Holt made a motion consider the proposal as it is, without noting any proposed changes. The motion was seconded by Neville. Six members voted to leave details of the proposed changes out of the report (Malesker, Low, Neville, Holt, Waldron, Sikes). One member voted to add language to the report noting desired changes (Dolphens). Motion carried.

The Committee members acted the proposal via an up/down roll call vote as follows:

Jacob Sikes (Chair)	ABSTAINED
Mark Malesker, PharmD, FCCP, FCCM, FASHP, BCPS	YES
Tami Dolphens, PA-C	NO
Kevin Low, DDS	YES
Judy Neville, CPhT, CSPT	YES
Brandon Holt, BSRT [R] (CT) (ARRT)	YES
Stacy Waldron, PhD voted	YES

The result of this roll call vote was five committee members voting to support the proposal. This means that the members of the Certified Nurse Midwives Technical Review Committee recommended approval of the Certified Nurse Midwives' proposal.